



## KANSAS CLAIM KIT INDEX

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## **PACKET INFORMATION & RESPONSIBILITIES KANSAS**

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.
- State forms as well as an explanation for completion and how to process:
  - Employer's Report of Accident – Form K-WC 1101-A (Rev. 2-06)
  - Information Required by Kansas Workers Compensation Laws – Form K-WC 119 (Rev. 4-06)
  - "Posting" Notice – Form K-WC 40 (Rev. 3/08)
  - Tips for Employers to Reduce Workers Compensation Liability – Form K-WC 304 (Rev. 4-06)
  - Employer Notification of Forms K-WC 27 and K-WC 270 (Spanish) to Employees - Form K-WC 530 (Rev. 12-06)
  - First Script Prescription Program
  - Job Analysis
  - Supervisor's Incident Report
  - Medical Authorization
  - Wage Statement
  - Return to Work Log
  - Attending Physicians Return to Work Recommendation 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 workers' compensation insurance coverage.

**Thank you for choosing SUA Insurance Company**

KS01 08/08



## HOW TO FILE A WORK INJURY OR OCCUPATIONAL DISEASE CLAIM

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

- Complete and submit the Employer's Report of Accident (Form K-WC 1101-A) via the online reporting system available at [www.suainsurance.com](http://www.suainsurance.com). Email the completed form to [claimsintake@suainsurance.com](mailto:claimsintake@suainsurance.com). **This is the preferred method of reporting an injury.**
- Complete the Employer's Report of Accident (Form K-WC 1101-A) and fax to SUA at 877-782-3292.
- Complete and mail the Employer's Report of Accident (Form K-WC 1101-A) 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.

KS02 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



# EMPLOYER'S REPORT OF ACCIDENT

DEPARTMENT OF LABOR

DIVISION OF WORKERS COMPENSATION  
800 SW JACKSON STE 600  
TOPEKA KS 66612-1227

Submit original report only

**OSHA Case or File Number** \_\_\_\_\_  
There is a \$250 penalty for repeated failure to file Accident Reports within 28 days of the employer's receipt of knowledge of the accident.

DO NOT WRITE IN THIS SPACE

**READ ATTACHED INSTRUCTIONS BEFORE COMPLETING THIS FORM.**

1. Federal Employer's Identification Number \_\_\_\_\_ Date of Hire: \_\_\_\_\_

2. Name of Employer \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

3. Mailing Address \_\_\_\_\_  
*Street City State Zip Code*

4. Location, if different from mailing address \_\_\_\_\_  
*Street City State Zip Code*

5. Nature of Business \_\_\_\_\_ NAICS or S.I.C. Code \_\_\_\_\_ Dept. or Division \_\_\_\_\_

6. Name of Employee \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
*First Middle Last*

7. Home Address \_\_\_\_\_  
*Street City State Zip Code*

8. Soc. Sec. # \_\_\_\_\_ Birth Date \_\_\_\_\_ Employee's Occupation \_\_\_\_\_ Home Phone Number (\_\_\_\_) \_\_\_\_\_

9. Date of Injury or Occupational Disease \_\_\_\_\_ Time of Injury \_\_\_\_\_ A.M./P.M.  
Date reported to employer \_\_\_\_\_ Date Disability Began \_\_\_\_\_ Gross Average Weekly Wage \$ \_\_\_\_\_

10. Place of Accident or last exposure \_\_\_\_\_  
*City County State*

11. Was accident or last exposure on employer's premises?  YES  NO

12. How did accident occur? \_\_\_\_\_

13. What was employee doing when injured? \_\_\_\_\_

14. Name substance or object that directly caused injury \_\_\_\_\_

15. Describe in detail nature and extent of injury, indicate part of body involved \_\_\_\_\_

16. Was worker admitted to hospital?  YES  NO Date \_\_\_\_\_ Treated by emergency room only?  YES  NO  
Hospital name & address \_\_\_\_\_

17. Name and address of attending physician or clinic \_\_\_\_\_

18. Has employee returned to regular duty?  YES  NO Light duty?  YES  NO Date \_\_\_\_\_

19. Is compensation now being paid?  YES  NO Date first/initial payment \_\_\_\_\_

20. Weekly compensation rate \$ \_\_\_\_\_ Is further medical aid needed?  YES  NO  UNKNOWN

21. Did employee die?  YES  NO If so, give date of death \_\_\_\_\_ (File amended report within 28 days if death subsequently occurs.)

