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BUSINESS

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INSURANCE GROUP

Claims Reporting Guide

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rev. 10/2/12

WELCOME

We are glad you insured with Alabama Workers' Compensation Self-Insurance Fund (AlaCOMP) through Business Insurance Group. We are confident you will be happy with your decision. Our goal is to offer the best services in the industry. We will strive to help you control your losses and improve safety practices, which in turn help your bottom line.

This **Claims Reporting Guide** was developed to assist you, our valued customer. Please ensure your worker's compensation claims manager/coordinator/HR director receives this guide.

Thank you for giving us the opportunity to serve your insurance needs. Please call us if have any questions. Our toll free customer service hotline telephone number is 888-661-7119.

Again, thank you and welcome!

EVELYN THOMAS
Business Insurance Group
Claims Manager

BUSINESS INSURANCE GROUP
P.O. Box 243007
Montgomery, AL 36124

(334) 215-8234
(888) 661-7119

Claims FAX: (334) 215-8480
Policy Admin/Underwriting FAX: (334) 215-8479
Loss Control FAX: (334) 215-8480

DISCLAIMER

This Claims Reporting Guide is not intended to be a comprehensive explanation of the Alabama Workers' Compensation Law. It is designed to assist you in reporting and managing your workers' compensation claims. This Claims Reporting Guide is intended for informational purposes only and is not intended to give legal advice and is subject to change without notice.

CLAIMS PHILOSOPHY

Our mission is to investigate all claims in a prompt and thorough manner. We manage claims with the objective of ensuring injured workers receive the best medical care to return them to their job. Services are provided with the ideal that employers want their employees to receive any and all benefits due in a fair, equitable and timely manner.

A successful claims administration program requires teamwork from all involved; the employer, medical provider/s, injured worker, and claims adjuster. It is the claims adjuster's responsibility to ensure that efforts of all are coordinated in an efficient and effective manner.

Business Insurance Group's staff of claims professionals are experienced in applying our team approach to claims administration to bring about cost-effective solutions to claims. Our practices, principles and beliefs have been embraced by self-insured employers, self-insured funds and insurance companies.

DEPARTMENT OF LABOR

The Alabama Department of Labor is responsible for the administration of the Alabama Workers' Compensation Law. Their website http://www.alalabor.alabama.gov/wc is an excellent resource for employers, employees and claims administrators. They provide forms and posters, guides and general information.

The Ombudsman Program is an excellent resource to answer workers compensation questions. Often an injured worker is looking for independent affirmation of what an employer and/or an adjuster has told them about workers compensation. Sometimes they retain an attorney simply because they don't understand workers compensation. An employer, an injured worker, and/or claims adjuster can call the Ombudsman toll free 1-800-528-5166 to verify their claim is being handled in compliance within the Alabama Workers' Compensation Law.

WHEN TO FILE A CLAIM AND WHY

I. The employer must file a worker's compensation claim immediately upon NOTICE from your employee that they have had an alleged on the job injury. (This is an Alabama Workers' Compensation statutory requirement.)

II. Alabama Case Law establishes that an injured worker must give you NOTICE within 90 days of the alleged injury. The instructions for filing WC First Report of Injury on the back of WCC Form 2 Rev. 10/2012 (see page 16 of this guide) states: "Employers should send a completed legible form to the insurance carrier or, if self-insured, to the designated office handling their workers' compensation claims. The insurance carrier or designated office should forward this First Report on to the Alabama Department of Labor, Workers' Compensation Division within fifteen (15) days from the date of Injury or date of notification to the employer for which compensation is claimed or paid…..". Item #11 ALACOMP's Participation Agreement states you have agreed to report to the service organization all accidents or illnesses which may give rise to a worker's compensation claim within the time prescribed by law and in such manner and on such forms that may be prescribed by the Fund or the service organization. Non-compliance of the Participation Agreement could adversely affect your ALACOMP Workers' Compensation Policy coverage.

