



OKLAHOMA CLAIM KIT INDEX

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PACKET INFORMATION & RESPONSIBILITIES OKLAHOMA

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:
 - Oklahoma Workers' Compensation Court – Employer's First Notice of Injury – Form 2 (rev. 2/06)
 - Oklahoma Workers' Compensation Court – Employee's First Notice of Occupational Disease and Claim for Compensation – Form 3B (rev. 2/06)
 - Oklahoma Workers' Compensation Notice and Instruction to Employers and Employees – Form 1A (rev. 07/05) – English/Spanish
 - Oklahoma Workers' Compensation Court – Employee's First Notice of Accidental Injury and Claim for Compensation – Form 3 (rev. 2/06)
 - Oklahoma Workers' Compensation Court – Claimant's First Notice of Death and Claim for Compensation – Form 3A (rev. 2/06)
- 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.
- Workers' Compensation Poster Requirement. 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

OK01 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 First Notice of Injury – Form 2 (rev. 2/06) via the online reporting system available at www.suainsurance.com. Email the completed form to claimsintake@suainsurance.com. **This is the preferred method of reporting an injury.**

- Complete the Employer's First Notice of Injury – Form 2 (rev. 2/06) and fax to SUA at 877-782-3292.

- Complete and submit the Employer's First Notice of Injury – Form 2 (rev. 2/06) 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.

OK02 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 _____



STATE FORMS OKLAHOMA

- **Oklahoma Workers' Compensation Court – Employer's First Notice of Injury – Form 2 (rev. 2/06)** – The employer must send to the Workers' Compensation Court and to their workers' compensation insurance carrier within 10 days, or a reasonable time thereafter, of learning that an employee has suffered an accidental injury which results in lost time beyond the shift, or requires medical attention away from the work site, fatal or otherwise.
- **Oklahoma Workers' Compensation Notice and Instruction to Employers and Employees – Form 1A (rev. 07/05) – English/Spanish** – This notice must be posted and maintained by the employer in one or more conspicuous places in the workplace.
- **Oklahoma Workers' Compensation Court – Employee's First Notice of Accidental Injury and Claim for Compensation – Form 3 (rev. 2/06)** - This form is generally filed by an attorney representing the injured employee with the Workers' Compensation Court; however the injured employee can file this form without attorney representation.
- **Oklahoma Workers' Compensation Court – Claimant's First Notice of Death and Claim for Compensation – Form 3A (rev. 2/06)** - This form is generally filed by an attorney representing the injured employee with the Workers' Compensation Court; however the injured employee can file this form without attorney representation.
- **Oklahoma Workers' Compensation Court – Employee's First Notice of Occupational Disease and Claim for Compensation – Form 3B (rev. 2/06)** – This form is generally filed by an attorney representing the injured employee with the Workers' Compensation Court; however the injured employee can file this form without attorney representation.

OK03 08/08

FORM 2

WORKERS' COMPENSATION COURT

EMPLOYER'S FIRST NOTICE OF INJURY

Send original to
Workers' Compensation Court and 1 copy to
Insurance Carrier

1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

Please type or print. Enter all dates in MM/DD/YY format.

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Full Name of Employee - LAST, FIRST, MIDDLE				
Complete Address		City	State	Zip
Telephone Number		Social Security Number		
Date of Birth	Sex	Length of Employment Years Months		
Average Weekly Wage	Occupation (job description)		Was employment agreement made in Oklahoma? YES <input type="checkbox"/> NO <input type="checkbox"/>	

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or in-state toll free (800) 522-8210.

