

# SUA South Carolina Claim Kit



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## **PACKET INFORMATION & RESPONSIBILITIES SOUTH CAROLINA**

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:
  - South Carolina First Report of Injury or Illness – Form 12A (Rev. 04/2006)
  - South Carolina Temporary Compensation Report – Form 15 (Rev. 10/2004)
  - South Carolina Supplemental Report of Varying Temporary Partial Payments – Form 15S (Rev. 03/1997)
  - South Carolina Receipt of Compensation – Form 17 (Rev. 03/1997)
  - South Carolina Workers' Compensation Poster – English/Spanish
- The responsibilities of each party involved in the claim. The information contained will assist you in understanding what each party's responsibilities include from the injured employee, client employer, PEO and insurance carrier.
- Coventry/First Script temporary prescription services ID information. This document should be provided to your injured employee at the time they report an injury and are seeking medical attention. The information contained will give pharmacists the information necessary to file the claim form with SUA and should prevent the injured employee from having to pay for the prescriptions related to the work injury. Once the claim is filed with SUA a prescription drug card will be issued to the injured worker for additional prescribed medication.
- Resources and contact information. Included in this information you will find useful internet links for state forms, Coventry Provider Network Information and key contact information for SUA, including names, department and telephone and fax numbers for staff members assigned to your account.
- Posting Notice. All employers operating under the Act, whether by law or by election, shall post publicly and keep posted in their place of business a Form 2, Employer's Notice of Being Subject to the Act.

**Thank you for choosing SUA Insurance Company**

SC01 08/08



## HOW TO FILE A WORK INJURY OR ILLNESS CLAIM

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

- Complete and submit the First Report of Injury or Illness – Form 12A (Rev. 04/2006) via the online reporting system available at [www.suainsurance.com](http://www.suainsurance.com). Email the completed form to [claimsintake@suainsurance.com](mailto:claimsintake@suainsurance.com). **This is the preferred method of reporting an injury.**
- Complete the First Report of Injury or Illness – Form 12A (Rev. 04/2006) and fax to SUA at 877-782-3292.
- Complete and mail the First Report of Injury or Illness – Form 12A (Rev. 4/2006) 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.

SC02 08/08



## TELEPHONE REPORTING GUIDE

### Employer Information

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

### Employee Information

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

### Time and Place of Injury

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

### Cause of Injury

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

### Nature of Injury

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

SUA03 08/08



## STATE FORMS SOUTH CAROLINA

- **South Carolina First Report of Injury or Illness – Form 12A (Rev. 04/2006)** - This form is to be completed by the employer when an employee reports an injury or accident. Please complete the form with as much available information as possible.
- **South Carolina Temporary Compensation Report – Form 15 (Rev. 10/2004)** – The insurance company must complete and file Form 15 with the South Carolina Claims Department within ten days after compensation begins or is terminated. The insurance company must serve the Form 15 on the claimant when compensation begins per R.67-211.
- **South Carolina Supplemental Report of Varying Temporary Partial Payments Form 15S (Rev. 03/1997)** – Supplemental payments shall be reported on a Form 15S, to be filed with the document stopping that period of temporary partial compensation.
- **South Carolina Receipt of Compensation – Form 17 (Rev. 03/1997)** – This form is to be filed with the South Carolina Claims Department no later than 31 days from the date the claimant returned to work to terminate temporary compensation after the first 150 days after employer's notice of the injury according to R.67-505. Within the 150 period, obtain Form 17 to document that claimant agrees he or she is able to return to work.
- **South Carolina Workers' Compensation Poster – English/Spanish**

## WORKERS' COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE	
		JURISDICTION	JURISDICTION CLAIM NUMBER		
		INSURED REPORT NUMBER			
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #	
INDUSTRY CODE	EMPLOYER FEIN			PHONE #	
<b>CARRIER/CLAIMS ADMINISTRATOR</b>					
CARRIER (NAME, ADDRESS, & PHONE #)		POLICY PERIOD  TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)		
		CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE			
CARRIER FEIN	POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN		
AGENT NAME & CODE NUMBER					
<b>EMPLOYEE/WAGE</b>					
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	MARITAL STATUS <input type="checkbox"/> Unmarried/Single/Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	OCCUPATION/JOB TITLE	
				EMPLOYMENT STATUS	
				NCCI CLASS CODE	
PHONE		# OF DEPENDENTS			
RATE PER:	<input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
			DID SALARY CONTINUE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>OCCURRENCE/TREATMENT</b>					
TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( <input type="checkbox"/> ) CANNOT BE DETERMINED	<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED	
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?  <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE	
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL				CAUSE OF INJURY CODE	
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
				<input type="checkbox"/> YES	<input type="checkbox"/> NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)		INITIAL TREATMENT	
				0 <input type="checkbox"/>	NO MEDICAL TREATMENT
				1 <input type="checkbox"/>	MINOR: BY EMPLOYER
				2 <input type="checkbox"/>	MINOR CLINIC/HOSP
				3 <input type="checkbox"/>	EMERGENCY CARE
				4 <input type="checkbox"/>	HOSPITALIZED >24 HOURS
				5 <input type="checkbox"/>	FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED
<b>OTHER</b>					
WITNESSES (NAME & PHONE #)					
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED	PREPARER'S NAME & TITLE		PHONE NUMBER

## EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

### DATES:

Enter all dates in MM/DD/YY format.

### INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

### CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

### CLAIMS ADMINISTRATOR:

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

### AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

### OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

### EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time On Strike Unknown Volunteer

Part-Time Disabled Apprenticeship Full-Time Seasonal

Not Employed Retired Apprenticeship Part-Time Piece Worker

### DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

### CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

### TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

### PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

### DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

**EMPLOYER'S INSTRUCTIONS – cont'd**

**ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:**

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

**SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:**

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

**WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:**

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

**HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:**

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

**DATE RETURN(ED) TO WORK:**

Enter the date following the most recent disability period on which the employee returned to work.

South Carolina Workers' Compensation Commission

1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723



WCC File #:
Carrier File #:
Carrier Code #:
Employer FEIN #:

Claimant's Name: SSN: Employer's Name:

Address: Address:

City: State: Zip: City: State: Zip:

Home Phone: Work Phone: Insurance Carrier:

Preparer's Name: Law Firm: Preparer's Phone #:

Date of injury: Date of Notice to Employer of Injury:

I. Payment of Temporary Compensation Check one: Initial period Additional period Corrected compensation rate

- A. Temporary Total at the compensation rate of \$ per week. For this period of disability, disability began on (m/d/yyyy) and the date of first payment was (m/d/yyyy).
B. Temporary Partial at the compensation rate of \$ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a Form 15S with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. For this period of disability, disability began on (m/d/yyyy), and the date of first payment was (m/d/yyyy).

Calculation of Temporary Partial Rate: Average weekly wage before injury \$
- Current weekly wage \$
= Difference in wages before injury and now \$ 0.00
x .6667 \$ 0.00
Temporary Partial Compensation Rate \$ 0.00

- C. Salary in lieu of Temporary Total Partial (choose one) compensation in the amount of \$ per week. For this period of disability, disability began on (m/d/yyyy) and the date of first payment of salary in lieu of temporary compensation was (m/d/yyyy).

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF INJURY. ATTACH DOCUMENTATION AS TO THE REASON OF THE TERMINATION.

II. Termination of Temporary Compensation Temporary compensation payments were stopped on (m/d/yyyy) for the following reason:

- Claimant has returned to work at least 15 days and no temporary partial compensation is due.
Claimant agrees he/she is able to return to work and has signed a Form 17.
Based on a good faith investigation, the claim is denied. Reason for denial:
Claimant has been released to return to work without restrictions and employment has been offered.
Claimant has been released to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

Signature of Claims Administrator

Date (m/d/yyyy)

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:

The employer's representative may stop temporary compensation within 150 days of the date of notice of injury for the above reasons. However, if you believe that the temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to SCWCC Judicial Department at the address at the top of this form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: Form 15(II) Has Has not been received.

Signature of Claimant or Legal Representative

Date (m/d/yyyy)

Employer's representative must complete and file Form 15 with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the Form 15 on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve Form 20 within thirty days of beginning compensation per R.67-1603. Employer's representative must serve per R.67-211 two copies of the Form 15 on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the Form 15 and filing it with Judicial Department.



Claimant's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_  
Preparer's Name: \_\_\_\_\_ Law Firm: \_\_\_\_\_ Preparer's Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of injury: \_\_\_\_\_  
(m/d/yyyy)

**Supplemental Report of Varying Temporary Partial Payments**

From \_\_\_\_\_ through \_\_\_\_\_, Claimant was paid \$\_\_\_\_\_ per week as temporary partial compensation. The weekly wage before the injury was \$\_\_\_\_\_. The weekly wage for this period was \$\_\_\_\_\_.

From \_\_\_\_\_ through \_\_\_\_\_, Claimant was paid \$\_\_\_\_\_ per week as temporary partial compensation. The weekly wage before the injury was \$\_\_\_\_\_. The weekly wage for this period was \$\_\_\_\_\_.

From \_\_\_\_\_ through \_\_\_\_\_, Claimant was paid \$\_\_\_\_\_ per week as temporary partial compensation. The weekly wage before the injury was \$\_\_\_\_\_. The weekly wage for this period was \$\_\_\_\_\_.

