

SUA Illinois Claim Kit



Resource List	IL07	06/08
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PACKET INFORMATION & RESPONSIBILITIES ILLINOIS

The following information is designed to assist with timely and accurate reporting, as well as for education on state forms and responsibilities within the claim process. Included in this packet is the following:

- How to file a work related injury or occupational disease (repetitive trauma) claim.
- State forms as well as an explanation for completion and how to process:
 - First Report of Injury-Form 45
 - Medical Authorization
 - First Script Prescription Program
 - Job Analysis
 - Application for Adjustment of Claim
 - Notice of Motion and Request for Hearing
 - Supervisor's Incident Report
 - Wage Statement
 - Attending Physicians Work Recommendation
 - Return to Work Log
 - Notice of Hearing
 - Petition for Immediate Hearing under Sect 19(b)
- Responsibilities of each party involved in the claim. The information contained will assist you in understanding what each party's responsibilities include from the injured employee, client employer, PEO and insurance carrier.
- Coventry/First Script temporary prescription services ID information. This document should be provided to your injured employee at the time they report an injury and are seeking medical attention. The information contained will give pharmacists the information necessary to file the claim form with SUA and should prevent the injured employee from having to pay for the prescriptions related to the work injury. Once the claim is filed with SUA a prescription drug card will be issued to the injured worker for additional prescribed medication.
- Resources and contact information. Included in this information you will find useful internet links for state forms, Coventry Provider Network Information and key contact information for SUA, including names, department and telephone and fax numbers for staff members assigned to your account.
- Posting Notice. The law requires every employer to post and maintain in a conspicuous place or places in and about the worksite, a notice stating the employer secured workers' compensation insurance coverage.

Thank you for choosing SUA Insurance Company

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HOW TO FILE A WORK INJURY OR OCCUPATIONAL DISEASE (REPETITIVE TRAUMA) CLAIM

Workers' compensation claims can be reported in several different ways, you can:

- Complete and submit the Employer's First Report of Injury (Form 45) via the online reporting system available at www.suainsurance.com. Email the completed form to claimsintake@suainsurance.com. **This is the preferred method of reporting an injury.**
- Complete the Employer's First Report of Injury (Form 45) and fax to SUA at 877-782-3292.
- Complete and mail the Employer's First Report of Injury (Form 45) to:

SUA Insurance Company
Attn: Claims Dept.
222 South Riverside Plaza, Suite 1600
Chicago, IL 60606-6001

- Call the SUA Claims office at 877-782-3291. **Please refer to the Telephone Reporting Guide for assistance.**
- By contacting your broker directly and providing the appropriate first report information.
- For injuries occurring after normal business hours, please call 877-782-2112. The after hours telephone number for reporting claims provides the opportunity to report a claim 24 hours a day 7 days a week. Loss details will be gathered to determine if an emergency exists and if an immediate field contact is indicated.

An explanation of how to complete each form is included in this packet. Also included are commonly used forms and notices and an explanation of each form's function.



TELEPHONE REPORTING GUIDE

Employer Information

Employer Name _____
Address _____
Telephone Number _____
Federal Employer Identification Number (FEIN) _____
Payroll Classification Code _____

Employee Information

Name _____
Address _____
Social Security Number _____
Telephone Number _____
Marital Status _____
Number of Children under 18 years _____
Date of Birth _____
Occupation when injured _____
Hours worked per day _____
Average weekly wage _____

Time and Place of Injury

Location of work site where injury occurred _____
Date of Injury _____
Date Disability Began _____
When did you or the Supervisor first know about the injury _____
Name of Supervisor _____
Telephone Number _____

Cause of Injury

Machine or Equipment that Caused the injury? _____
Was safety appliance provided and in use? _____
Was injury due to failure to use a safety device? _____
Describe how the injury occurred? _____

Nature of Injury

Body Part(s) injured _____
Has the employee died _____
Probable length of disability _____
Date of return to work _____
Doctor's name, address and phone number _____