Date of accident or last exposure		Time of accident or exposure _____ o'clock <input type="checkbox"/> AM <input type="checkbox"/> PM		Date Employer Notified		Time workday began _____ o'clock <input type="checkbox"/> AM <input type="checkbox"/> PM	
Last date employee worked		Has employee returned to work? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, on what date _____			Did the employee die? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, on what date _____		
OSHA Log Case #		Place of Accident or Occurrence City: _____ County: _____ State: _____					
Injury Resulted from:		Single Incident <input type="checkbox"/> Cumulative Trauma <input type="checkbox"/>		Does employee participate in a certified workplace medical plan: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, name of CWMP: _____			
Nature of Injury or Illness							
Describe activities when injury occurred with details of how event occurred. Include object or substance which directly injured the employee.							
Identify part(s) of body involved in injury or illness							
Full Name and address of Treating Physician (please be complete)							
Employer's Insurance Carrier or Own Risk Group				Policy/Self-Insured Number			
Name		Phone		Policy Period — from _____ to _____			
Address		City		State		Zip	
Employer's Name and Complete Address							
Name		Federal ID#		Phone #			
Address		City		State		Zip	
Type of business (Example: manufacturing, food service, construction)						SIC Number	
Type of Ownership: Private <input type="checkbox"/> State Government <input type="checkbox"/> County Government <input type="checkbox"/> Local Government <input type="checkbox"/>							

Upon filing this Notice of Injury, permission is given to the Administrator of the Worker's Compensation Court, the Insurance Commissioner, the Attorney General, a District Attorney or their designees to examine all records relating to the notice, any matter contained in the notice, and any matter relating to the notice.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

I hereby declare under penalty of perjury that I have examined this notice, and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Signed this _____ day _____, _____

Prepared by _____

Title _____

I hereby certify that this Form 2 was sent to the Workers' Compensation Court and a copy thereof to the insurer on the date described below:

SUBMISSION OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

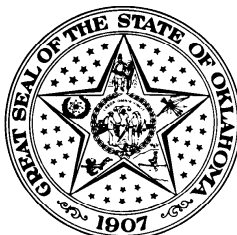
A Form 2 must be sent to the Workers' Compensation Court and to the Employer's Workers' Compensation Insurance Carrier within 10 days, or a reasonable time thereafter, of learning that an employee has suffered an accidental injury which results in lost time beyond the shift, or requires medical attention away from the work site, fatal or otherwise. Form 2s filed with the Workers' Compensation Court are confidential and not subject to public disclosure except as authorized by law.

All employees of this employer who are entitled to benefits of the Workers' Compensation Act are hereby notified that this employer has complied with all rules of the Workers' Compensation Court and that this employer has secured payment of compensation for all employees and their dependents in accordance with the Act. All employees are further notified this employer will furnish first aid, medical, surgical and any other like services required by law as well as payments of compensation to any injured employee as provided in the Workers' Compensation Act.

Any employee who has suffered a compensable injury covered by the Workers' Compensation Act shall be entitled to vocational rehabilitation services, including retraining and job placement, if, as a result of the injury, the employee is unable to perform the same occupational duties the employee was performing prior to the injury.

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or in-state toll free (800) 522-8210.

The Oklahoma Workers' Compensation Court has a counselor program to provide information to injured workers, employers, and other interested parties. Counselors assist unrepresented parties to enable them to protect their rights under the workers' compensation system.



Signature of Employer

Insurer & Insurer Phone Number

Employee's Responsibilities in Case of Accidental Injury or Occupational Disease

If accidentally injured or affected by an occupational disease arising out of and in the course of employment, however slight, the employee should notify the employer immediately. If this employer is a partnership, notice shall be given to any partner. If this employer is a corporation, notice shall be given to any agent or officer of the corporation upon whom legal process may be served. Notice shall also be given to the person in charge of business at the location of operations where the injury occurred. Unless notice is given to the employer or medical treatment is rendered within thirty (30) days of injury, any claim for compensation may be forever barred.

If accidentally injured or affected by an occupational disease, the employee may file a claim for compensation with the Workers' Compensation Court. This employer is required to furnish the employee with appropriate forms to file a compensation claim.