From \_\_\_\_\_ through \_\_\_\_\_, Claimant was paid \$\_\_\_\_\_ per week as temporary partial compensation. The weekly wage before the injury was \$\_\_\_\_\_. The weekly wage for this period was \$\_\_\_\_\_.

From \_\_\_\_\_ through \_\_\_\_\_, Claimant was paid \$\_\_\_\_\_ per week as temporary partial compensation. The weekly wage before the injury was \$\_\_\_\_\_. The weekly wage for this period was \$\_\_\_\_\_.

From \_\_\_\_\_ through \_\_\_\_\_, Claimant was paid \$\_\_\_\_\_ per week as temporary partial compensation. The weekly wage before the injury was \$\_\_\_\_\_. The weekly wage for this period was \$\_\_\_\_\_.

From \_\_\_\_\_ through \_\_\_\_\_, Claimant was paid \$\_\_\_\_\_ per week as temporary partial compensation. The weekly wage before the injury was \$\_\_\_\_\_. The weekly wage for this period was \$\_\_\_\_\_.

From \_\_\_\_\_ through \_\_\_\_\_, Claimant was paid \$\_\_\_\_\_ per week as temporary partial compensation. The weekly wage before the injury was \$\_\_\_\_\_. The weekly wage for this period was \$\_\_\_\_\_.

From \_\_\_\_\_ through \_\_\_\_\_, Claimant was paid \$\_\_\_\_\_ per week as temporary partial compensation. The weekly wage before the injury was \$\_\_\_\_\_. The weekly wage for this period was \$\_\_\_\_\_.

In an ongoing period of temporary partial, when the compensation rate varies from week to week, the employer's representative shall report the first payment on a Form 15 according to R.67-503. Supplemental payments shall be reported on a Form 15S, to be filed with the document stopping that period of temporary partial compensation or with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. R.67-503.



Claimant's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ ( ) - \_\_\_\_\_ Work Phone: \_\_\_\_\_ ( ) - \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_  
 Preparer's Name: \_\_\_\_\_ Law Firm: \_\_\_\_\_ Preparer's Phone #: \_\_\_\_\_ ( ) - \_\_\_\_\_

Date of injury: \_\_\_\_\_ (m/d/yyyy)

1. Temporary Compensation Paid:

Number of Weeks	From	To	Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

2. The claimant returned to work on \_\_\_\_\_ (m/d/yyyy)  With restrictions but at a salary not less than before the injury.  
 Without restrictions.

3. The claimant agrees he or she was able to return to work on \_\_\_\_\_ (m/d/yyyy).

I agree that I was disabled for the period(s) indicated and I was paid compensation as shown above. **I UNDERSTAND THAT MY WEEKLY TEMPORARY COMPENSATION CHECKS WILL STOP; HOWEVER, I GIVE UP NO RIGHTS TO COMPENSATION FOR FUTURE DISABILITY, FOR PERMANENT DISABILITY, DISFIGUREMENT OR MEDICAL CARE.** The effect of this form has been fully explained to me, and I have received a copy of it. I understand that I should not sign this form until 15 days after I have returned to work or agree I was able to return to work.

\_\_\_\_\_  
 Claimant's Signature

\_\_\_\_\_  
 Employer's Representative Signature

(Check one)  Witness  Claimant's Attorney

\_\_\_\_\_  
 Date Agreement Signed

File this form with the Claims Department no later than 31 days from the date the claimant returned to work to terminate temporary compensation after the first 150 days after employer's notice of the injury according to R.67-505. Within the 150 period, obtain Form 17 to document that claimant agrees he or she is able to return to work.

# **Workers' Compensation**

## **If you are injured on the job, you should:**

1. Notify your employer at once. You can't receive benefits unless your employer knows you're injured.
2. Tell the doctor your employer sends you to that you're covered by Workers' Comp.
3. Notify the Workers' Comp. Provider below or the S.C. Workers' Comp. Commission at (803) 737-5700 if you experience undue delays or problems with your claim.

## **Workers' Compensation:**

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

## **We are operating under and subject to the S.C. Workers' Compensation Act**

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

**S.C. Workers' Compensation Commission  
P.O. Box 1715, 1612 Marion Street  
Columbia, S.C. 29202-1715  
(803) 737-5700  
[www.wcc.sc.gov](http://www.wcc.sc.gov)**

# Compensación del Trabajador

## Si usted se lesiona en el trabajo, usted debe:

1. Notificar a su patrón inmediatamente. Usted no puede recibir beneficios a menos que su patrón sepa que se ha lesionado.
2. Decirle al doctor al que su patrón le envíe que usted está cubierto por la Compensación del Trabajador.
3. Notificar al Proveedor de Compensación del Trabajador abajo mencionado o a la Comisión de Compensación del Trabajador de Carolina del Sur al (803) 737-5700 si usted tiene retrasos o problemas indebidos con su reclamación.

