



INDIANA CLAIM KIT INDEX

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PACKET INFORMATION & RESPONSIBILITIES INDIANA

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 illness claim.
- State forms as well as an explanation for completion and how to process:
 - Indiana Worker's Compensation First Report of Employee Injury, Illness – Form 34401
 - Worker's Compensation Clearance Certification Application – Form 45899
 - Indiana Worker's Compensation Notice – English/Spanish
 - Medical Authorization
 - First Script Prescription Program
 - Job Analysis
 - Supervisor's Incident Report
 - Wage Statement
 - Return to Work Log
 - Attending Physicians Return to Work Recommendations Record
- The 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 that the employer has secured worker's compensation insurance coverage.

Thank you for choosing SUA Insurance Company

IN01 08/08



HOW TO FILE A WORK INJURY OR ILLNESS CLAIM

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

- Complete and submit the Indiana Worker's Compensation First Report of Employee Injury, Illness (Form 34401) 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 Indiana Worker's Compensation First Report of Employee Injury, Illness (Form 34401) and fax to SUA at 877-782-3292.
- Complete and mail the Indiana Worker's Compensation First Report of Employee Injury, Illness (Form 34401) 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.

IN02 08/08



TELEPHONE REPORTING GUIDE

Employer Information

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

Employee Information

Name _____
Address _____
Social Security Number _____
Nationality _____
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 _____

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 _____

SUA03 08/08



**INDIANA WORKER'S COMPENSATION
FIRST REPORT OF EMPLOYEE INJURY, ILLNESS**

State Form 34401 (R10 / 1-02)

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION										
Social Security number		Date of birth		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown			Occupation / Job title		NCCI class code	
Name (last, first, middle)				Marital status <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		Date hired		State of hire		Employee status
Address (number and street, city, state, ZIP code)						Hrs / Day	Days / Wk	Avg Wg / Wk	<input type="checkbox"/> Paid Day of Injury <input type="checkbox"/> Salary Continued	
Telephone number (include area code)				Number of dependents		Wage	Per	<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month		
						\$	<input type="checkbox"/> Year <input type="checkbox"/> Other			
EMPLOYER INFORMATION										
Name of employer				Employer ID#			SIC code		Insured report number	
Address of employer (number and street, city, state, ZIP code)				Location number		Employer's location address (if different)				
				Telephone number						
				Carrier / Administrator claim number		OSHA log number		Report purpose code		
Actual location of accident / exposure (if not on employer's premises):										
CARRIER / CLAIMS ADMINISTRATOR INFORMATION										
Name of claims administrator				Carrier federal ID number			Check if appropriate <input type="checkbox"/> Self Insurance			
Address of claims administrator (number and street, city, state, ZIP code)				<input type="checkbox"/> Insurance Carrier		Policy / Self-insured number				
Telephone number				<input type="checkbox"/> Third Party Admin.		Policy period		From		To
Name of agent				Code number						
OCCURRENCE / TREATMENT INFORMATION										
Date of Inj. / Exp.		Time of occurrence <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Cannot be determined		Date employer notified		Type of injury / exposure			Type code	
Last work date		Time workday began		Date disability began		Part of body			Part code	
RTW date		Date of death		Injury / Exposure occurred on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of contact		Telephone number		
Department or location where accident / exposure occurred				All equipment, materials, or chemicals involved in accident						
Specific activity engaged in during accident / exposure				Work process employee engaged in during accident / exposure						
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.									Cause of injury code	
Name of physician / health care provider										
Hospital or offsite treatment (name and address)								INITIAL TREATMENT <input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinic / Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/> Future Major Medical / Lost Time Anticipated		
Name of witness				Telephone number		Date administrator notified				
Date prepared		Name of preparer		Title		Telephone number				

An employer's failure to report an occupational injury or illness may result in a \$50 fine (IC 22-3-4-13).

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.
2. Enter all dates in MM/DD/YY format.
3. Please return completed form electronically by an approved EDI process.
4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME & CODE NUMBER: Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (e.g. *Acetylene cutting torch, metal plate, etc.*).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME / PHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc.*)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwise designated by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc.*).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-Time, Apprentice Full-Time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as follows: *FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE or UK*).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (e.g. *Right forearm, Low Back, etc.*).