A claim for compensation must be filed with the court within a period of time specified by statute, or be forever barred. Based on statute effective July 1, 2005, if a claim for compensation for any accidental injury or death is not filed with the Court within two (2) years from the date of the accidental injury or death or if a claim for compensation for occupational disease or cumulative trauma is not filed within two (2) years of either the last hazardous exposure or from the date the disease first became manifest, which ever last occurred, the claim for compensation may be forever barred. Provided, claims may be filed within two (2) years from the date of the last medical treatment authorized by the employer or payment of any compensation or remuneration paid in lieu of compensation. Post termination claims must be filed within six (6) months of termination of employment.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

Employer's Responsibilities

The employer must provide employees with immediate first aid, medical and surgical care and other like services necessary. This applies to care for all injuries and illnesses arising out of and in the course of employment, regardless of their character. If an employee is injured and this results in the loss of time beyond his/her shift, or requires medical attention away from the work site (fatal or otherwise), the employer MUST file a Form 2 within ten (10) days of the notice of injury or a reasonable time thereafter. The employer must provide a copy of such Form 2 to the employer's workers' compensation insurance carrier, if any.

No agreement by any employee to pay any portion of premiums paid by the employer to maintain or carry compensation insurance as required by law shall be valid. Any employer who deducts money from the wages or salary of any employee for that purpose who is entitled to workers' compensation shall be guilty of a misdemeanor.

If the employer has notice of an undisputed injury and the employer's insurance carrier fails to commence weekly temporary total disability benefit payments due within the time provided by law, the insurer may be subject to a penalty of fifteen percent (15%) of the unpaid or delayed weekly benefits due and payable to the employee.

No agreement by any employee to waive workers' compensation rights and benefits shall be valid.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Workers' Compensation Court
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918
(405) 522-8600 WATS # 1-800-522-8210

Todos los trabajadores (los empleados) de este empleador (de este patrón) que tengan el derecho a recibir beneficios del Acta de Compensación para los Trabajadores son avisados por esta notificación que este empleador ha cumplido con todas las reglas de la Corte de Compensación para los Trabajadores y que este empleador ha obtenido pagos de compensación para todos los trabajadores y sus mantenidos de acuerdo con el Acta. También se les notifica a todos los trabajadores que este empleador proveerá primeros auxilios, servicios de asistencia médica y quirúrgica, y otros servicios similares requeridos por la Ley, así como pagos de compensación para los Trabajadores a cualquier trabajador lesionado (lastimado) tal como lo indica el Acta de Compensación de Trabajadores.

Cualquier trabajador que haya sufrido cubierta por el Acta de Compensación para los Trabajadores, tendrá el derecho a recibir servicios de enseñanza de oficios (rehabilitación profesional), incluyendo readiestramiento y colocación de empleo, si, con motivo de una lesión, el trabajador no puede desempeñar los mismos deberes profesionales que el trabajador desempeñaba antes de la lesión. La denegación de aceptar servicios de rehabilitación por parte del trabajador no disminuye en lo más mínimo los beneficios permisibles para el trabajador.

NOTA: Mediación es disponible en ciertos conflictos de compensación laboral, que pone a la disponibilidad de los trabajadores la Corte de Compensación. Los interesados deben llamar al (405) 522-8760 o al llamada gratis dentro de este estado (800) 522-8210 (llamada gratis) para más información.

La Corte de Compensación para los Trabajadores de Oklahoma tiene un equipo de consejeros (asesores) para proveerles información a los trabajadores lesionados y a los empleadores y otras partes interesadas. Consejeros suministran ayuda a las personas no representadas por abogados para protegerles sus derechos bajo el sistema de Compensación de Trabajadores.



Firma del Patrón

**Compañía de Seguros
Número Telefónico de la Compañía de Seguros**

Las Responsabilidades De Los Trabajadores En Caso De Lesión Accidental O Enfermedad Profesional

Si se lesiona (se lastima) accidentalmente o es afectado por una enfermedad profesional como resultado de, o en el transcurso de, su empleo, aún si es leve, el trabajador debe notificarle al empleador inmediatamente. Si dicho empleador es una sociedad colectiva, se le puede dar notificación a cualquier socio. Si el empleador es una sociedad anónima (corporación), se debe notificar a cualquier agente u oficial de la corporación autorizado a recibir notificación. También se debe dar notificación a la persona que esté a cargo del negocio en el lugar de operación del negocio en donde ocurrió la lesión. A menos que se le haya otorgado notificación al empleador o que se haya otorgado asistencia médica dentro de un plazo de treinta (30) días a partir de la lesión, cualquier reclamo por compensación podría estar exceptuado.