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STATE FORMS ILLINOIS

- ***Illinois Form 45: Employers First Report of Injury*** – This form is to be completed when an employee reports an injury or occupational disease (repetitive trauma) injury. Please complete the form with as much available information as possible. This will assist in the prompt and accurate claims set up. A sample form is attached noting mandatory fields.
- ***Wage Statement*** – This form should be completed if the injured employee will miss more than 3 scheduled days of employment. Illinois requires that the average weekly wage calculation be computed on the 52 weeks **prior to the date of injury**.
- ***Medical Authorization*** – This form requires the signature of the injured employee and is supplied to medical facilities for medical records related to the work injury. This information is required in order to determine eligibility of workers' compensation benefits.
- ***Application for Adjustment of Claim*** – This form is generally filed by an attorney representing the injured employee; however the injured employee can file this form without attorney representation. **Should you receive the Application for Adjustment of Claim, please contact your Claims Adjuster immediately.** The form is notice that additional litigation will be imminent.
- ***Notice of Motion and Order*** – This form can be filed by the injured employee's attorney or defense counsel. This form signifies that the filing party will appear before the Arbitrator. The Notice of Motion and Order must be 15 days prior to the next status date that the specific claim will appear on the Arbitrator's call. This is generally every 60 days from the first date listed on the Notice of Hearing that is generated by the Illinois Workers' Compensation Commission. **Should you receive the Notice of Motion and Order, please contact your Claims Adjuster immediately.**
- ***Request for Hearing*** – The Request for Hearing will accompany the Notice of Motion and Order and will set forth the issues of dispute. There are a number of reasons for a Request for Hearing to be filed and an appearance before an Arbitrator. The most common reasons included non-payment medical bills, and medical treatment that is not authorized, non-payment of temporary total or temporary partial benefits as well as disputes over the extent of disability. **Should you receive the Request for Hearing, please contact your Claims Adjuster immediately.**
- ***Petition for an Immediate Hearing under Section 19(b)*** - This form is filed by the injured employee's attorney in conjunction with the Notice of Motion and Order and can **only** be filed if medical treatment and/or lost time benefits are not being paid by the insured and or insurer. This form also is to be filed 15 days prior to the next Arbitrator status. The distinction between the Request for Hearing and the Petition for Immediate Hearing is that with the Petition for Immediate Hearing is it not necessary that the claim be listed on that months status call. **Should you receive the Petition for Immediate Hearing under Section 19(b) please contact your Claims Adjuster immediately**
- ***Notice of Hearing*** – This form is generated by the Illinois Workers' Compensation Commission in confirmation of the filing of an Application for Adjustment of Claim. This form will denote the first date that the case will appear on the Arbitrator's call as well as where the case will be heard. The jurisdiction will vary depending on the location of the injury. **Please contact your Claims Adjuster for additional information.**

Except for the Wage Statement, Medical Authorization and the Notice of Hearing, these forms are available at the State of Illinois Workers Compensation Commission's web site www.iwcc.il.gov and can be printed and downloaded for your use. If you have any additional questions please contact your Claims Adjuster at 877-782-2103.

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ILLINOIS FIRST REPORT OF INJURY FORMS PACKET

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY – EXAMPLE

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY – ENGLISH

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY – SPANISH

ILLINOIS WORKPLACE NOTICE – ENGLISH/SPANISH

ILLINOIS WORKERS' COMPENSATION COMMISSION APPLICATION FOR ADJUSTMENT OF CLAIM

ILLINOIS WORKERS' COMPENSATION COMMISSION NOTICE OF MOTION AND ORDER

ILLINOIS WORKERS' COMPENSATION COMMISSION REQUEST FOR HEARING

ILLINOIS WORKERS' COMPENSATION COMMISSION PETITION FOR AN IMMEDIATE
HEARING UNDER SECTION 19(B) OF THE ACT

SUPERVISOR'S INCIDENT REPORT

MEDICAL AUTHORIZATION

WAGE STATEMENT

ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

JOB ANALYSIS

RETURN TO WORK LOG

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ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? Yes/ No
Employer's name		Doing business as	
Employer's mailing address			
Nature of business or service		SIC code	
Name of workers' compensation carrier/admin.	Policy/Contract #	Self-insured? Yes / No	
Employee's full name	Social Security #	Birthdate	
Employee's mailing address		Employee's e-mail address	
Male / Female	Married/ Single	# Dependents	Employee's average weekly wage
Job title or occupation		Date hired	
Time employee began work AM PM	Date and time of accident	Last day employee worked	
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? Yes / No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? Yes / No	Was the employee hospitalized overnight as an inpatient? Yes / No		
Report prepared by	Signature	Title and telephone #	

Please send this form to the ILLINOIS WORKERS' COMPENSATION COMMISSION 701 S. SECOND STREET SPRINGFIELD, IL 62704. IC45 12/04
 By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any sense. This information is confidential.