III. What if you have proper NOTICE from your employee of an on the job injury; **but**, you do not believe it is worker's compensation? Refer to **Item I** above (first paragraph this page), and file the claim. On separate company letterhead state/identify why you believe it is not worker's compensation and ensure it is signed and dated.

IV. What if you have assurances from an at fault third party that they will cover the claim, do I have to file a worker's compensation claim? **YES**. (Refer to **Items I & II** above.)

V. What if you receive NOTICE after 90 days of an alleged on the job injury, do I have to file a worker's compensation claim? **YES**.

VI. What if you receive a letter of representation from an attorney representing an employee alleging worker's compensation injury and this is your first NOTICE, does the employer have to file a worker's compensation claim? **YES**.

VII. What if you receive a Summons and Complaint with interrogatories regarding a Count of Worker's Compensation? **Send it to us immediately**. ALACOMP's attorneys will defend and answer the interrogatories.

CLAIMS REPORTING

I. Complete EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE (WC Form 2). Mail or fax WC Form 2 along with any other related documentation (i.e. internal/supervisors accident investigation report, medical billing/records, DPS Accident Reports, etc.) to:

Business Insurance Group
Claims Department
P.O. Box 243007
Montgomery, AL 36124

Fax: (334) 215-8480
e-mail: claimsfirstreport@alacompins.com

II. Refer injured employee to authorized treating physician. It is the employer's choice (see Medical Protocol in this guide).

III. Assist the assigned claims adjuster with the investigation and handling of the claim (identify your concerns on a questionable claim).

IV. Provide light/modified duty whenever possible even if available on part-time basis and/or you cannot pay the injured worker their usual wage. In such cases, we will pay temporary partial disability.

V. Immediately forward originals or copies of all correspondence, including but not limited to medical bills and records, to:

Business Insurance Group
Attention Claims
Department P.O. Box 243007
Montgomery, AL 36124

Fax: (334) 215-8480

VI. Stay in touch and follow your claim with the claims adjuster, keeping each other abreast of return to work issues, medical treatment and other relevant and pertinent information is essential for cost-effective management of the claim.

MEDICAL COST CONTAINMENT

The most important right an employer has under Alabama Workers' Compensation Law is the right to choose the medical provider(s). However, the majority of employers fail to exercise this right. We encourage all employers to implement a medical protocol.

An established medical protocol is the most cost effective measure in claims handling. (a.) It stops an employee from going to their family physician and stops an authorized physician from making a referral to a specialist who is not approved by you, the employer. (b.) It authorizes Emergency Rooms to issue only enough medication to get the employee to the next business day. (c.) It authorizes Emergency Rooms to only refer to your companies authorized primary treating physician. (d.) It virtually eliminates multiple Emergency Room visits for the sole purpose of seeking unauthorized treatment and medication.

We encourage you to establish a medical protocol program if you do not already have one. To assist you, we recommend you utilize the suggested medical protocol:

1. MEDICAL PROTOCOL FOR WORKERS COMPENSATION INJURIES. (This form standardizes your program. It is coordinated between you the employer and your authorized primary care physician. It is a reference guide for your HR and/or WC Coordinator. This form should be incorporated in your company's employee handbook.)

2. EMERGENCY PROTOCOL FOR WORKERS COMPENSATION INJURIES. (This form is coordinated between you the employer and the local Emergency Room.)

3. LETTER TO ALL EMPLOYEES IMPLEMENTING YOUR WORKERS COMPENSATION MEDICAL PROTOCOL. (One time mass mailing or stuff in employee pay envelops.)

The suggested medical protocol is provided simply as a guide. Please feel free to modify in any way to fit your company's needs. It does take effort to coordinate with your medical providers to set up and establish your medical protocol. However, once implemented it will pay dividends in medical containment and cost effectiveness.

(COMPANY NAME)

MEDICAL PROTOCOL FOR WORKERS COMPENSATION INJURIES

I. CONTACT PERSONNEL

A. (Company Name). The telephone number is (XXX) XXX-XXXX. The contact person is XXXXXX XXXXXXX.

B. Business Insurance Group – at P.O. Box 230517, Montgomery, Alabama, 36123-0517. Telephone (334) 215-8234. FAX: (334) 215-8480.

