

SUA Michigan Claim Kit



MICHIGAN CLAIM KIT INDEX

Document Name	Document Number	Revised
Packet Outline Letter MI	MI01	08/08
How to File a Work Injury	MI02	08/08
Telephone Reporting Guide	SUA03	08/08
State Forms Packet: <ul style="list-style-type: none"> • Michigan Form WC-100 – Employer’s Basic Report of Injury • Michigan Form WC-106 – Supplemental Report of Fatal Injury • Michigan Form WC-117 – Employee’s Report of Claim • Michigan Form BWC-107 – Notice of Dispute 	MI03	08/08
First Report Packet	MI04	08/08
First Report of Injury MI (Example)	MI05	08/08
Supervisor’s Incident Report	SUA04	08/08
Medical Authorization	SUA05	08/08
Wage Statement	SUA06	08/08
Attending Physician Return to Work Recommendation Record	SUA07	08/08
Job Analysis	SUA08	08/08
Return to Work Log	SUA09	08/08
Roles & Responsibilities	MI06	08/08
Subrogation Program	SUA10	08/08
Resource List	MI07	08/08



PACKET INFORMATION & RESPONSIBILITIES MICHIGAN

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

- How to file a work related injury or occupational disease (repetitive trauma) claim.
- State forms as well as an explanation for completion and how to process:
 - Employer's Basic Report of Injury – Form WC-100
 - Supplemental Report of Fatal Injury – Form WC-106
 - Notice of Dispute – Form BWC-107
 - Employee's Report of Claim – Form WC-117
 - Medical Authorization
 - First Script Prescription Program
 - Job Analysis
 - Supervisor's Incident Report
 - 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

Thank you for choosing SUA Insurance Company

MI01 08/08



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

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

- Complete and submit the Employer's Basic Report of Injury (Form WC-100) via the online reporting system available at www.suainsurance.com. Email the completed form to claimsintake@suainsurance.com. **This is the preferred method of reporting an injury.**
- Complete the Employer's Basic Report of Injury (Form WC-100) and fax to SUA at 877-782-3292.
- Complete and mail the Employer's Basic Report of Injury (Form WC-100) to:

SUA Insurance Company
Attn: Claims Dept.
P.O. Box 06110
Chicago, IL 60606-6110
- 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.

MI02 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 _____

SUA04 08/08



STATE FORMS MICHIGAN

- ***Michigan Form WC-100: Employer's Basic Report of Injury*** – This form is to be completed when an employee reports an injury or occupational disease (repetitive trauma) injury. Please complete the form with as much available information as possible. This will assist in the prompt and accurate claims set up. A sample form is attached noting mandatory fields.
- ***Michigan Form WC-106: Supplemental Report of Fatal Injury*** – This report is to be completed by the employer immediately after the death of an injured employee.
- ***Michigan Form WC-117: Employee's Report of Claim*** – This form is to be completed by the employee and submitted to their employer as soon as an injury or occupational disease (repetitive trauma) injury has occurred. This form is optional.
- ***Michigan Form BWC-107: Notice of Dispute*** - This form is filed by the employer or its workers' compensation insurance company with the Bureau of Workers' Disability Compensation when there is a question or a dispute concerning the possible workers' compensation benefits to which the employee may be entitled.

MI03 08/08

EMPLOYER'S BASIC REPORT OF INJURY

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
PO Box 30016, Lansing, MI 48909

An employer shall report immediately to the agency on Form WC-100 all injuries, including diseases, which arise out of and in the course of the employment, or on which a claim is made and result in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific losses. In case of death, an employer shall also immediately file an additional report on WC-106. See instructions on reverse side for filing/mailling procedures.