Si el trabajador se lesiona o es afectado por una enfermedad profesional, puede presentarle un reclamo para compensación a la Corte de Compensación para los Trabajadores. El empleador está requerido a proveerle al trabajador las formas apropiadas (los formularios) para poder presentar el reclamo de compensación.

Cualquier pretensión por compensación debe de entablarse con la Corte dentro del plazo de tiempo especificado por los Estatutos, o si no puede ser precluido indefinidamente a base de los Estatutos vigentes el 1 de Julio, 2005, si el trabajador no presenta el reclamo (la demanda) de compensación por lesión accidental o muerte dentro de un plazo de dos (2) años a partir desde la fecha del accidente, lesión o muerte, o si no se presenta un reclamo (demanda) por enfermedad profesional o por trauma acumulativo dentro de un plazo de dos (2) años desde la fecha en que estuvo expuesto al peligro por última vez o la fecha en que la enfermedad se manifestó por primera vez, cual ocurriera último, su reclamo (demanda) de compensación podría ser invalidado permanentemente. Sin embargo, se puede presentar un reclamo dentro de un plazo de dos (2) años a partir del último tratamiento médico rendido por el empleador de pago por cualquier compensación, o remuneración en lugar de compensación. Reclamos o pretensiones realizadas posteriormente al despido deben de ser entabladas dentro de un plazo de seis (6) meses después del despido del empleo.

Cualquier persona que reciba beneficios de incapacidad temporal de un empleador, o de la compañía de seguros ("aseguranza") que asegure al trabajador, deberá reportarle sin demora por escrito al patrón o a la compañía de seguros cualquier cambio en los hechos pertinentes, cambio en la cantidad de ingresos que el trabajador esté recibiendo, o cambio en su situación de empleo, que ocurra durante el plazo de tiempo en el que el trabajador esté recibiendo dichos beneficios.

Responsabilidades Del Empleador

El empleador debe rendirle de inmediato a los trabajadores primeros auxilios, atención médica, cirugía y otros servicios similares cuando sea necesario. Esto es igualmente aplicable para todas las lesiones y enfermedades que resulten del empleo o durante la labor, sin importar de que tipo sean. Si un trabajador se lesiona (se lastima) y esto resulta en que el trabajador pierda tiempo de trabajo, además del tiempo perdido en su turno de trabajo, o requiere asistencia médica en un lugar fuera del sitio de trabajo (lesión mortal o no), el empleador ESTA OBLIGADO a presentar la Forma 2 dentro de un plazo de diez (10) días a partir del día en que se le notificó que había ocurrido la lesión, o después de un plazo de tiempo razonable. El empleador debe suministrar presentar una copia de dicha Forma 2 a la compañía de seguros de Compensación para los Trabajadores, si tiene alguna.

No será válido ningún acuerdo entre un empleador y un trabajador de compartir el pago para mantener en vigor el seguro de compensación tal como lo requiere la Ley. Cualquier empleador que tome deducciones de dinero del sueldo o salario de un trabajador que tenga derecho a la compensación de trabajadores será culpable de un delito menor.

Si el empleador tiene notificación de una lesión incontrovertible y la compañía de seguros del trabajador falla en iniciar los pagos por beneficios semanales de incapacidad total temporal dentro del plazo de tiempo que requiere la Ley, la compañía de seguros puede estar sujeta a la imposición de una sanción del quince por ciento (15%) de los beneficios semanales impagados o pospuestos vencidos y pagaderos al trabajador.

Nunca se considerará válido ningún acuerdo por parte de cualquier trabajador a renunciar a sus derechos o beneficios de compensación para los trabajadores.

Cualquier persona que cometa fraude de compensación para los trabajadores, una vez se le haya procesado, será culpable de un delito mayor.