II. INITIAL TREATING PHYSICIAN

A. The initial treating physician is ****Physician Name & Address****. The telephone number is ****Physician Telephone****.

III. REFERRAL BEYOND THE INITIAL TREATING PHYSICIAN

A. All back and /or spine injuries, i.e. any back sprains or any medical condition that could be related to the cervical, lumbar or thoracic spine, that must be referred to a specialist, must be referred by the initial treating physician to ****Physician Name & Address****. The telephone number is ****Physician Telephone****.

If ****Physician Name**** determines that a neurosurgeon is need, he will refer to ****Physician Name****.

B. Any injury related to joints or ligaments that must be referred to a specialist, must be referred by the initial treating physician ****Physician Name & Address****. The telephone number is ****Physician Telephone****.

IV. EMERGENCY ROOM

A. All non-emergency injuries occurring on the weekends or at night should go to ****ER Facility****. The telephone number is ****ER Telephone****.

B. ****ER Facility**** Emergency Room is the designated emergency room for all cases where the employee must go to the emergency room rather that the designated initial treating physician.

C. ****ER Facility**** Emergency Room personnel are authorized to treat emergencies in regards to the above referenced cases; however, in the event further treatment is necessary, the emergency room physician shall refer the employee back to the designated treating physician which is ****Physician Name****.

D. Emergency Room Referral – (non-emergency cases) In no event shall the emergency room physician authorize the employee to go to his family physician should further treatment be necessary or to any other physician except in the case of emergency.

E. ****ER Facility**** has the authority to issue enough prescription drugs to last until the next business day. Then, the emergency room physicians should instruct the employee to go back to the designated treating physician (****Physician Name****) for any further prescriptions. The intent is to have all prescription management handled by one doctor.

V. PHYSICAL THERAPY

A. All physical therapy shall be conducted at the office of ****Physical Therapist Name & Address****.

VI. NARCOTIC PRESCRIPTIONS

A. The authorized treating physician shall prescribe generic drugs on prescriptions when available.

VII. CT SCAN AND MRI

A. All CT Scans and MRI diagnostic imaging procedures shall be conducted at an office to be specified by the initial treating physician, in non-emergency cases.

VII. PRE-CERTIFICATION PROCEDURES

A. To pre-cert, please call (334) 215-8234.

B. The following list of services requires pre-certification:

1. All outpatient physical therapy, occupational therapy and speech therapy services, after the initial evaluation by the therapist and approval by the referring physician, at which time a full treatment plan which with all required components would be clearly specified. In some cases, the referring physician may specify a detailed treatment plan at the outset, which may then be considered for pre-certification.

2. All chiropractic services after the initial evaluation visit, at which time a full treatment plan with all required components would be clearly specified.

3. Outpatient services as listed below:

    a. Magnetic Resonance Imaging on second study
    b. CAT Scans on second study
    c. Myelograms, Discograms, Service Electromyograms on second study

4. Referrals to specialists by the initial treating physician (not an emergency physician) for the purpose of the specialists assuming full case management responsibilities.

5. Work conditioning.

(COMPANY NAME)

EMERGENCY PROTOCOL FOR WORKERS COMPENSATION INJURIES

This protocol does not apply to injuries in which the emergency room physician determines to be life threatening or traumatic physical injuries.

This protocol is to apply to standard non-traumatic, non-life threatening workers compensation injuries.

Business Insurance Group at P.O. Box 243007, Montgomery, Alabama, 36124. The telephone number is (334) 215-8234. FAX (334) 215-8480.

A. All non-emergency injuries occurring on the weekends or at night should go to the ****ER Facility**** Emergency Room.

B. ****ER Facility**** ER is the designated emergency room for all cases where the employee must go to the emergency room rather than the designated initial treating physician.