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (*Return to Work Date*): Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (e.g. *Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (e.g. *Contusion, Laceration, Fracture, etc.*)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (e.g. *Building maintenance*).



WCE-1
State Form
45899
R3 / 7-06

Indiana Department of Revenue

**WORKER'S COMPENSATION CLEARANCE
CERTIFICATE APPLICATION**

Name of Independent Contractor (<i>type or print</i>) Last, First		Business Name	Specified Trade
Address (<i>number, and street, city, state, ZIP code</i>)			Telephone Number (<i>including area code</i>)
E-mail Address	Social Security Number	Affidavit of Exemption Number (<i>State Use Only</i>)	

Are you an Indiana resident? Yes No If no, please enter your state of residence: _____

Under the provisions of IC 22-3-2-14.5 and/or IC 22-3-7-34.5, I, the undersigned, am hereby requesting issuance to me of an Independent Contractor Affidavit of Exemption:

- I am an independent contractor working in the construction trades, as defined by IC 22-3-6-1 (b) (7) and/or IC 22-3-7-9 (b) (5).
 - I am the sole proprietor as defined by IC 22-3-6-1 (b) (4) and IC 22-3-7-9 (b) (2) and am thereby exempted from worker's compensation coverage. Sole proprietorship name: _____ SSN: _____
 - I am a partner in a partnership as defined by IC 22-3-6-1 (b) (5) and IC 22-3-7-9 (b) (3) and am thereby exempted from worker's compensation coverage. Partnership name: _____ FID: _____
- My independent contractor business is incorporated and I am an officer of that corporation: Yes No
- I have employees: Yes No If yes, please complete the following, (if extra space is needed attach another sheet):

Employee Name	SSN / TIN / FID	Indiana Resident?
		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, state of residence is: _____
		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, state of residence is: _____
		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, state of residence is: _____

Signature of Applicant	Date signed
------------------------	-------------

This affidavit certifies that the above named person is an independent contractor as defined by the indicated provisions of law, that the above named person has worker's compensation insurance or is a qualified self-insurer as to any and all employees in their hire, and that the above named person desires to be exempt from worker's compensation coverage and foregoes the right of recovery under the Worker's Compensation Act from anyone for whom this person works as an independent contractor. This affidavit is binding and holds harmless any person and their worker's compensation insurance carrier contracting with the above named person (as an independent contractor) and their worker's compensation insurance carrier. This affidavit is valid for one year from the date of issue. **You must re-apply each year to maintain exempt status. This information may be shared with the Internal Revenue Service and/or other**

State Use Only

<p>\$20 Non-Refundable Filing Fee Required</p> <p><input type="checkbox"/> \$ 5.00 DOR filing fee</p> <p><input type="checkbox"/> \$15.00 WCB filing fee</p>	Date issued
---	-------------

Payment must be made using money order or certified check.

Please mail to: Indiana Department of Revenue
P.O. Box 1924
Indianapolis, IN 46204-1924

Worker's Compensation Application Checklist

This form is only to be used by independent contractors in the building and/or construction trades.

This Application for Certification of Exemption represents a statement by you that you are an independent contractor in the building and/or construction trade and are therefore not required to carry worker's compensation insurance on yourself. **The Indiana Department of Revenue may share this information with the Internal Revenue Service (IRS) and /or other states.**

The status establishing this registration process states that an independent contractor is defined similarly to the IRS tax guidelines for determining independent contractor status. The IRS uses several factors to determine whether an individual is an independent contractor or an employee. Listed below are some of the characteristics of each. *If you fail to meet these qualifications, you will not receive certification.*

An independent contractor generally:

- directs his own work and performs the work in the manner he chooses, without direction from the general contractor;
- sets his own hours;
- may hire assistants;
- provides his own tools and materials;
- is paid by the job rather than by the hour;
- may make a profit or suffer a loss on a job; and
- is free to work for more than one person or firm and to offer his services to the general public.

An employee generally:

- is under the control of his employer;
- has income taxes withheld from his pay;
- must work the hours specified by the employer;
- receives pay on an hourly basis;
- must perform the work in the manner indicated by the employer;
- receives training, tools and equipment provided by the employer;
- is not free to offer his services to many persons or firms or to the general public; and
- can be fired at any time.