I. EMPLOYEE DATA

1. Social Security Number	2. Date of injury	3. Employee name (Last, First, MI)		
4. Address (Number & Street)		5. City	6. State	7. Zip Code
8. Date of birth (MM/DD/YYYY)	9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	10. Number of dependents	11. Telephone number	
12. Tax filing status: <input type="checkbox"/> A. Single <input type="checkbox"/> B. Single, Head of Household <input type="checkbox"/> C. Married, Filing Joint <input type="checkbox"/> D. Married, Filing Separate				

II. EMPLOYER/CARRIER DATA

13. Employer name			14. Federal ID Number	
15. Injury location code	16. Mailing location code	17. UI number	18. Type of business (SIC/NAICS)	
19. Employer street address		20. City	21. State	22. Zip code
23. Insurance company name (if employer not self-insured)			24. Insurance company telephone number (if known)	

III. INJURY/MEDICAL DATA

25. Last day worked	26. Date employee returned to work (if applicable)		27. Did employee die? <input type="checkbox"/> Yes <input type="checkbox"/> No	28. If yes, date of death
29. Injury city	30. Injury state	31. Injury county	32. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, see item 53)	
33. Case number from OSHA/MIOSHA log		34. Time employee began work <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	35. Time of event <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. If time cannot be determined, check here <input type="checkbox"/>	
36. 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.				
37. How did the injury occur? Examples: "When ladder slipped on wet floor, worker fell 20 feet;" "Worker was sprayed with chlorine when gasket broke during replacement"				
38. Describe the nature of injury or illness			39. Part of body directly affected by the injury or illness	
40. 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.				
41. Name of physician or other health care professional		42. Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		43. Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
44. If treatment was given away from the worksite, where was it given? (Include name, address, city, state and zip code of facility)				

IV. OCCUPATION AND WAGE DATA

45. Date hired	46. Total gross weekly wage (highest 39 of 52)	47. Number of weeks used	48. Value of discontinued fringes	
49. Occupation (Be specific)	50. Was employee a volunteer worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	51. Was employee certified as vocationally handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No		
52. Date employer notified by employee		53. If temporary service agency, provide name/address of employer where injury occurred.		

V. PREPARER DATA I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.			
54. Preparer's name (Please print or type)	55. Preparer's signature	56. Telephone number	57. Date prepared

Notice to employee: Questions or errors should be reported immediately to the individual listed above in space 54

If you are using this form as a replacement for the Form 301 to document the specifics of an injury or illness for purposes of compliance with the work-related injury and illness logging requirements, follow the instructions in Section A only.

If you are using this form to report a workers' compensation injury, follow the instructions in Section A and B.

Section A

This form can be used in lieu of the MIOSHA Form 301, *Injury and Illness Incident Report*. It is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* (Form 300) and the accompanying *Summary* (Form 300A), these forms help the employer and MIOSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out questions 1-9, 27-28, 33-45 and 54-57.

According to Public Law of 1970 (P.L. 91-596) and Michigan Occupational Safety and Health Act 154, P.A. 1974, Part 11, Michigan Administrative Rule for Recording and Reporting of Injuries and Illnesses, you must keep this form on file for 5 years following the year to which it pertains. **DO NOT mail this form to the Workers' Compensation Agency unless it meets the conditions listed below in Section B.**

Section B

You must complete all questions on this form if the injury or disease results in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific loss. The original form must be mailed to the Workers' Compensation Agency, P.O. Box 30016, Lansing, MI 48909.

<p>Authority: Workers' Disability Compensation Act, 408.31(1)(3) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631</p>	<p>The Department of Labor and Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.</p>
---	---

SUPPLEMENTAL REPORT OF FATAL INJURY

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
PO Box 30016, Lansing, MI 48909

THIS REPORT IS TO BE FILED BY THE EMPLOYER IMMEDIATELY AFTER THE DEATH OF AN INJURED EMPLOYEE.

I. DECEASED EMPLOYEE

1. Social Security Number	2. Date of Injury	3. Date of Death	
4. Name (Last, First, Middle Initial)			
5. Street Address	6. City	7. State	8. ZIP Code

II. EMPLOYER DATA

9. Employer Name	10. Federal I.D. Number		
11. Street Address	12. City	13. State	14. ZIP Code
15. Amount of Burial Expenses Paid (If Not Previously Reported) \$			

III. DEPENDENTS OF EMPLOYEE

16. Name	17. Date of Birth	18. Relationship to Deceased (Spouse, Child, or Other - Please Specify Other)	19. Extent of Dependency (Total/Partial)

20. Employer's Signature	21. Title	22. Date
--------------------------	-----------	----------

The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.	Authority: Workers' Disability Compensation Act, R408.31(3) Completion: Mandatory Penalty: Workers' Disability Compensation Act 418.631
--	---