22. Name and address of dependents (death cases only) \_\_\_\_\_

23. Insurance Carrier and Third Party Administrator \_\_\_\_\_  
Address \_\_\_\_\_  
*Street City State ZIP Phone*  
Policy Number \_\_\_\_\_ Name of Agent \_\_\_\_\_  
Claim Number \_\_\_\_\_ Name of Claim Representative \_\_\_\_\_

24. Date of Report \_\_\_\_\_ Completed by \_\_\_\_\_ Title \_\_\_\_\_

COUNTY \_\_\_\_\_

CAUSE \_\_\_\_\_

NATURE \_\_\_\_\_

SEVERITY  
0 - NO TIME LOST  
1 - TIME LOST  
2 - MEDICAL  
3 - FATAL

SOURCE \_\_\_\_\_

MEMBER \_\_\_\_\_

DO NOT WRITE IN THIS SPACE

Questions or comments can be directed to the Kansas Division of Workers Compensation, Topeka, KS - Phone: 1-800-332-0353

**OSHA Case Information**  
**(not to be filed with the Division of Workers Compensation)**

25. Case number from the Log \_\_\_\_\_ (Transfer the case number from the Log after you record the case.)

26. Date of injury or illness \_\_\_\_\_

27. Time employee began work \_\_\_\_\_ A.M / P.M

28. Time of event \_\_\_\_\_ A.M./ P.M. Check if time cannot be determined.

29. **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. *Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."*

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30. **What happened?** Tell us how the injury occurred. *Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was spraying with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."*

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31. **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected. Be more specific than "hurt," "pain", or "sore." *Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."*

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32. **What object or substance directly harmed the employee?** *Examples: "concrete floor"; "chlorine"; "radial arm saw."* If this question does not apply to the incident, leave it blank.

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33. **If the employee died, when did death occur?** Date of death \_\_\_\_\_

## General Instructions

Please answer every question on the accident report. Failure to provide all answers may cause the accident report to be returned to the employer. Returned accident reports would most likely cause delays in benefits being paid to the injured employees and could subject the employer to fines.

Submit the original report only. Reports must be typewritten, computer generated, or neatly printed in black ink. Please avoid faxing or sending copies of accident reports, as they are difficult for the Division to microfilm.

The employer should send this accident report to its insurance carrier, third party administrator, or pool association as indicated in the employer's insurance contract. The employer is responsible for submitting or causing the original report to be sent to the Division's office within 28 days of the date of the employer's receipt of knowledge of the accident.

Submission of this Employer's Report of Accident does not constitute a written claim.

## Definition of an Incapacitating Injury

The Workers' Compensation Act sets forth a strict time frame for filing of accident reports with the Division. The controlling statute is K.S.A. 44-557(a), which reads as follows:

(a) it is hereby made the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

Accident reports are not required for every work related injury. The statute requires a report to be filed when the worker's whole or partial incapacity continues beyond the "day, turn, or shift which such injuries are sustained" as the result of accident. "Incapacity" is not specifically defined within the law, but the Division believes that the Legislature's intent was to reference a worker's whole or partial loss of the ability to perform his or her ordinary job tasks. When in doubt, keep in mind the law contains no penalty for filing a report that ultimately proves to be unnecessary. There are penalties, however, for failing to file a report when one was required. Those penalties are fines and limitations on the defenses the employer may assert should a claim be filed.

## Instructions for Specific Items

- Item 14: Name the object or substance which directly injured the employee. Examples: machine or object employee struck or struck employee; vapor or poison employee inhaled or swallowed; chemicals or radiation which irritated employee's skin; if hernia, the object employee was lifting or pulling; etc.
- Item 15: Please be as specific as possible indicating all that is known about the injury. Name part of body injured.

# ***Attention Kansas Employers***

## **Information Required By Kansas Workers Compensation Laws**

### **Employer Posting Notice**

Employers operating under the Kansas Workers Compensation Act are required by law, K.A.R. 51-12-2, to post the **Employer Posting Notice (K-WC 40)** in one or more conspicuous places.

### **Information for Injured Employees**

Immediately upon receiving notice of injury to or death of an employee, the employer shall mail or deliver to the employee or legal beneficiary the **Information for Injured Employees (K-WC 27, English) or (K-WC 270, Spanish)** mandated by the Legislature under K.S.A. 44-5,102(a).