FORMULARIO 45 ILLINOIS: PRIMER REPORTE DE LA LESION DE UN EMPLEADO escriba en letra de molde

FEIN del empleador		Fecha del reporte		Archivo numero		Indique si este es un caso de pérdida de un día laboral Si / No	
Nombre del empleador				Nombre del negocio			
Dirección postal							
Índole del negocio o servicio						Código SIC	
Nombre del encargado de la indemnización del trabajador West Bend Mutual Insurance Company Fax: 262-334-6378			# de póliza/contrato		Asegurado por su propia cuenta Si / No		
Nombre completo del empleado				# de seguro social		Fecha de nacimiento	
Dirección postal del empleado						Correo electrónico del empleado	
Género Masculino / Femenino		Soltero/a / Casado/a		# de dependientes		Salario semanal promedio del empleado	
Ocupación						Fecha en que lo/la contrataron	
Hora en que el empleado/a iniciaba sus labores AM PM			Fecha y hora del accidente			Ultima fecha en que trabajó el empleado	
Si el empleado/ murió en el accidente, especifique la fecha de muerte				¿Ocurrió el accidente en las en el negocio del patrón? Si / No			
Dirección en donde ocurrió el accidente							
¿Qué hacia el empleado cuando ocurrió el accidente?							
¿Cuál fue el accidente o enfermedad? Indique la parte del cuerpo que fue afectada y como fue afectada.							
¿Qué objeto o sustancia , si la hay, perjudicó al empleado?							
Nombre y dirección del doctor o lugar de servicios médicos							
Si le suministraron servicios médicos al empleado fuera del lugar de trabajo, indique el nombre y la dirección del lugar							
¿Trataron al empleado en una sala de emergencia? Si / No				¿Hospitalizaron al empleado por la noche? Si / No			
Persona que preparó este reporte			Firma			Ocupación y numero de teléfono	

Envíe este formulario a ILLINOIS WORKERS' COMPENSATION COMMISSION 701 S. SECOND STREET SPRINGFIELD, IL 62704. IC45 12/04

Por ley, los empleados deben de guardar record de todas las lesiones y enfermedades relacionadas con el trabajo (excepto por lesiones menores). El patrón debe de reportar a la Comisión todas las lesiones que resulten en la pérdida de tres o mas días de trabajo. Llenar este formulario no le afecta ni lo compromete bajo el Decreto de Workers' compensation. Esta información es confidencial.



WORKERS' COMPENSATION

is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU SUFFER FROM A WORK-RELATED INJURY OR ILLNESS, YOU SHOULD TAKE THE FOLLOWING STEPS:

- 1. GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. The employee may choose two physicians, surgeons, or hospitals. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits.
- 2. NOTIFY YOUR EMPLOYER.** You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.
- 3. LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.

- 4. KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033 Chicago: 312/814-6611 Peoria: 309/671-3019 Springfield: 217/785-7087
 Web site: www.iwcc.il.gov Collinsville: 618/346-3450 Rockford: 815/987-7292 TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.

Party handling workers' compensation claims			
Business address			
Business phone			
Effective date		Termination date	
Policy number		Employer's FEIN	

COMPENSACION A LOS TRABAJADORES



es un sistema de beneficios que por ley se provee a la mayoría de trabajadores que se han enfermado o accidentado en el trabajo. Los beneficios son pagados por lesiones que son causadas en parte o completamente por el trabajo del trabajador. Esto puede incluir el agravante o una condición pre-existente, lesiones causadas por uso repetitivo de una parte del cuerpo, ataques cardíacos, o cualquier otro problema físico causado por el trabajo. Los beneficios son pagados sin importar la causa.