## La Compensación del Trabajador:

1. Paga el 100% de sus recibos médicos y otros gastos.
2. Le compensa por el 66 2/3% de su salario, limitado al salario máximo establecido por la ley, si usted no puede trabajar por más de siete (7) días calendario.

## Trabajamos conforme al Acto de Compensación del Trabajador de Carolina del Sur

En caso de lesión accidental o muerte de un empleado, el empleado lesionado, o alguien que le represente, tiene que avisar inmediatamente al patrón o agente autorizado general. El hecho de no avisar inmediatamente puede causar una demora seria en el pago de la compensación al empleado lesionado o a sus dependientes y puede resultar en el impago de los beneficios de compensación según estipula la ley.

**S.C. Workers' Compensation Commission  
(Comisión de Compensación de Trabajadores)  
P.O. Box 1715, 1612 Marion Street  
Columbia, SC 29202-1715  
(803) 737-5700  
[www.wcc.state.sc.us](http://www.wcc.state.sc.us)**



## **SOUTH CAROLINA FIRST REPORT OF INJURY FORMS PACKET**

South Carolina First Report of Injury or Illness – Form 12A (Rev. 04/2006)

South Carolina Temporary Compensation Report – Form 15 (Rev. 10/2004)

South Carolina Supplemental Report of Varying Temporary Partial Payments – Form 15S (Rev. 03/1997)

South Carolina Receipt of Compensation – Form 17 (Rev. 03/1997)

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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)

---



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How could this incident been prevented?

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What corrective action has been taken?

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

Comments \_\_\_\_\_

Supervisor Signature \_\_\_\_\_

Date \_\_\_\_\_

SUA04 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

SUA05 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									
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18									44									
19									45									
20									46									
21									47									
22									48									
23									49									
24									50									
25									51									
26									52									
<b>SUBTOTAL</b>										<b>SUBTOTAL</b>								
										<b>GRAND TOTAL</b>								

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

Employer's Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_



## ATTENDING PHYSICIAN RETURN TO WORK RECOMMENDATION RECORD

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





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 or injury should take place, it is your responsibility to take the following actions, injury permitting:

- You must report the accident and injury immediately, in writing if possible, to your employer.
- If it is an emergency and your employer is not available to tell you where to go for treatment, go to the nearest emergency room and let your employer know as soon as possible what has happened.
- You must keep and attend all appointments with your doctor, or benefits may be suspended.
- 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 accident you should take the following steps:

- You must complete and submit the First Report of Injury or Illness – Form 12A (Rev. 04/2006) to the insurance carrier or administrator responsible for the workers' compensation program via the agreed upon method, e.g. online reporting, facsimile, or telephonic reporting. Note: You shall keep a record of all work-related injuries reported by your employees on the Form 12A and retain the record for a period of two years.
- 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.
- If the injury requires less than five hundred dollars in medical treatment and does not cause more than one lost workday or permanency, you may pay for the medical treatment. You are not required to make a written report to the insurance company or to the Commission.
- If you deny the claim for injuries or does not elect to pay for the medical treatment, you shall send a copy of the Form 12A to the insurance company immediately after the occurrence and knowledge of the injury.
- If the injury requires five hundred dollars or more in medical treatments or when it is determined more than one workday will be missed as a result of the injury or there is likely to be permanency, you shall send a copy of the Form 12A to the insurance company immediately.
- 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 or accident 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.
- If the injury requires less than two thousand five hundred dollars in medical treatments and does not result in compensable lost time or permanency, SUA shall retain the Form 12A filed by the employer for two years. SUA shall make a report of this injury in this category to the Commission's Accident Reporting Division annually as required in R.67-412.
- If the injury requires two thousand five hundred dollars or more in medical treatments or results in compensable lost time or permanency, SUA shall send the Form 12A to the Commission's Accident Reporting Division within ten business days after the occurrence and the employer's knowledge of the injury.
- SUA will 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 specialists on staff overseeing all aspects of the investigation and timely notification to all parties while ensuring our lien is protected and utilized in the most advantageous means to resolve the issue.

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

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

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



## RESOURCES

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

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

South Carolina Workers' Compensation Commission - <http://www.wcc.sc.gov/> - For General Questions  
1-803-737-5700

South Carolina Workers' Compensation Benefits Information –  
<http://www.wcc.sc.gov/Welcome+and+Overview/Compensation+Rates/> and  
[http://www.wcc.sc.gov/Welcome+and+Overview/faqs/#inj\\_med](http://www.wcc.sc.gov/Welcome+and+Overview/faqs/#inj_med)

State of South Carolina Workers' Compensation Poster -  
<http://www.llr.state.sc.us/aboutUs/index.asp?file=Posters.htm>