EMPLOYEE'S REPORT OF CLAIM
 Michigan Department of Labor & Economic Growth
 Workers' Compensation Agency
 P.O. Box 30016, Lansing, MI 48909

1. Social Security Number		2. Date of Injury		3. Date of Birth (MM/DD/YYYY)		4. Employee Telephone Number	
5. Employee Name (Last, First, MI)				6. Employer Name			
7. Employee Street Address				8. Employer Street Address			
9. Employee City		10. State	11. ZIP Code	12. Employer City		13. State	14. ZIP Code
15. Describe the type of injury and explain how it happened. (If a medical report is available, please attach a copy.)							
16. Are you making a claim for payment of medical expenses? Yes No If yes, please attach a copy of medical bill(s) if available.				17. Last Day Worked			
18. Have you gone back to work? Yes No If yes, date of return _____/_____/_____				19. Was the injury reported to your employer? Yes No If yes, date reported _____/_____/_____			

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

20. Employee Signature		21. Date of this report	
------------------------	--	-------------------------	--

OFFICE USE ONLY	
Carrier Name	

The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.	Authority: Workers' Disability Compensation Act, 408.31(4) Completion: Voluntary Penalty: None
---	---

NOTICE OF DISPUTE

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
P O Box 30016, Lansing, MI 48909

1. Social Security No.	2. Date of Injury	3. Employee Name (Last, First, MI)		
4. Employee Address (Street No. and Name)		5. City	6. State	7. Zip Code
8. Employer Name				9. Federal ID No.
10. Employer Street Address		11. City	12. State	13. Zip Code
14. Carrier or Self-Insured Name			15. NAIC or Self-Insured No.	16. Zip Code
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	19. Zip Code
20. Claim or File No.		21. County of Injury		22. County Code (if known)
23. Reason for Dispute A. <input type="checkbox"/> Injury not work related B. <input type="checkbox"/> Medical treatment not related to injury C. <input type="checkbox"/> Further investigation required (please specify below) D. <input type="checkbox"/> Additional information required from employee (please specify below) E. <input type="checkbox"/> Vocational rehabilitation dispute only (please specify below) F. <input type="checkbox"/> Other (please specify below)				
<i>Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.</i>			Authority: Workers' Disability Compensation Act, R408.33 (1) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631; 418.801; R408.33	

This is to certify that a copy of this form has been mailed or given to the injured employee.

24. Preparer's Name (Please print)	25. Signature	26. Telephone No.	27. Date
------------------------------------	---------------	-------------------	----------

NOTICE TO EMPLOYEE

By filing this form, your employer or its workers' compensation insurance company has indicated to the Workers' Compensation Agency that it has a question or a dispute concerning the possible workers' compensation benefits to which you may be entitled. You may or may not agree with the position taken by the employer or insurance company.

If you feel that you are not receiving the benefits to which you are entitled, you should discuss this with your employer or a representative of its insurance company. If you have already done that or you are not satisfied with the discussion, you may file a formal application for mediation or hearing. You can obtain the appropriate forms or more information by contacting the Workers' Compensation Agency at our toll-free number of 1-888-396-5041 (if necessary, a TTY device is available at 517-322-5987). Additional information may also be found on our website at www.michigan.gov/wca.

The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Form # WC-107 **Form Name:** Notice of Dispute

When Required: A carrier shall notify the Workers' Compensation Agency on or before the fourteenth day after the employer has notice or knowledge of the alleged injury or death, in all cases where the right of the injured or dependent to compensation is disputed.

Required Fields: All applicable fields must be completed.

- ✓ Forms will be returned if fields 1-3, 8, and 14 are not completed.
- ✓ You will receive a letter if fields 4 and 23 are not completed.
- ✓ Do not use "Other" as reason for dispute unless absolutely necessary.