C. ****ER Facility**** Emergency Room personnel are authorized to treat emergencies in regards to the above referenced cases; however, in the event further treatment is necessary, the emergency room physician shall refer the employee back to the designated treating physician which is ****Physician Name****.

D. Emergency Room Referral – (non-emergency cases) In no event shall the emergency room physician authorize the employee to go to his family physician should further treatment be necessary or to any other physician except in the case of emergency.

E. ****ER Facility**** Emergency Room has the authority to issue enough prescription drugs to last until the next business day. Then, the emergency room physician should instruct the employee to go back to the designated treating physician (****Physician Name****) for any further prescriptions. The intent is to have all prescription management handled by one doctor.

(COMPANY NAME)
MEMORANDUM

TO: (Employee)

FROM: Human Resource Department

DATE: October 1, 2010

RE: Workers Compensation Medical Protocol

Dear Employee:

The following is the established medical protocol for workers compensation injuries that occur during the day and night shifts or on the weekends that are not life threatening or do not involve serious bodily injuries.

Mandatory notice

A. You must report all incidences of injury to your supervisor immediately.

Daytime workers compensation incidences

A. If you are injured during any day shift, you are to report to ****Physician Name & Address****. The telephone number is ****Physician Telephone Number****.

Nighttime workers compensation incidences

A. If you are injured during the night shift, i.e. when ****Physician Name**** office is closed, you are to report to ****ER Facility**** Emergency Room.

Emergency Needs

A. If you need to see the approved doctor on the weekends and the approved doctor's office is closed or if you need care on a weekday and the approved doctor's office is closed, the approved emergency room is ****ER Facility**** Emergency Room.

Failure to report to the above listed medical providers may jeopardize your worker's compensation benefits.

THE ALACOMP RX PROGRAM

We offer a pharmacy services to injured workers using two networks: Carlisle Medical and EQUIAN. We use them interchangeably. Both include national and independent pharmacies.

Once the authorized treating physician (see your medical protocol on page 7) and writes a pharmacy prescription, the injured worker may take the prescription to their pharmacy of choice. Have the pharmacy call us at (334) 215-8234 or (888) 661-7119 to obtain authorization from the assigned claims adjuster.

Note: ALACOMP does not have legal authority to administer/adjudicate any claim with the insured until the EMPLOYER'S FIRST REPORT OF INJUTY OR OCCUPATIONAL DISEASE (WC Form 2) has been filed/sent to us (see page 5).

If an injured worker chooses to pay for the initial pharmacy prescription(s), they may do so. To get reimbursed for this out of pocket expense, they may submit a copy to the pharmacy receipt for reimbursement. This receipt must reflect name of medication, quantity, and prescribing physician. Send their reimbursement request to:

Business Insurance Group, LLC
P.O. Box 243007
Montgomery, AL 36124

EMPLOYER DRUG POLICY

Section 25-5-51 of the Alabama Code states that no compensation shall be allowed for an injury or death caused "by an accident due to the injured employee being intoxicated from the use of alcohol or being impaired by illegal drugs".

This company requires that you submit to drug testing in accordance with the standards adopted for drug testing by the U.S. Department of Transportation in 49 C.F.R. Part 40 immediately after you experience a work related accident or as soon after such accident is medically possible.

Section 25-5-51 of the Alabama Code also states that no compensation shall be allowed if an employee refuses to submit to or cooperate with a blood or urine test as set out above after a work related accident after the employee has been warned in writing that such refusal would forfeit the employee's right to recover compensation benefits.

Give a copy of this Drug Policy to each employee. Have them sign for receipt of their copy and keep it on file in their personnel folder. All employees need to know there will be no compensation if they test positive and their impairment from same is the proximate cause of the injury.