SI USTED SUFRE DE UNA LESION O ENFERMEDAD RELACIONADA AL TRABAJO, USTED DEBE TOMAR LAS SIGUIENTES MEDIDAS:

- 1. OBTENGA AYUDA MEDICA.** Por ley, su empleador debe pagar por todos los servicios médicos necesarios que se requieran para aliviar los síntomas de lesión o enfermedad. El trabajador puede escoger dos doctores, cirujanos u Hospitales. Si es necesario, el empleador debe pagar por rehabilitación física, mental o profesional dentro de los límites establecidos.
- 2. NOTIFIQUE A SU EMPLEADOR.** Usted debe notificar a su empleador del accidente o enfermedad dentro de 45 días, ya sea por escrito o verbalmente. Para evitar posibles demoras, es recomendable que la nota incluya su nombre, dirección, número telefónico, número de Seguro Social, y una breve descripción de la lesión o enfermedad.
- 3. CONOZCA SUS DERECHOS.** Su empleador por ley debe reportar accidentes que resulten en más de tres días de ausencia al trabajo, a la Comisión de Compensación para Trabajadores. Una vez que el accidente es reportado, usted recibirá un manual que explica la ley, beneficios y procedimientos. Si necesita un manual, por favor llame a la Comisión o visite nuestra red.

Si usted tiene que faltar al trabajo para recuperarse de la lesión o enfermedad, usted tiene derecho a recibir pagos semanales y atención médica necesaria hasta que este capacitado para regresar a trabajar y que el trabajo este de acuerdo a sus capacidades.

Es contra la ley que el empleador moleste, despida o se niegue a reemplazar o de alguna manera discrimine contra un trabajador por ejercitar sus derechos de conformidad con las leyes que rigen el seguro de accidentes de trabajo de enfermedades profesionales. Si usted hace una demanda fraudulenta, podrá ser castigado por la ley.

- 4. MANTENGASE DENTRO DEL LIMITE DE TIEMPO.** Usualmente, las quejas deben ser presentadas dentro de los primeros tres años del accidente o incapacidad de una enfermedad profesional, o dentro de dos años del último pago de compensación de trabajo, lo que sea más reciente. Quejas por neumoconiosis, exposición radiológica, asbestos, o enfermedades similares tienen requerimientos especiales.

Los trabajadores accidentados tienen derecho para volver a abrir su caso dentro de 30 meses después que la Comisión haya otorgado una decisión y la incapacidad haya incrementado, pero en casos resueltos por una suma global aprobada por la Comisión no pueden volver a abrirse. Únicamente las decisiones aprobadas por la Comisión son obligatorias.

Para mas información, visite la Red de la Comisión de Compensación para Trabajadores o llame a nuestras oficinas:

Toll-free: 866/352-3033 Chicago: 312/814-6611 Peoria: 309/671-3019 Springfield: 217/785-7087
Web site: www.iwcc.il.gov Collinsville: 618/346-3450 Rockford: 815/987-7292 TDD (Sordo): 312/814-2959

LOS EMPLEADORES DEBEN EXHIBIR ESTE AVISO EN UN LUGAR VISIBLE PARA TODOS LOS TRABAJADORES Y LLENAR LA INFORMACIÓN REFERENTE A LA COMPAÑIA DE SEGUROS.

Nombre:			
Dirección de la Compañía:			
Teléfono de la Compañía:			
Fecha efectiva:		Fecha de terminación:	
Número de Póliza:		FEIN del Empleador:	

ILLINOIS WORKERS' COMPENSATION COMMISSION
APPLICATION FOR ADJUSTMENT OF CLAIM (APPLICATION FOR BENEFITS)

ATTENTION. Please type or print. Answer all questions. File three copies of this form.

Workers' Compensation Act Occupational Diseases Act Fatal case? No Yes Date of death _____

Employee/Petitioner
v.

Case #
(Office use only)

Employer/Respondent

Location of accident
or last exposure _____
City, State _____

Injured employee's name ⁱ _____
Street address, City, State, Zip code

Employer's name _____
Street address, City, State, Zip code

Employee information: Social Security # _____ Male Female Married Single

Dependents under age 18 _____ Birthdate _____ Average weekly wage \$ _____

Date of accident ⁱⁱ _____ The employer was notified of the accident orally in writing .

How did the accident occur? _____

What part of the body was affected? _____

What is the nature of the injury? _____ Return-to-work date ⁱⁱⁱ _____

Is a *Petition for an Immediate Hearing* attached? Yes No

Is the injured employee currently receiving temporary total disability benefits? Yes No

If a prior application was ever filed for this employee, list the case number and its status _____

ATTENTION, PETITIONER. This is a legal document. Be sure all blanks are completed correctly and you understand the statements before you sign this. Refer to the Commission's *Handbook on Workers' Compensation and Occupational Diseases* ^{iv} for more information.