To obtain forms or to ask questions regarding workers compensation forms and their usage, contact the Ombudsman Unit at **(800) 332-0353**. These forms may be copied for your use. All workers compensation forms are online at **[www.dol.ks.gov](http://www.dol.ks.gov)**.



This notice must be posted and maintained by the employer in one or more conspicuous places.

# ★ NOTICE ★

Your employer is subject to the Kansas Workers Compensation law which provides compensation for job-related injuries.

**1-800-332-0353**

## WHAT TO DO IF AN INJURY OCCURS ON THE JOB

Notify your employer immediately. **Your claim may be denied if you fail to tell your employer within 10 DAYS of the injury.** For just cause you may have 75 days to tell the employer of your injury. Thereafter you **must** file a written claim within 200 days of the accident or last date benefits are paid. Submission of Employer's Report of Accident does not constitute a written claim.

## MEDICAL BENEFITS

An employer is required to furnish all necessary medical treatment and has the right to designate the treating physician. If the employee seeks treatment from a doctor not authorized by the employer, the employer or its insurance carrier is only liable up to \$500.00.

## WEEKLY BENEFITS

Benefits are paid by the employer's insurance carrier or self-insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3% of his average weekly wage up to a maximum of 75% of the state's average weekly wage.

These benefits are subject to legislative changes and for the latest information on benefit levels, please contact the Division at the address and phone number below. If the injury results in permanent disability, the Kansas compensation law provides for additional benefits.

## Helpful Information – Ombudsman

Contact the **Ombudsman/Claims Advisory Section** at the Division of Workers Compensation immediately if you do not receive compensation in a timely manner. The Division has full-time personnel who specialize in aiding injured workers with claim problems. They can give information on what benefits an injured worker

is entitled to receive. Such problems as benefits not being paid on time, unpaid medical bills, questions in regard to proper settlement amounts, etc., should be brought to the attention of the **Ombudsman/Claims Advisory Section**. Our toll free telephone number: **1-800-332-0353**.

## WHERE TO GET HELP WITH YOUR CLAIM:

Current claims are being administered by \_\_\_\_\_

The claims office is located at \_\_\_\_\_ telephone (\_\_\_\_) \_\_\_\_\_

## INFORMACIÓN SOBRE COMPENSACIÓN DE TRABAJADORES

La ley exige que cuando un trabajador llega a sufrir un accidente, una herida, o una enfermedad a causa de su empleo, el empleador debe proporcionarle al trabajador incapacitado tratamiento médico y otros beneficios sin ningún costo al trabajador. El trabajador incapacitado tiene derecho a recibir un sueldo reducido, mientras se restablece. La ley también protege los derechos del trabajador incapacitado en otras maneras, por ejemplo: se prohíbe el desempleo de un trabajador solo por haber reclamado los beneficios de la compensación de trabajadores. Reporte cada accidente o lastimadura industrial inmediatamente al patrón, o al empleador.

Su reclamo puede ser negado si usted no notifica (avisa) a su empleador (patrón) dentro de 10 días del accidente o lastimadura. Por buena causa usted puede tener 75 días para avisarle a su empleador (patrón) de su accidente o lastimadura. De allí en adelante, usted debe entregar un aviso por escrito dentro de 200 días del accidente o último día que recibió tratamiento médico, o que recibió beneficios. Un reporte de accidente no constituye un aviso por escrito. Para más información acerca de los beneficios o para recibir asistencia con un reclamo, llame al teléfono 1-800-332-0353 (gratis) o al 785-296-2996.



Division of Workers Compensation  
800 S.W. Jackson Street, Suite 600, Topeka, KS 66612-1227  
Phone: 785-296-2996  
Web site: [www.dol.ks.gov](http://www.dol.ks.gov) • E-mail: [wc@dol.ks.gov](mailto:wc@dol.ks.gov)

# Tips for Employers to Reduce Workers Compensation Liability

**Communication with employees during all phases of the employment relationship is the key to reducing liability.**

## **Inform employees of their workers compensation rights and the 10-day reporting requirements.**

The Kansas Workers Compensation Act requires employers to educate and inform employees of their rights to workers compensation benefits as well as the reporting requirements under the Act, K.A.R. 51-13-1 and K.S.A. 44-5,101. K-WC 40 (Workers Compensation Notice) must be posted in a conspicuous place where all workers can see this notice of their rights and responsibilities under the Workers Compensation Act. These notices are free and can be obtained from the Division of Workers Compensation by calling (785) 296-3441 or going online at [www.dol.ks.gov](http://www.dol.ks.gov).