HELP US HELP YOU

- Assist the claims adjuster with the initial investigation. The more information you provide the adjuster with at the outset of the claim the greater the likelihood of success.
    - Report the claim in a timely manner.
    - Advise the adjuster of any witnesses and the availability of light/modified duty at the time a claim is reported.
    - Advise the adjuster of any questions or concerns you may have about the reported injury; we do not know your employees as well as you do.
- Respond promptly to requests for information and/or assistance.
- Help coordinate a timely return to work by providing light/modified duty work assignment.
- Promptly advise us of an injured worker's return to work.
- Promptly forward all correspondence and inquiries, including but not limited to medical bills and records. Mail or fax to:

Business Insurance Group
Claims Department
P.O. Box 243007
Montgomery, AL 36124

Fax: (334) 215-8480

- Unless the injured worker is represented by an attorney, stay in touch with them by calling or seeing them in person. Keep a record of such contacts and if a pattern of not being able to reach them develops advise the adjuster.
- Advise us of any sightings or rumors of injured worker activities that are inconsistent with the injury or disability that is being claimed.
- ASK US QUESTIONS ABOUT YOUR INJURED WORKERS.

FRAUD

Not all fraudulent claims are injuries or illnesses that did not arise out of and while they were in the course and scope of their employment. Some fraudulent claims involve injuries or illnesses with legitimate beginnings. Alabama Criminal Code 13A-11-124 defines workers' compensation fraud as:

> "Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining compensation as defined in Section 25-5-1(1), as amended, for himself or herself or any other person is guilty of a Class C felony."

Business Insurance Group, LLC takes fraud very seriously and is committed to the identification and investigation of claim fraud. The identification of claim fraud begins when the claim is reported and does not end until it is closed. Private investigators are used as a part of this ongoing process, however they are very costly and is often a matter of being in the right place at the right time. The employer is typically the best source of information because both they and coworkers typically live in the same community as the injured worker. Thus we encourage employers to keep us advised of known and/or rumored activities of their injured employees that are peculiar given the nature and extent of claimed injury(s); not consistent with subjective complaints; working elsewhere; not able to contact them; unwilling to return to work; or any other activity that doesn't seem appropriate given their claim. Having said this, it is most often the case that rumors are just in fact that, rumors and without merit.

In the event fraud is found to exist, the matter is referred to legal counsel for review and a determination is made as to whether or not additional investigation is needed and if referral to the State of Alabama for their own investigation and possible prosecution are appropriate. Workers' compensation claim fraud is a Class C Felony and is punishable by both fine of up to $5,000 and/or imprisonment of one to ten years. For employers or employees that are reluctant to report suspected fraud, there is a Fraud Hot Line where suspected fraudulent claims can be reported (1-334-242-7345 or 1-800-923-2533).

We also encourage posters informing and warning employees of workers' compensation fraud being posted about the workplace. A poster, provided by the State of Alabama, Department of Labor, is one recommended posting and it's free; just call the Department (1-334-242-2868 or 1-800-5628-5166) or visit their website www.alalabor.alabama.gov/wc .

WCC Form 2
Rev. 9/2006

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE
Ombudsman 1-800-528-5166

CLAIM REFERENCE

1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name 5. Physical Address 1 6. Physical Address 2 7. City 8. State 9. Zip	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS 10. Mailing Address 1 11. Mailing Address 2 or Telephone Number 12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number	17. NAICS

INSURER / FILING OFFICE

18. Insurer Name Alacomp 19. Insurer Federal ID Number 63-1061602 20. Type Insurer ☐ Insurance Co. Ins Co # ☐ Self-Insurer SI # ☒ Group Fund GF # 19-	21. Filing Office Name Business Insurance Group L.L.C. 21a. Service Co. #59214 22. Mailing Address 1 PO Box 243007 23. Mailing Address 2 or Telephone Number 334-215-8234 24. City Montgomery 25. State AL 26. Zip 36124 27. Filing Office Federal ID Number 33-1024937

EMPLOYEE / WAGES

28. First Name 29. Middle Name 30. Last Name 31 Last Name Suffix (ie. Jr., Sr., III)	32. Employee ID Number 33. Type Employee ID Number SSN ☐ Passport Number ☐ Green Card ☐ Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1 35. Mailing Address 2 36. City 37. State 38. Zip 39. Phone	40. Gender Male ☐ Female ☐	41. Date of Birth 42.Nbr of Dependents