**Workers' Compensation Court
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918
(405) 522-8600 WATS # 1-800-522-8210**

FORM 3

Send original and 4 copies to:
Workers' Compensation Court

WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

THIS SPACE FOR COURT USE ONLY

Name of Claimant (Injured Employee)
Name of Employer
Court Use Only

Please check appropriate box

I. Original Filing

II. Amends Previously Filed Form 3 (Must clearly state whether amendment is in addition to, or substitute for, prior information.)

EMPLOYEE'S FIRST NOTICE OF ACCIDENTAL INJURY AND CLAIM FOR COMPENSATION

FILE NO. _____

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or in-state toll free (800) 522-8210.

(Please type or print)

EMPLOYEE NAME (Last, First, Middle):		Social Security #:	Phone: ()
Mailing Address (include City, State & Zip):		Date of Birth:	Age: Sex:
Occupation:	Was your employment agreement in Oklahoma? YES <input type="checkbox"/> NO <input type="checkbox"/>	Avg. Weekly Wage:	Length of Employment years _____ months _____
Date of Accident or Last Exposure:	Injury resulted from: Single Incident <input type="checkbox"/> Cumulative Injury <input type="checkbox"/>	Time Injury Occurred _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
Describe parts of the body injured or affected		Place of Injury: City/County/State	
What is the nature of the Injury or Illness:	Describe with details how the injury occurred. Include object or substance which directly injured you:		
Treating Physician (full name):	Address:	City:	State: Zip:
Employer:	Employer's FEI # (Federal ID Number):		Telephone:
Complete Mailing Address:	City:		State: Zip:
Complete Street Address (if different from above):	City:		State: Zip:

Are you a previously impaired person due to a prior workers' compensation injury or obvious and apparent pre-existing disability? _____ If "YES", you may be entitled to benefits for combined disabilities. Any claim made for benefits for combined disabilities must be commenced by filing a "Form 3E" or "Form 3F", as appropriate, with the Workers' Compensation Court.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

I declare under penalty of perjury that I have examined this notice and claim, and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Name of claimant's attorney if represented:

Type or Print Name of Attorney:	OBA#
Mailing Address:	
City	State Zip
Telephone #: ()	

Upon filing this Notice of Accidental Injury And Claim For Compensation, permission is given to the Administrator of the Workers' Compensation Court, the Insurance Commissioner, the Attorney General, a district attorney or their designees to examine all records relating to the notice. The permission granted to the above named individuals or their designees authorizes them access to medical records pursuant to Section 19 of Title 76 of the Oklahoma Statutes, including waiver of any privilege granted by law concerning communications made to a physician or health care provider or knowledge obtained by such physician or health care provider by personal examination.

Signed this _____ day of _____, _____

Signature of Claimant (must be signed by claimant)

Signature of Attorney for Claimant

This form is not intended for use as a medical authorization.

Nothing shall be construed to waive, limit or impair any evidentiary privilege recognized by law.

FORM 3A

Send original and 4 copies to
Workers' Compensation Court

WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

THIS SPACE FOR COURT USE ONLY

IN THE MATTER OF THE DEATH OF (deceased employee)
Name of Claimant (individual filing claim)
Name of Employer
Court Use Only

Please check appropriate box

I. Original Filing

II. Amends Previously Filed Form 3A (Must clearly state whether amendment is in addition to, or substitute for, prior information.)

CLAIMANT'S FIRST NOTICE OF DEATH AND CLAIM FOR COMPENSATION

FILE NO.

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or in-state toll free (800) 522-8210.

(Please type or print)

DECEASED EMPLOYEE NAME (Last, First, Middle):		Social Security #:	Phone: ()
Mailing Address (include City, State & Zip):		Date of Birth:	Age: Sex:
Occupation:	Was deceased employment agreement made in Oklahoma? YES <input type="checkbox"/> NO <input type="checkbox"/>		Average Weekly Wage:
Claimant's Name (Last, First, Middle):		Phone: ()	
Mailing Address (include City, State & Zip):		Relationship to Deceased	
Date of Accidental Injury	Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/>	Place of Injury: City/County/State	
Date of Death	Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/>	Place of Death: City/County/State	
Nature of Injury		Body part(s) injured	
Describe activities when injury occurred, with details of how event occurred. Include object or substance which directly injured deceased.			
Cause of death (normally shown on Death Certificate)		Has deceased filed a claim for compensation regarding this accident? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Employer:	Federal ID#	Telephone:	
Complete Mailing &/or Street Address:	City:	State:	Zip:

Has a personal representative been appointed for the estate of the deceased? YES NO If so, state the name and address below.