One of the best ways to inform workers of workers compensation benefits and reporting requirements is during the orientation process. The company might consider including the Notice (K-WC 40) and the Information for Injured Employees (K-WC 27) in every orientation packet and having each worker sign a statement that he received, read and understood the notice.

K.S.A. 44-520 provides that a worker must

give notice of an injury within 10 days after the date of accident, unless the employer has actual notice and knowledge of the accident. The 10-day notice requirement can be extended for up to 75 days if the claimant can establish just cause for failing to notify within 10 days. An employer increases the chance of prevailing on the 10-day notice issue if the employer can demonstrate it took steps to inform all workers of their rights to workers compensation benefits and the 10-day reporting requirements under the 1993 Act.

In *Longhofer v. Advanced Engine Rebuilders, Inc.*, Docket No. 193,037 (October 19, 1994), the Appeals Board for the Division of Workers Compensation held that an employee had good cause for failure to give the 10-day notice when he was unaware of the reporting requirements, had never before filed for workers compensation benefits and the employer admitted that the company had no written policy concerning injuries at work and admitted that a Form K-WC 40 was not posted at the work place, nor was any other notice posted advising the employee what to do in case of injury.

Contrary to popular belief, insurance statistics demonstrate that employers who openly communicate about workers

compensation benefits and rights actually have a lower claims experience than those who do not.

**Communicate your concern for the welfare of your employees when they are hurt on the job by providing immediate medical attention.**

When someone is legitimately hurt on the job, it is very important to provide immediate quality medical care. In fact, it is often wise to give the employee a choice of three physicians at the onset. Then the employee has input from the very beginning as to his course of medical treatment. Choosing a medical provider is very important. Although cost is a factor, quality should be of utmost importance. It is very important to choose doctors who will spend adequate time, show concern for the employee's well-being and conduct a thorough examination. There is nothing that will cause an employee to hire an attorney faster than uncaring, cursory medical treatment. Injured workers want to be reassured they are receiving good quality medical care. If they have confidence in the medical provider, they will most likely have a positive feeling about their recovery and their prospects for returning to work.

**Communicate your concern by sending get-well cards.**

The cost of a first-class stamp will go a long way to help reduce liability. Invest in a supply of get-well cards. Not only should management send a get-well card, but the co-workers and supervisors also should be encouraged to send a get-well card or note. This concept goes back to the

basic tenet of common courtesy. If we treat others as we would want to be treated in the same situation, the lines of communication stay open, and the employer/employee relationship stays successfully in tact.

**Send a letter telling the employee you are holding his job for him.**

One of the biggest factors in litigation is uncertainty. Communication alleviates uncertainty. By sending a letter to your injured worker telling him you are holding his job for him, you increase the chances that he will not feel the need to contact a lawyer. Communication between the employer and the employee after the injury reduces the chance of litigation.

**Utilize temporary service workers to provide temporary help so the job can be held for the employee.**

Many employers do not have enough workers and they cannot afford to be without help. Rather than permanently filling the injured worker's position, the services of a temporary agency could be utilized. Temporary service workers provide a stopgap measure so that the injured worker's job can be held for him once he is released from medical treatment. In addition, once the temporary service worker is laid off, the temporary agency is liable for any unemployment benefits. Likewise, if the temporary worker is injured while working on your premises, the temporary agency is liable for the workers compensation benefits. A temporary service worker is a win/win situation for all sides. By preserving the employer/employee relationship and holding

the injured worker's job, the employer will greatly reduce the potential liability. The 1993 Legislature amended K.S.A. 44-510e(a). The statute prohibits an employee from receiving a work disability in excess of his functional impairment as long as the employee is engaging in any work for wages equal to 90 percent or more of the average gross weekly wage that the employee was earning at the time of injury. The work disability portion of the statute is triggered only if the employer fails to return the claimant to work or make a reasonable accommodation offer for the medical restrictions.