43. Marital Status Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐	44. Date Hired
45. Occupation Description	46. Number of Days Worked Per Week
47. Wages $ 48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐	49. Received Full Pay For Day of Injury? Yes ☐ No ☐ 50. Did Salary Continue? Yes ☐ No ☐

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE 56. Site Address 57. City 58. State 59. Zip 60. County	61. Injury Occurred on Employer's Premises? Yes ☐ No ☐ 62. Date Employer Notified

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// DIR.ALABAMA.GOV/WC

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

67. Initial Treatment No Medical Treatment ☐ First Aid By Employer ☐ Minor Clinic / Hospital ☐ Emergency Room ☐ Hospitalized > 24 Hours ☐ Major medical/Lost time ☐ Hospitalized Overnight ☐	68. Name of Treatment Facility 69. Address 70. City 71. State 72. Zip

73. Name of Physician or Other Health Care Professional	74. Has Injured Returned to Work Yes ☐ No ☐	If so, 75. Date 76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name	79. Last Name	80. Title	81. Preparer's Telephone Number

NATURE OF INJURY	PART OF BODY	CAUSE OF INJURY
01. No Physical Injury	10. Multiple Head Injury	01. Chemicals
02. Amputation	11. Skull	02. Hot Objects or Substances
03. Angina Pectoris	12. Brain	03. Temperature Extremes
04. Burn	13. Ear(s)	04. Fire or Flame
07. Concussion	14. Eye(s)	05. Steam or Hot Fluids
10. Contusion	15. Nose	06. Dust, Gases, Fumes or Vapors
13. Crushing	16. Teeth	07. Welding Operation
16. Dislocation	17 Mouth	08. Radiation
19. Electric Shock	18. Soft Tissue	09. Contact With, NOC.
22. Enucleation	19. Facial Bones	10. Machine or Machinery
25. Foreign Body	20. Multiple Neck Injury	11. Cold Objects or Substances
28. Fracture	21. Vertebrae	12. Object Handled
30. Freezing	22. Disc	13. Caught In, Under or Between, NOC.
31. Hearing Loss or Impairment	23. Spinal Cord	14. Abnormal Air Pressure
32. Heat Prostration	24. Larynx	15. Broken Glass
34. Hernia	25. Soft Tissue	16. Hand Tool, Utensil; Not Powered
36. Infection	26. Trachea	17. Object Being Lifted or Handled
37. Inflammation	30. Multiple Upper Extremities	18. Powered Hand Tool, Appliance
40. Laceration	31. Upper Arm	19. Caught, Puncture, Scrape, NOC.
41. Myocardial Infarction	32. Elbow	20. Collapsing Materials (Slides of Earth) Either Man Made or Natural
42. Poisoning - General	33. Lower Arm	25. From Different Level (Elevation) Off Wall, Catwalk, Bridge, Etc.
43. Puncture	34. Wrist	26. From Ladder or Scaffolding
46. Rupture	35. Hand	27. From Liquid or Grease Spills
47. Severance	36. Finger(s)	28. Into Openings Shafts, Excavations, Floor Openings, Etc.
49. Sprain or Tear	38. Shoulder(s)	29. On Same Level
52. Strain or Tear	39. Wrist (s) & Hand(s)	30. Slipped, Do Not Fall
53. Syncope	40. Multiple Trunk	31. Fall, Slip or Trip, NOC.
54. Asphyxiation	41. Upper Back Area	32. On Ice or Snow
55. Vascular	42. Lower Back Area	33. On Stairs
58. Vision Loss	43. Disc	40. Crash of Water Vehicle
59. All Other Specific Injuries, NOC	44. Chest	41. Crash of Rail Vehicle
60. Dust Disease, NOC	45. Sacrum and Coccyx	45. Collision or Sideswipe With Another Vehicle
61. Asbestosis	46. Pelvis	46. Collision with a Fixed Object Standing Vehicle or Stationary Object
62. Black Lung	47. Spinal Cord	47. Crash of Airplane
63. Byssinosis	48. Internal Organs	48. Vehicle Upset Overturned or Jackknifed
64. Silicosis	49. Heart	50. Motor Vehicle, NOC.
65. Respiratory Disorders	50. Multiple Lower Extremities	52. Continual Noise
66. Poisoning - Chemical, (Other Than Metals)	51. Hip	53. Twisting
67. Poisoning - Metal	52. Upper Leg	54. Jumping
68. Dermatitis	53. Knee	55. Holding or Carrying
69. Mental Disorder	54. Lower Leg	56. Lifting
70. Radiation	55. Ankle	57. Pushing or Pulling
71. All Other Occupational Disease Injury, NOC	56. Foot	58. Reaching
72. Loss of Hearing	57. Toes	59. Using Tool or Machinery
73. Contagious Disease	58. Big Toes	60. Strain or Injury By, NOC.
74. Cancer	60. Lungs	61. Wielding or Throwing
75. AIDS	61. Abdomen Including Groin	65. Moving Part of Machine
76. VDT - Related Diseases	62. Buttocks	66. Object Being Lifted or Handled
77. Mental Stress	63. Lumbar & or Sacral Vertebrae	67. Sanding, Scraping, Cleaning Operation
78. Carpal Tunnel Syndrome	64. Artificial Appliance	68. Stationary Object
79. Hepatitis C	65. Insufficient Info to Properly Identify	69. Stepping on Sharp Object
80. All Other Cumulative Injury, NOC	66. No Physical Injury	70. Striking Against or Stepping On, NOC.
90. Multiple Physical Injuries Only	90. Multiple Body Parts	74. Fellow Worker; Patient
91. Multiple Injuries Including Both Physical & Psychological	91. Body Systems and Multiple Body	75. Falling or Flying Object
	99. Whole Body	76. Hand Tool or Machine in Use
		77. Motor Vehicle
		78. Moving Parts of Machine
		79. Object Being Lifted or Handled
		80. Object Handled By Others
		81. Struck or Injured, NOC.
		82. Absorption, Ingestion or Inhalation, NOC
		84. Electrical Current
		85. Animal or Insect
		86. Explosion or Flare Back
		87. Foreign Matter (Body) in Eye(s)
		88. Natural Disasters
		89. Person in Act of a Crime
		90. Other Than Physical Cause of Injury
		91. Mold
		94. Repetitive Motion Callous, Blister, Etc.
		95. Rubbed or Abraded, NOC
		96. Terrorism
		97. Repetitive Motion Carpel Tunnel Syndrome
		98. Cumulative, NOC
		99. Other - Miscellaneous, NOC