List names, relationships, addresses and dates of birth of all heirs at law of deceased and any other person who actually depended upon deceased at the time of death. (on the reverse side)

I declare under penalty of perjury that I have examined this notice and claim, and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Name of claimant's attorney if represented:

Type or Print Name of Attorney:	OBA #	
Mailing Address:		
City	State	Zip
Telephone #: ()		

Upon filing this *Notice of Death And Claim For Compensation*, permission is given to the Administrator of the Workers' Compensation Court, the Insurance Commissioner, the Attorney General, a district attorney or their designees to examine all records relating to the notice. The permission granted to the above named individuals or their designees authorizes them access to medical records pursuant to Section 19 of Title 76 of the Oklahoma Statutes, including waiver of any privilege granted by law concerning communications made to a physician or health care provider or knowledge obtained by such physician or health care provider by personal examination.

Signed this _____ day of _____, _____

Signature of Attorney for Claimant

Signature of Claimant (must be signed by claimant)

FORM 3B

Send original and 4 copies to:
Workers' Compensation Court

WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

THIS SPACE FOR COURT USE ONLY

Please check appropriate box

I. Original Filing

II. Amends Previously Filed Form 3B (Must clearly state whether amendment is in addition to, or substitute for, prior information.)

Name of Claimant (Injured Employee)

Name of Employer

Court use only

EMPLOYEE'S FIRST NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION

FILE NO. _____

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or in-state toll free (800) 522-8210.

(Please type or print)

EMPLOYEE NAME (Last, First, Middle):		Social Security #:	Phone: ()
Mailing Address (include City, State & Zip):		Date of Birth:	Age: Sex:
Occupation:	Was your employment agreement in Oklahoma? YES <input type="checkbox"/> NO <input type="checkbox"/>	Avg. Weekly Wage:	Length of Employment months _____ years _____
Date of last exposure to hazard which caused disease:	Date of first distinct manifestation:	Place of Injury: City/County/State	
Nature of Disease (example: Reduced breathing capacity or loss of vision)		Body Part(s) Injured:	
Describe how you were exposed to the disease with details of how event occurred. Include object or substance which directly injured you:			
Employer:	Employer's FEI # (Federal ID Number):	Telephone:	
Complete Mailing Address:	City:	State:	Zip:
Complete Street Address (if different from above):	City:	State:	Zip:

Are you a previously impaired person due to a prior workers' compensation injury or obvious and apparent pre-existing disability? _____ If "YES", you may be entitled to benefits for combined disabilities. Any claim made for benefits for combined disabilities must be commenced by filing a "Form 3E" or "Form 3F", as appropriate, with the Workers' Compensation Court.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

I declare under penalty of perjury that I have examined this notice and claim, and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Name of claimant's attorney if represented: _____

Type or Print Name of Attorney: _____ OBA# _____

Mailing Address: _____

City _____ State _____ Zip _____

Telephone #: _____
()

Upon filing this *Notice of Occupational Disease And Claim For Compensation*, permission is given to the Administrator of the Workers' Compensation Court, the Insurance Commissioner, the Attorney General, a district attorney or their designees to examine all records relating to the notice. The permission granted to the above named individuals or their designees authorizes them access to medical records pursuant to § 19 of Title 76 of the Oklahoma Statutes, including waiver of any privilege granted by law concerning communications made to a physician or health care provider or knowledge obtained by such physician or health care provider by personal examination.

This form is not intended for use as a medical authorization.