Signature of petitioner

Date

APPEARANCE OF PETITIONER'S ATTORNEY
Please attach a copy of the *Attorney Representation Agreement*.

Signature of attorney

Street address

Attorney's name and IC code # ^v (please print)

City, State, Zip code

Firm name

Telephone number

E-mail address

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.
If you prefer, you may submit the front of this application form with the *Proof of Service* on a separate page.

I, _____, affirm that I delivered mailed with proper postage
in the city of _____ a copy of this form
at _____ AM on _____ to the respondent listed on this application and to each
additional party, if any, at the address listed below.

Signature of person completing *Proof of Service*

Signed and sworn to before me on _____

Notary Public

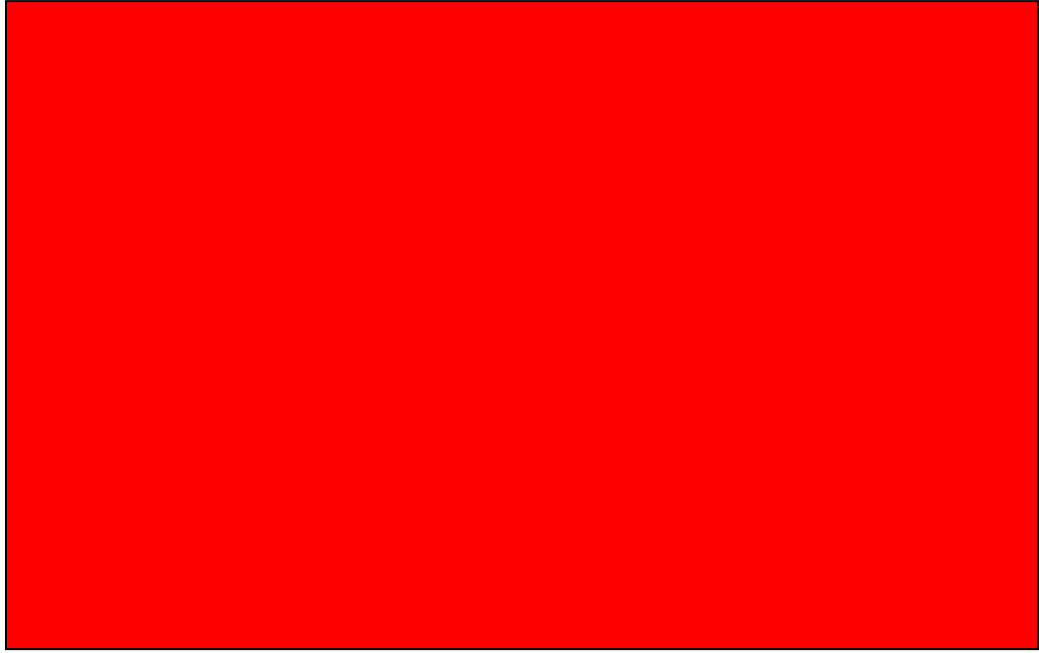
ⁱ In most cases, the injured employee files this application and is referred to as the petitioner. If the injury was fatal, or if the worker is a minor or incapacitated, another person (as allowed by law) may file. In those cases, the person filing the application is the petitioner, and the worker is referred to as the injured employee. Please complete information related to age, etc., for the injured employee.

ⁱⁱ This may be the date of the accident, last exposure, disability, or death.

ⁱⁱⁱ If the employee has not returned to work, leave this space blank.

^{iv} The Commission publishes a handbook that explains the workers' compensation system. If you would like a copy, please call any Commission office.

^v The Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.





SUPERVISOR'S INCIDENT REPORT

 Injury(work related)

 Incident

 Illness (work related)

Employee Name (First, MI, Last)			Social Security Number			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			Home Telephone Number		
Employee's Street Address						City			State		Zip Code
Age	Birth date		Job Title			Department					
	Mo	Day	Yr								
Employee's Scheduled Work Week When Injured		Start time	End time	Hrs Per Day	Hrs Per Wk	Days Per Wk	Normal Full-Time Schedule for Injured's Work	Start Time	End Time		
Injury date		Hour of Day		Last Day Worked			Last Day Worked			<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return	
Mo	Day	Yr		Mo	Day	Yr	Mo	Day	Yr		

Did employee seek medical attention? Yes No

If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will employee complete a drug screening? Yes No

Name of Witnesses Names (Attach statements if available)

1. _____

2. _____

Injured employee's statement of what happened. (Identify circumstances and equipment involved)

How could this incident been prevented?