Instructions: **Completing the Form:**

- ✓ Select the hand tool from the Acrobat toolbar menu. You can use the hand tool to move the page around so that you can view all areas.
- ✓ Position the hand pointer inside a form field and click. The I-beam pointer allows you to type text.
- ✓ To complete the "red boxes," using your mouse, position the cursor over the applicable box until the pointing finger icon appears and click.
- ✓ Press Tab to accept the field change and go to the next field, or Press Shift + Tab to accept the field change and go to the previous field.
- ✓ Use your mouse to select an area of the form that is not inside a form field before printing your form.
- ✓ To print, be sure to use the printer button on the Acrobat toolbar menu to print the form instead of your web browser's print function. You may need to select the "Print as image" option in the print dialog box to print the completed form.
- ✓ If you wish to print the form only, select "Print Current Page" or "Pages From: 1 To: 1"

NOTE: Please complete all date fields with the **MM/DD/YYYY** format.

If you have any comments on this fill-in form, please send them to wcinfo@michigan.gov. Please include the keyword "Fill-In Form 107" with your comments.

How to Submit This Form:

- ✓ Print the completed form
- ✓ Sign and make 2 copies
 - ❖ Give a copy of the report to the employee
 - ❖ Keep a copy for your records
 - ❖ Mail the original signed Form 107 to:

**Workers' Compensation Agency
P O Box 30016
Lansing MI 48909**



MICHIGAN FIRST REPORT OF INJURY FORMS PACKET

MICHIGAN WC-100 FORM: EMPLOYER'S BASIC REPORT OF INJURY – EXAMPLE

MICHIGAN WC-100 FORM: EMPLOYER'S BASIC REPORT OF INJURY – BLANK

MICHIGAN WC-106 FORM: SUPPLEMENTAL REPORT OF FATAL INJURY

MICHIGAN BWC-107 FORM: NOTICE OF DISPUTE

MICHIGAN WC-117 FORM: EMPLOYEE'S REPORT OF CLAIM

SUPERVISOR'S INCIDENT REPORT

MEDICAL AUTHORIZATION

WAGE STATEMENT

ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

JOB ANALYSIS

RETURN TO WORK LOG

MI04 08/08



EMPLOYER'S BASIC REPORT OF INJURY
 Michigan Department of Labor & Economic Growth
 Workers' Compensation Agency
 PO Box 30016, Lansing, MI 48909

An employer shall report immediately to the agency on Form Wc-100 all injuries, including disease, which arise out of and in the course of the employment, or on which a claim is made and result in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific losses. In cases of death an employer shall also immediately file an additional report on WC-106. See instructions on reverse side for filling/mailling procedures

I. EMPLOYEE DATA

1. Social Security Number Mandatory	2. Date of Injury Mandatory	3 Employee Name (Last, First, MI) Mandatory		
4. Address (Number & Street) Mandatory		5. City Mandatory	6. State Mandatory	7. Zip Code Mandatory
8. Date of Birth (MM/DD/YYYY) Mandatory	9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	10. Number of Dependents Mandatory	11. Telephone Number Mandatory	
12 Tax filing status: <input type="checkbox"/> A. Single <input type="checkbox"/> B. Single, Head of Household <input type="checkbox"/> C. Married, Filing Joint <input type="checkbox"/> D. Married, Filing Separate				

II. EMPLOYER/CARRIER DATA

13. Employer Name Mandatory		14. Federal ID Number Mandatory		
15. Injury location code Mandatory	16. Mailing location code Mandatory	17. UI Number Mandatory	18. Type of Business (SIC/NAICS) Mandatory	
19. Employer street address Mandatory		20. City Mandatory	21. State Mandatory	22. Zip code Mandatory
23. Insurance company Name (if employer not self-insured) Mandatory			24. Insurance company telephone number (if known) Mandatory	

III. INJURY/MEDICAL DATA

25. Last day worked Mandatory	26. Date employee returned to work (if applicable) Mandatory		27. Did employee die? <input type="checkbox"/> Yes <input type="checkbox"/> No	28. If yes, date of death
29. Injury city Mandatory	30. Injury state Mandatory	31. Injury County Mandatory	32. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, see item 53)	
33. Case number from OSHA/MIOSHA log Mandatory		34. Time employee began work Mandatory	35. Time of event <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Check here <input type="checkbox"/> If time cannot be determined	
36. What was the employee doing just before the incident occurred? Describe the activity, as well as any tools equipment or material the employee was using. Be specific Mandatory				
37. How did the injury occur? Examples: "When ladder slipped on wet floor, worker fell 20 feet;" "Worker was sprayed with chlorine when gasket broke during replacement" Mandatory				
38. Describe the nature of injury or illness Mandatory		39. Part of body directly affected by the injury or illness Mandatory		
40. 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. Mandatory				
41. Name of physician or other health care professional Mandatory	42. Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		43. Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
44. If treatment was given away from the worksite, where was it given? (Include name, address, city, state and zip code of facility) Mandatory				