Nothing shall be construed to waive, limit or impair any evidentiary privilege recognized by law

Signed this _____ day of _____, _____



OKLAHOMA FIRST REPORT OF INJURY FORMS PACKET

Oklahoma Workers' Compensation Court – Employer's First Notice of Injury – Form 2
(rev. 2/06)

Oklahoma Workers' Compensation Notice and Instruction to Employers and Employees –
Form 1A (rev. 07/05) – English/Spanish

Oklahoma Workers' Compensation Court – Employee's First Notice of Accidental Injury
and Claim for Compensation – Form 3 (rev. 2/06)

Oklahoma Workers' Compensation Court – Claimant's First Notice of Death and Claim for
Compensation – Form 3A (rev. 2/06)

Oklahoma Workers' Compensation Court – Employee's First Notice of Occupational
Disease and Claim for Compensation – Form 3B (rev. 2/06)

Supervisor's Incident Report

Wage Statement

Medical Authorization

Attending Physicians Return to Work Recommendation Record

Job Analysis

Return to Work Log

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SUPERVISOR'S INCIDENT REPORT

 Injury(work related)

 Incident

 Illness (work related)

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

Did employee seek medical attention? Yes No

If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will employee complete a drug screening? Yes No

Name of Witnesses Names (Attach statements if available)

1. _____ 2. _____

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

How could this incident been prevented?

What corrective action has been taken?

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

Comments _____

Supervisor Signature _____

Date _____

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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								
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18									44								
19									45								
20									46								
21									47								
22									48								
23									49								
24									50								
25									51								
26									52								
SUBTOTAL										SUBTOTAL							
										GRAND TOTAL							

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

Employer's Signature _____ Title _____ Date _____



ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

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

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



RETURN TO WORK LOG

Employee
Name _____

Supervisor

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

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

Employee
Signature _____

Date _____



RETURN TO WORK LOG

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

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the 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 give oral or written notice of the injury or occupational disease to your employer immediately. Unless notice is given to the employer or medical treatment is rendered within thirty (30) days of the injury, any claim for compensation may be forever barred.
- You may file a claim for compensation with the Workers' Compensation Court. Your employer is required to furnish you with appropriate forms to file a compensation claim.
- You must file a claim for compensation with the Court within a period of time specified by statute, or be forever barred. According to Oklahoma law, if a claim for compensation for any accidental injury or death is not filed with the Court within two (2) years from the date of the accidental injury or death or if a claim for compensation for occupational disease or cumulative trauma is not filed within two (2) years of either the last hazardous exposure or from the date the disease first became manifest, which ever last occurred, the claim for compensation may be forever barred. Provided, claims may be filed within two (2) years from the date of the last medical treatment authorized by your employer or payment of any compensation or remuneration paid in lieu of compensation. Post termination claims must be filed within six (6) months of termination of employment.
- If you are receiving temporary disability benefits from your employer or its insurance carrier you shall promptly report in writing to your employer or its insurance carrier any change in a material fact or the amount of income you are receiving or any change in your employment status, occurring during the period of receipt of such benefits.
- Comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.

Employer:

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

- You must report the injury or illness to your insurance carrier or administrator responsible for the workers' compensation program by completing Form 2 (rev. 2/96) and submitting it via the agreed upon method, e.g. online reporting, facsimile, or telephonic reporting within ten (10) days of the notice of injury or a reasonable time thereafter.
- 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.
- You must provide the employee with immediate first aid, medical and surgical care and other like services necessary.
- 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 First Notice of Injury, Form 1A (rev. 07/05), as well as all other required reports to the Workers' Compensation Court.
- 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

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

Oklahoma Workers' Compensation Court - <http://www.owcc.state.ok.us/index.htm> - For General Questions 800-522-8210

Oklahoma Workers' Compensation Benefits Information – http://www.owcc.state.ok.us/Laws_Rules.htm

Oklahoma Workers' Compensation Fraud Resources/Information – <http://www.compsourceok.com/fraud.htm>

Oklahoma Workers' Compensation Compliance Notice and Instruction to Employers and Employees (WC workplace poster) - <http://www.owcc.state.ok.us/Forms.htm>