What corrective action has been taken?

Part of Body Affected							
<input type="checkbox"/> Eye	<input type="checkbox"/> Hip	<input type="checkbox"/> Head	<input type="checkbox"/> Foot	<input type="checkbox"/> Neck	<input type="checkbox"/> Wrist	<input type="checkbox"/> Back	<input type="checkbox"/> Hand
<input type="checkbox"/> Arm	<input type="checkbox"/> Toes	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Ankle	<input type="checkbox"/> Fingers	<input type="checkbox"/> Elbow	<input type="checkbox"/> Leg	<input type="checkbox"/> Other
Type of Injury							
<input type="checkbox"/> Cut/Abrasion	<input type="checkbox"/> Bruise/Contusion	<input type="checkbox"/> Foreign Object	<input type="checkbox"/> Burn	<input type="checkbox"/> Break	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Exposure	
<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Other						

Comments _____

Supervisor Signature _____

Date _____

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WORKERS COMPENSATION INJURY MEDICAL AUTHORIZATION

Authorization for Medical Records And Communication Release

By this form or copy thereof, I _____, hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other related medical or medically related facility, insurance company or other organization, institution, or person, that has any records or knowledge of my mental, physical health, history, condition or well being, to supply such information to my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment and as to any other issues including but not limited to diagnosis, prognosis, causal connection of care and treatment to my work injury or duties and ability to work. In conjunction with this, I authorize any treating physician or medical provider to review any additional medical records provided to them.

I understand that by signing this authorization for medical records and communication release that my applicable medical provider will be releasing information subject to the HIPPA restrictions. I specifically waive any rights or protections that I may have under the HIPPA regulation and request that the medical providers release the requested information.

A photo copy of this authorization shall be valid as the original. This release shall remain valid for the length of my claim.

Name (Please Print)

Address (Street, City/Town, Zip Code)

Signature

Date Signed

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WAGE STATEMENT

Employer: _____

Employee: _____

Please provide the **52 weeks** of wages prior to the date of injury of _____

Date employee ceased to work: _____ Date Hired _____

Number of Hours employee is scheduled to work per week: _____ Claim Number _____

Is employee paid by hour, day, week or month _____ At what rate: _____

Does employee work Overtime Yes No If yes, is Overtime mandatory Yes No

State the date and amount of any pay increases during the past 52 weeks

Date _____ Amount _____ Date _____ Amount _____

Date _____ Amount _____ Date _____ Amount _____

	Dates Incl of each Week Pd			Hrs Wkd	Regular Pay		Overtime Pay			Dates Incl of each Week Pd			Hrs Wkd	Regular Pay		Overtime Pay	
	From	To	Yr							From	To	Yr					
1									27								
2									28								
3									29								
4									30								
5									31								
6									32								
7									33								
8									34								
9									35								
10									36								
11									37								
12									38								
13									39								
14									40								
15									41								
16									42								
17									43								
18									44								
19									45								
20									46								
21									47								
22									48								
23									49								
24									50								
25									51								
26									52								
SUBTOTAL										SUBTOTAL							
										GRAND TOTAL							

This is a correct statement of Employee's earnings as actually taken from Payroll Records