**While the injured worker is off work, pay the difference between his temporary total disability and his salary, if possible.**

Temporary total disability reimburses the worker 66 2/3 percent of his weekly salary, up to the statutory maximum per week. Most of us would have to admit that if we had a one-third immediate reduction in our salary, it would cause a budget crunch in the family. Employers can go a long way to building goodwill with their injured workers by supplementing their temporary total disability with the one-third remaining salary. This should only be done if it is financially feasible. The failure to do so will not be catastrophic to the employer/employee relationship.

**Keep in close personal contact with the employee on a weekly basis.**

A representative of the employer should be designated to have weekly contact with injured workers. This contact could be in person or by telephone. The more contact the employer has with the employee, the less likely litigation will result on the claim.

**Offer the employee a light duty job and communicate this offer in writing.**

Many times workers, while undergoing medical care and treatment, have certain restrictions. If you have light duty work available, immediately offer such work to the worker. It makes more economic sense to a worker to be earning a full weekly wage rather than two-thirds of a weekly wage.

**Return an injured worker to work as soon as possible and make accommodations.**

One of the biggest factors in litigation is when workers return to work they feel their medical restrictions are not accommodated. These problems can be avoided by sitting down with the employee, one on one, and coming up with a return-to-work plan. This way the injured worker has input into the return-to-work plan, the job and the job duties. Employers who knowingly and intentionally violate doctors' restrictions are virtually guaranteeing themselves that work-related injuries will turn into full-blown litigation.

**Prepare the injured worker's co-workers for his return to work.**

When an injured worker returns to work but cannot perform all his prior work tasks, a tense situation can arise between the injured worker and co-workers. The employer has the obligation to diffuse this kind of tension and prevent it from occurring. The best prevention is educating co-workers on the employer's return-to-work policy and the requirements of the Americans With Disabilities Act. It is very important for the employer to notify co-workers that teasing and harassment of an injured worker will not be tolerated and will result in disciplinary action, up to and including termination.

**Communicate with your insurance carrier or self-insured employer to get them to make timely payments.**

As an employer, you pay a premium. Part of the premium goes for claims service. Although insurance adjusters are very busy people, most of them do a good job. Occasionally, neglect on the part of the carrier will cause extreme frustration and cause the claim to become litigated. There is nothing more frustrating to an injured worker than having to deal with a claims adjuster's voice mail and never being able to talk to a human being. Since you, as the employer, have paid the premium, you have the right to demand good service on the claim. Make certain that you convey

your desire to have the medical bills and temporary total payments paid in a prompt and timely manner. Bills that are not paid result in collection suits against injured workers, which in turn result in the worker hiring a lawyer. Untimely checks glean the same results.

**Do not ignore workers compensation problems.**

For years, there has been a management philosophy that if problems are ignored, they will go away. This "ignore it" philosophy is a prominent characteristic of many companies. Ignoring problems will not make them go away. It will only cause claims to blow up, get out of control and be litigated in perpetuity.

**Communication and common courtesy will build good will.**

Communication and common courtesy will build more good will than ignoring the situation. If every employer treats every injured worker as though he were a relative, litigation, litigation costs, attorney fees and payouts for workers compensation claims would dramatically decline. Workers compensation claims involve human relationships. An employer enhances that relationship and reduces the potential liability by openly communicating with workers and practicing common courtesy.



DEPARTMENT OF LABOR

Division of Workers Compensation

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## Employee Notification Forms Available Online

Important Information for Employers Regarding Forms K-WC 27 and K-WC 270 (Spanish)

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Kansas law requires employers to provide information to employees about what to do if they experience a work-related accident. Employers must provide Form K-WC 27 and/or K-WC 270, which advise workers about their rights and responsibilities if injured on the job. Both of these forms are available for employees online at [www.dol.ks.gov](http://www.dol.ks.gov).

The Legislature mandated under K.S.A. 44-5,102 (c): "The commissioner of insurance shall distribute a copy of such information to each insurance company authorized to transact workers compensation insurance in this state and each group-funded self-insurance plan. Each such insurance company and group-funded self-insurance plan shall reproduce or arrange for the reproduction and distribution of such information in sufficient quantities, and in both English and Spanish language versions, when requested, to continuously accommodate the needs of their respective insured employers and members in order to comply with this section and shall provide such information to such insured employers and members therefor."