Are you new to the state of Indiana or the United States? If so, you will be required to submit verification of your residency. Some examples include:

- valid Indiana Driver's Licence;
- Permanent Resident Card (green card);
- copy of income tax return from another state;
- copy of federal income tax return;
- voter's registration card;
- Individual Tax Identification Number (ITIN) (resident aliens)

This application for a Certification of Exemption from worker's compensation in Indiana will be processed by verifying your status as an Independent Contractor. The Indiana Department of Revenue will examine your past tax records to determine if you have identified yourself as an independent contractor in past years and are current on your individual tax filings. Failure to comply will result in denial of certification.

I.C.22-3-2-14.5 requires that you be certified by the Department of Revenue. The Certification is filed for you with the Indiana Worker's Compensation Board to obtain your Independent Contractor status. You are required to pay a \$20 fee, \$5 (**nonrefundable**) to the Indiana Department of Revenue and \$15 to the Indiana Worker's Compensation Board, for making the application. *Please allow up to seven business days for the Department of Revenue and an additional seven days for the Workers Compensation Board to process this request.* If you do not meet the criteria for establishing your status as an independent contractor, you will be contacted with instructions on providing additional information, or notification of denial.

Your certification is not valid until the Worker's Compensation Board has stamped it. Mail your application to the Indiana Department of Revenue for processing. Upon approval of both the Department of Revenue and the Worker's Compensation Board, you will receive your validated Certificate of Exemption and a copy of Income Tax Information Bulletin #86 in the mail.

Note: Until you receive a Certificate of Exemption from the Indiana Worker's Compensation Board, you are required to be covered by a worker's compensation policy under Indiana law.

WORKER'S COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Worker's Compensation Act of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The worker's compensation insurance carrier or the administrator for

_____ **is:** _____
(name of company) (name of insurance carrier or administrator)

(name of carrier/administrator)

(mailing address)

(city, state, zip)

(telephone number)

(contact person)

For more information about rights or procedures under the Indiana Worker's Compensation system, call or write:

**Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667**

NOTICIA DE COMPENSACION PARA TRABAJADORES

A su empleador le es requerido proveer pagos de beneficios bajo el Acta de Compensación para Trabajadores del Estado de Indiana.

Cualquier empleado que sea lesionado mientras esté trabajando debe reportar el accidente laboral inmediatamente a su supervisor, empleador o representante designado.

La compañía de seguro de compensación del trabajador o el administrador de la compañía _____ es:

(nombre de la compañía)

(nombre de la compañía de seguro/administrador)

(dirección)

(ciudad, estado, código postal)

(número de teléfono)

(persona de contacto)

Para más información acerca de sus derechos o los procedimientos bajo el sistema de compensación para trabajadores de Indiana, llame o escriba a:

**Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667**



STATE FORMS INDIANA

- ***Indiana Form 34401: Indiana Worker's Compensation First Report of Employee Injury, Illness*** – This form is to be completed when an employee reports a work related injury or illness. Please complete the form with as much available information as possible. This will assist in the prompt and accurate claims set up.
- ***Indiana Form 45899: Worker's Compensation Clearance Certificate Application*** – This form is to be completed by the independent contractor to certify that he/she is exempt from worker's compensation coverage and foregoes the right of recovery under the Worker's Compensation Act while working as an independent contractor for the employer.
- ***Indiana Worker's Compensation Notice – English/Spanish*** – This information is made available to the employees and should be posted in a visible location in the workplace.

IN03 08/08



INDIANA FIRST REPORT OF INJURY FORMS PACKET

INDIANA FORM 34401: INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

INDIANA FORM 45899: WORKER'S COMPENSATION CLEARANCE CERTIFICATE APPLICATION

INDIANA WORKER'S COMPENSATION NOTICE – ENGLISH/SPANISH

SUPERVISOR'S INCIDENT REPORT

MEDICAL AUTHORIZATION

WAGE STATEMENT

ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

JOB ANALYSIS

RETURN TO WORK LOG

IN04 08/08

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 Mo Day Yr			Job Title			Department				
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 Mo Day Yr		Hour of Day		Last Day Worked Mo Day Yr			Last Day Worked Mo Day Yr			<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return		

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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WORKER'S 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 _____

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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:																									
<input type="checkbox"/> Medium Heavy Work. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds		<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"/> 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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JOB ANALYSIS