Employer's Signature _____ Title _____ Date _____



ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

Claim No																											
Patients Name (First)	(Middle Initial)	(Last Name)	Date of Injury/Illness																								
TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK																											
Diagnosis/Condition (Brief Explanation)																											
I saw the and treated this patient on _____ and based on the above description of the patient's current medical problem:																											
1) <input type="checkbox"/> Recommend his/her return to work with no limitations on _____																											
2) <input type="checkbox"/> He/She may return to work on _____ capable of performing the degree of work checked below with the following restrictions:																											
<input type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as docket, ledgers and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met	1. In an 8 hour day patient may: a) Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 1-4 hours <input type="checkbox"/> 4-6 hours <input type="checkbox"/> 6-8 hours b) Sit <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours c) Drive <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours																										
<input type="checkbox"/> Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls	2. Patient may use hand(s) for repetitive: <input type="checkbox"/> Single Grasping <input type="checkbox"/> Pushing & Pulling <input type="checkbox"/> Fine Manipulation																										
<input type="checkbox"/> Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.	3. Patient may use foot/feet for repetitive movement as in operating foot controls <input type="checkbox"/> Yes <input type="checkbox"/> No																										
<input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.	4. Patient is able to: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Frequently</th> <th style="text-align: center;">Occasionally</th> <th style="text-align: center;">Not at All</th> </tr> </thead> <tbody> <tr> <td>Bend</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Squat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Climb</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Twist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Reach</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>				Frequently	Occasionally	Not at All	Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
<input type="checkbox"/> Medium Heavy Work. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds																											
<input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds																											
Other Instructions and/or Limitations Including Prescribed Medications:																											
The restrictions are in effect until _____ or until patient is reevaluated on _____																											
3) <input type="checkbox"/> He/She is total incapacitated at this time. Patient will be re-evaluated on _____.																											
Physician's Signature			Date																								

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Hand Coordination Activities					
Movement Required	Tool/Machine		Right	Left	Both
Major hand					
Fine manipulation					
Gross manipulation					
Simple grasping					
Power grip					
Hand twisting					
Pushing					
Pulling					
Tools Used by Worker		Weight	No. of Hands Needed to Move		
Objects Worker must Move During Day		Weight	Distance	No. of Workers Needed to Move	
Physical Surroundings		Does Employee Walk on Uneven Ground?			
Does Employee Work <input type="checkbox"/> Inside ____% <input type="checkbox"/> Outside ____%		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does Employee Work Around Moving Machinery?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does Employee Drive Automotive Equipment?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, describe:					
Does the Employee Come in Contact with the Following? (indicated type)	Yes	No	Type		
Fumes					
Dust					
Mist					
Steam					
Strong Odors					
Poor Ventilation					
Air Conditioning					
Characteristics of Job that cannot be Modified by Employer for this Employee					
Comments and/or Observations					
<input type="checkbox"/> Job Site Evaluation Done			<input type="checkbox"/> Narrative		
Name(s) of Person(s) Interviewed			Title		
Person Completing Analysis			Title		Date



RETURN TO WORK LOG

Employee Name _____

Supervisor _____

Date	Hours Worked		Tasks Performed	Comment Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
	In	Out				
Sunday / /						
Monday / /						
Tuesday / /						
Wednesday / /						
Thursday / /						
Friday / /						
Saturday / /						

I understand, take responsibility for and acknowledge the _____ has placed me on limitations my physician, Dr. _____ while Participating in this temporary transitional work program.

Employee Signature _____

Date _____



RETURN TO WORK LOG

The Return to Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty. It helps to eliminate potential conflicts should questions arise regarding your employees performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employee's restrictions to the log.
- Have employees write their name on top of the log and have the Supervisor write their name.
- Remind the employees it is their responsibility to follow the restrictions.
- Remind the employees that the restrictions apply to occupational and non-occupational activities.
- Employees and Supervisors review all tasks completed each day, indicate any concerns. Initial after each day in confirmation of the review of tasks and consideration of concerns.
- Have the employees sign and date the Log at each week's end.



ROLES & RESPONSIBILITIES

Employee:

If a work place accident should take place, it is your responsibility to take the following actions, injury permitting:

- Report any injury immediately to your supervisor or manager. The law requires that you notify your employer of the date and place of the accident, if known.
- Seek medical attention, by law your employer must pay for all necessary medical services required to cure or relieve the effects of your injury or occupational disease.
- Notice of injury to a fellow worker who is not a member of management is not considered notice to your employer.
- Delayed reporting of an injury can delay the payment of benefits. Additionally a delay in reporting of more than 45 days could result in the loss of all benefits.
- For occupational diseases, you should notify your employer as soon as practicable after you become aware of your condition.