The Insurance Commissioner sent certified letters to each insurance company licensed to sell workers compensation insurance in Kansas, as well as each group self-insurance pool. Each company returned a signed form stating the company had received the required forms and would provide the required form to each employer that they insure or that is a member of the approved "pool." The Director of the Division of Workers Compensation provides the same information to each of the approved self-insured employers. Effective December 1, 1993, every employer was under statutory requirement to provide a copy of the form K-WC 27 or K-WC 270 to injured employees.

K.S.A. 44-5,102(a) states: "Immediately on receiving notice of injury to or death of an

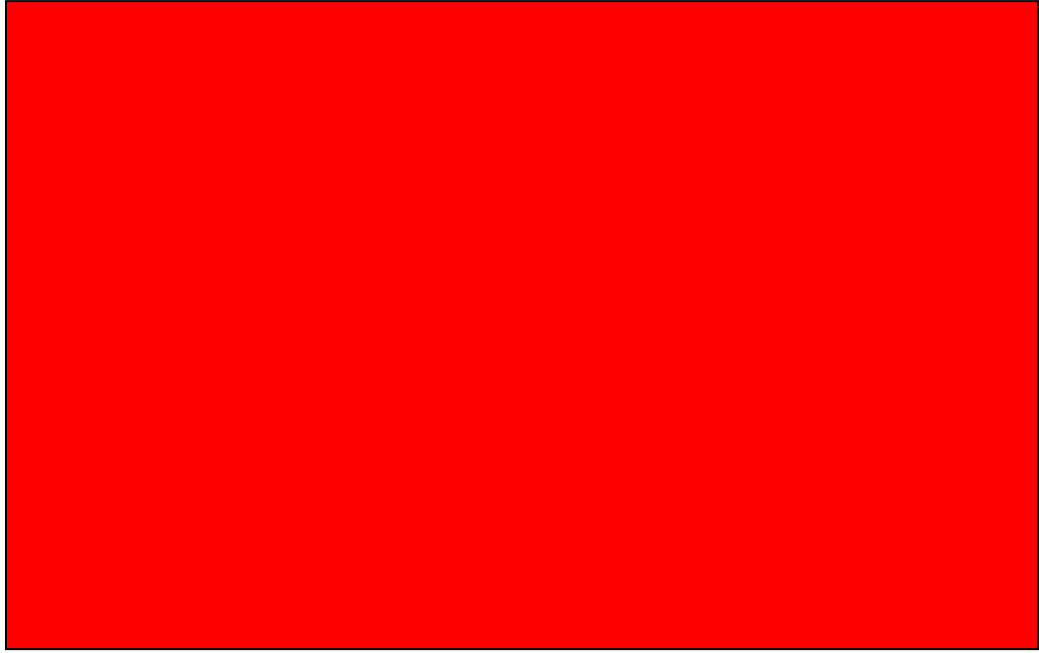
employee, the employer shall mail or deliver to the employee or legal beneficiary" the form K-WC 27 or K-WC 270 provided by the Director of the Division of Workers Compensation. The Division has provided numerous educational opportunities through the annual Workers Compensation Seminars, Employer Institutes, other presentations, and individualized employer technical assistance visits since the requirement has been in effect. There has been an improvement in the utilization of the required informational. However, over half of the employers attending these training sessions were not using the required forms and informed the presenters that they had never received or seen these forms.

In an effort to assist employers in reaching compliance, the Division encourages employers to make copies of these forms, front and back (without changing the content). Employers should contact their insurance company if they haven't received this material.

Recurring questions from employers at the training sessions have been: "How do we prove that we gave the employee a copy of the form? Do we have to send it certified? Do we have to make them sign a piece of paper stating they received the form?"

Most employers keep a personnel log on employees. Generally, an entry in the log stating there was an alleged injury on this date and that a form K-WC 27 or K-WC 270 was given or sent to the employee should be adequate documentation of compliance with the requirement.

Questions regarding the form and its usage can be directed to the Ombudsman Section at 785-296-2996. A Spanish interpreter is available to explain the form if an employer/employee needs assistance in Spanish.