Name				Claim Number			
Address				Employer			
Date Hire		Date of Injury		Job Title		Check One <input type="checkbox"/> Skilled <input type="checkbox"/> Unskilled	
Training Required to Learn Job							
Was employee working as a Supervisor <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, number of people Supervised		Employee worked: <input type="checkbox"/> Alone <input type="checkbox"/> Small Group (3-5) <input type="checkbox"/> Large Group			
Days worked per week (Circle) M Tu W Th F Sat Sun		From		Hours worked during week To		Shift	
Work Breaks (Daily Rest Periods and Lunch)							
Morning		Lunch		Afternoon			
—		—		—		—	
Minutes		Minutes		Minutes			
Overtime Per Week Number of Hours		How Often		Was Employee Hired with Any Restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, Specify							
Body Movements							
Sitting		%		Standing		%	
Check Appropriate Column				None	Occasionally (1/3 or Less)	Frequently (1/3 – 2/3)	Continuously (2/3 or More)
Reaching above shoulder length							
Working with body bent over at waist							
Working in kneeling position							
Crawling							
Bending, stooping, squatting							
Repetitive foot movements as in foot controls – L/R - Both							
Climbing stairs							
Climbing ladders							
Working with arms extended at shoulder level							
Working with arms above shoulder height							
Height from floor to object to be reached and/or worked (use space for drawing, if needed)							
Object				Height			
Weights Handled		Item		Alone or Assisted	Push, Pull or Lift	Times Per Hour	Times Per Day
1 - 10 lbs							
15 – 20 lbs							
25 – 35 lbs							
45 – 60 lbs							
65 – 80 lbs							
85 – 100 lbs							
<input type="checkbox"/> No lifting required for this job							



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 Worker's 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 employees' 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 the restrictions apply to occupational and non-occupational activities.
- Employees and Supervisors review all tasks completed each day and 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:

- Note the hour, date, cause of the accident or illness, and the names of any witnesses to the accident. If possible, obtain a written statement from these witnesses. This information may be important in pursuing your claim.
- Immediately report the accident and injury to your supervisor, first aid person, company nurse or physician, or directly to your employer. Do not wait to report injuries or illnesses and do not conceal injuries or illnesses if you wish to pursue a worker's compensation claim.
- If you work for a unionized employer, report the injury to your union representative.
- Request medical treatment under worker's compensation.
- Do not sign any papers unless you understand what you are signing. However, remember that your signature may be required at various steps in the handling of your claim. Your delay in signing may lead to a delay in receiving compensation.
- You do not have to allow claims investigators to take a tape recorded statement from you as a condition for receiving worker's compensation.
- If your claim is denied, you have the right to a hearing before the Worker's Compensation Board.

Employer:

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

- Inform the insurance carrier or administrator responsible for the worker's compensation program via the agreed upon method, e.g. online reporting, facsimile, or telephonic reporting.
- Ensure Employee receives immediate medical treatment and evaluation.
- Inform the treating physician of the physical demands of an injured employee's job so that the doctor can make a realistic determination of the employee's ability to return to work.
- To avoid delay of processing the 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
 - Authorization Release of Medical Information
 - Wage Earnings History
 - Notice of Claim Received
 - Witness statements and supervisor reports, if available



- Comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.
- Coordinate the return to productive work of employees whose injury or illness causes an interruption in employment, including provision of reasonable accommodations and/or placement assistance if necessary (Case Management).

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 providers.
- 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.
- Ensure a timely determination of compensability by requesting from affected parties any information need to determine:
 - a. If a temporary or permanent disability exists relative to the employee's ability to do their job.
 - b. If the disability is caused by the employee's work.



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 worker's 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 insureds, 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 312-258-6822.

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RESOURCES

SUA Insurance – www.suainsurance.com

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

Worker's Compensation Board of Indiana - <http://www.in.gov/wcb/> General Questions 1-800-824-COMP

Indiana Worker's Compensation Disability Benefit - <http://www.in.gov/wcb/files/HANDBK2007.doc>

Indiana Worker's Compensation Fraud Information - <http://www.in.gov/wcb/files/HANDBK2007.doc>

State of Indiana Required Labor Law Poster - <http://www.in.gov/wcb/2331.htm>