Employer:

Upon notice of a work injury or occupational disease you should take the following steps:

- Inform the insurance carrier or administrator responsible for the workers' compensation program via the agreed upon method, e.g. online reporting, facsimile, or telephonic reporting.
- Provide all necessary first aid and medical services.
- Comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.
- To avoid delay of processing your employee's claim it is recommended that at a minimum the following information be provided to the insurance carrier or administrator:
 - Employee's name
 - Address
 - Telephone number
 - Social security number
 - Brief description of the injury, accident or disease
 - Medical Authorization
 - Wage Statement (If disability will exceed 3 scheduled work days)
 - Witness statements and supervisor reports, if available

Insurance carrier:

Once SUA receives notice of a work place injury via the agreed reporting method and the claim has been properly verified and set up, SUA will take the following steps:

- Three (3) point contact for all lost time claims, contact to the employer, employee and provider(s).
- For claims exceeding 3 scheduled days, file the Employer's First Report of Injury with the Illinois Workers' Compensation Commission.
- Accurate compensability determination for payment of medical and lost time benefits and/or appropriate written notification for a delay in benefit payment and approval or written explanation of why benefits are being denied.



- If claim deemed compensable approval and payment of appropriate medical treatment and related lost time benefits, appropriate use of managed care services e.g. field and telephonic medical case management, utilization review and bill review services in an effort to manage medical costs and services.
- Maintain contact with employer and employee for medical status and return to work availability.



SUA INSURANCE COMPANY SUBROGATION PROGRAM

SUA Insurance Company (SUA) recognizes the importance of subrogation and recovery in all lines of business it writes. SUA's dedicated team of professionals works diligently to aggressively identify subrogation, second injury fund, salvage, deductible, and any other type of recovery to mitigate the overall payout of the claim.

SUA claims are handled by experienced claim professionals skilled in all aspects of workers' compensation claims handling and subrogation.

SUA maintains full-time dedicated subrogation specialists on staff overseeing all aspects of the investigation and timely notification to all parties while ensuring our lien is protected and utilized in the most advantageous means to resolve the issue.

SUA's philosophy on recovery is multifaceted and factors in all parties involved with our claims which include the insured, Partner Agents, claim examiners, Corporate Claim Analysts, and SUA Management.

SUA believes its multifaceted approach gives each party an opportunity to recognize opportunities to help mitigate the overall payout on claims received while also recognizing possible safety hazards that can prevent future accidents from occurring.

For additional information, please contact Ed Eisman at SUA Insurance 312-258-6822.

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COMMONLY USED ABBREVIATIONS & DEFINITIONS

Abbreviation	Terminology	Definition
AWW	Average Weekly Wage	Average of employee's gross wages during the 52 weeks prior to the date of injury. The rate is fixed at the time of injury and does not change with changes in the employee's salary or statewide
TTD	Temporary Total Disability	Two thirds (66 2/3%) of the employee's gross average weekly wage, subject to certain minimums and maximums
TPD	Temporary Partial Disability	Two thirds of the difference between the average weekly wage and actual wages earned when an employee is able to return to work with restrictions and is earning less than the pre-injury average weekly wage
MMI	Maximum Medical Improvement	Maximum medical improvement is assigned by a licensed physician when an injured employee has reached a medical end point in relationship to the work injury
PPD	Permanent Partial Disability	Complete or partial loss or loss of use of a part of the body, or the partial loss of use of the whole body. This benefit is paid at sixty percent (60%) of average weekly wage, subject to state mandated minimums and maximums. Permanent Partial Disability is allocated on a case by case basis as determined by the Illinois Workers' Compensation Commission
PTD	Permanent Total Disability	A complete disability which renders the employee permanently unable to do any kind of work for which there is reasonably stable employment market; or the loss of use both hands, both arms, both feet, both legs, both eyes or any two such parts, e.g. one leg and one arm
IME	Independent Medical Evaluation	An appointment with an Independent Physician for the purpose of addressing the need for ongoing medical treatment, the treatment's relationship to the work injury, the level to which the injured work can return to work e.g. light duty or full duty and permanent disability. This appointment is typically scheduled by the insurer.

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RESOURCES

SUA Insurance – www.suainsurance.com

Coventry Workers' Comp Services – <http://coventrywcs.com>

Illinois Workers Compensation Commission - www.iwcc.il.gov – For General Questions 866-352-3033

Illinois Workers' Compensation Disability Benefit Rates - <http://www.iwcc.il.gov/benefits.htm>

Illinois Workers' Compensation Fraud Unit - <http://www.idfpr.com/DOI/General/WorkCompFraudCheckList.asp>

State of Illinois Required Labor Postings - <http://www.state.il.us/agency/idol/Posters/poster.htm>