## STATE FORMS KANSAS

- ***Kansas Form K-WC 1101-A: Employer's Report of Accident*** – This form is to be completed when an employee reports a work-related injury or disease. Please complete the form with as much available information as possible. This will assist in the prompt and accurate claims set up.
- ***Kansas Form K-WC 119: Attention Kansas Employers***
- ***Kansas Form K-WC 40: Posting Notice***
- ***Kansas Form K-WC 304: Tips for Employers to Reduce Workers Compensation Liability***
- ***Kansas Form K-WC 530: Employee Notification***
- ***Kansas Form K-WC 27: Information for Injured Employees (English)***
- ***Kansas Form K-WC 270: Information for Injured Employees (Spanish)***



## **KANSAS FIRST REPORT OF INJURY FORMS PACKET**

Kansas Form K-WC 1101-A: Employer's Report of Accident

Kansas Form K-WC 119: Attention Kansas Employers

Kansas Form K-WC 40: Posting Notice

Kansas Form K-WC 304: Tips for Employers to Reduce Workers Compensation Liability

Kansas Form K-WC 530: Employee Notification

Kansas Form K-WC 27: Information for Injured Employees (English)

Kansas Form K-WC 270: Information for Injured Employees (Spanish)

SUPERVISOR'S INCIDENT REPORT

WAGE STATEMENT

MEDICAL AUTHORIZATION

ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

JOB ANALYSIS

RETURN TO WORK LOG

KS04 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)

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How could this incident been prevented?

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What corrective action has been taken?

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<b>Part of Body Affected</b>							
<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
<b>Type of Injury</b>							
<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									
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18									44									
19									45									
20									46									
21									47									
22									48									
23									49									
24									50									
25									51									
26									52									
<b>SUBTOTAL</b>										<b>SUBTOTAL</b>								
										<b>GRAND TOTAL</b>								

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"/> <b>Sedentary Work.</b> Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, 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"/> <b>Light Work.</b> 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"/> <b>Light Medium Work.</b> 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"/> <b>Medium Work.</b> 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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Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
<input type="checkbox"/> <b>Medium Heavy Work.</b> Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds																											
<input type="checkbox"/> <b>Heavy Work.</b> 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																									



## 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	
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 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 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:

- You must report, in writing if possible, any injury immediately to your supervisor or manager injury permitting or within 10 days or 75 days if there is just cause for failure to report within 10 days.
- For occupational diseases, you should notify your employer as soon as practicable after you become aware of the condition.
- You may seek the services of an unauthorized doctor up to a limit of \$500.

### Employer:

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

- You must 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.
- You must file, or cause to be filed, an accident report with the Division of Workers Compensation within 28 days from the date of reportable injury, death or employer notification of such. Failure to do so may result in legal and financial penalties.
- Immediately upon learning of an employee's injury or death, the employer must furnish written information to the employee or employee's dependents on available benefits, the claim process, an employer or insurance company contact for workers compensation claims, and other matters as required by law. Forms K-WC 27 and 270 are available from the Division of Workers Compensation, insurance carrier or group-funded pool.
- Employers are responsible for providing reasonable medical treatment for the injury. Employers have the right to select the treating physician.
- An accident must be reported if an employee is wholly or partially incapacitated for more than the remainder of the day, shift or turn on which the injury was sustained.
- To avoid delay of processing the claim it is recommended, 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.



**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.
- SUA will report injuries on an Employer's Report of Accident (Form K-WC 1101-A) as well as all other required reports to the Division of Workers' Compensation
- SUA will ensure a timely determination of compensability by requesting from affected parties any information needed 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 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 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.



## RESOURCES

SUA Insurance – [www.suainsurance.com](http://www.suainsurance.com)

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

Kansas Division of Workers Compensation - [http://www.dol.ks.gov/WC/HTML/wc\\_ALL.html](http://www.dol.ks.gov/WC/HTML/wc_ALL.html) - For General Questions 785-296-3441 or Ombudsmen 785-296-2996

Kansas Workers Compensation Benefits Information – [http://www.dol.ks.gov/wc/html/wcinjwkr\\_EMP.html](http://www.dol.ks.gov/wc/html/wcinjwkr_EMP.html)

Kansas Workers Compensation Fraud and Abuse Section - [http://www.dol.ks.gov/wc/html/wcfraud\\_ALL.html](http://www.dol.ks.gov/wc/html/wcfraud_ALL.html)

State of Kansas Workplace Laws and Requirements – Posting Notice - [http://www.dol.ks.gov/es/html/posters\\_DBR.html](http://www.dol.ks.gov/es/html/posters_DBR.html)