IV. OCCUPATION AND WAGE DATA

45. Date hired Mandatory	46. Total gross weekly wage (highest 39 of 52) Mandatory	47. Number of weeks used Mandatory	48. Value of discounted fringes Mandatory
49. Occupation Mandatory	50. Was employee a volunteer worker? <input type="checkbox"/> Yes <input type="checkbox"/> No		51. Was employee certified as vocationally handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No
52. Date employer notified by employee Mandatory		53. If temporary service agency, provide name/address of employer where injury occurred. Mandatory	

V. PREPARER DATA I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

<i>Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both and denial of benefits</i>			
54. Preparer's Name (Please Print or type) Mandatory	55. Preparer's signature Mandatory	56. Telephone number Mandatory	57. Date Prepared Mandatory

Notice to employee: Questions or errors should be reported immediately to the individual listed above in space 52



If you are using this form as a replacement for the Form 301 to document the specifics of an injury or illness for purposes of compliance with the work related injury and illness logging requirements, follow the instructions in Section A only.

If you are using this form to report a workers' compensation injury, follow the instructions in Section A and B.

Section A

This form can be used in lieu of the MIOSHA Form 301, *Injury and Illness Incident Report*. It is one of the first forms you must fill out when a reasonable work related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illness* (Form 300) and the accompanying *Summary* (Form 300A), these forms help the employer and MIOSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you have received information that a recordable work-related injury or illness has occurred, you must fill out questions 1-9, 27-28, 33-45 and 54-74.

According to Public Law of 1970 (P.L. 91-596) and Michigan Occupational Safety and Health Act 154, P.A. 1974, Part 11, Michigan Administrative Rule for Recording and Reporting of Injuries and Illness, you must keep this form on file for 5 years following the year to which it pertains. **DO NOT mail this form to the Workers' Compensation Agency unless it meets the conditions listed below in Section B.**

Section B

You must complete all questions on this form if the injury or disease results in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific loss. The original form must be mailed to the Workers' Compensation Agency, P.O. Box 30016, Lansing, MI 48909

Authority: Workers Disability Compensation Act, 408.31 (1)(3) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631	The Department of Labor and Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing etc., under the Americans with Disability Act, you may make your needs known to this agency.
--	--



SUPERVISOR'S INCIDENT REPORT

 Injury(work related)

 Incident

 Illness (work related)

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

Did employee seek medical attention? Yes No

If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will employee complete a drug screening? Yes No

Name of Witnesses Names (Attach statements if available)

1. _____

2. _____

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

How could this incident been prevented?

What corrective action has been taken?

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

Comments _____

Supervisor Signature _____

Date _____

SUA05 08/08



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

SUA06 08/08



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 _____

MI07 08/08



ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

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

SUA07 08/08



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		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		Walking				
%		%		%		%		
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	Times Per Week	Times Per Month
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 _____

SUA09 08/08



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:

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

Employer:

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

- Inform the insurance carrier or administrator responsible for the workers' compensation program via the agreed upon method, e.g. online reporting, facsimile, or telephonic reporting.
- Ensure Employee seeks/receives immediate medical treatment and evaluation.
- 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.
- 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 workers' compensation claims handling and subrogation.

SUA maintains full-time dedicated subrogation specialist 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.

SUA10 08/08



RESOURCES

SUA Insurance – www.suainsurance.com

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

Department of Labor and Economic Growth - <http://www.michigan.gov/wca> For General Questions 1-888-396-5041

Michigan Workers' Compensation Disability Benefit Rates <http://www.michigan.gov/wca/0,1607,7-191--108224--,00.html>

Michigan Workers' Compensation Fraud Unit - <http://michcomplaw.typepad.com/>

State of Michigan Required Labor Law Poster - <http://store.postersolution.com/total-labor-law-poster-page-michigan-above-500.html>