INSTRUCTIONS FOR FILING WC FIRST REPORT OF INJURY

Employers should send a completed legible form to the insurance carrier or, if self-insured, to the designated office handling their workers' compensation claims. The insurance carrier or designated office should forward this First Report on to the Workers' Compensation Division, Department of Industrial Relations, Montgomery, Alabama 36131 within fifteen (15) days from the date of injury or date of notification to the employer for all injuries for which compensation is claimed or paid. This includes deaths, permanent disabilities or temporary disabilities exceeding three (3) days).

Block 1. A number assigned by the insured to identify a specific claim
Block 2. An identifier for a specific claim within a claim administrator's claims processing system.
Block 3. Case number from log maintained for OSHA
Block 4 - Block 14. Self Explanatory
Block 15. Employer Federal ID number
Block 16. Employer Unemployment Compensation Account Number
Block 17. NAICS Industry Codes http://dlr.alabama.gov/docs/forms/wc_naics.pdf
Block 18. Carrier's name
Block 19. Carrier's FEIN
Block 20. A code representing the kind of entity providing financial responsibility for the claim, exp: (I) Insurance Carrier (S) Self Insurer (G) Guarantee Fund/Group
Block 21 through Block 63. Self Explanatory
Block 64. Nature of Injury Codes http://dlr.alabama.gov/docs/forms/wcio_nature_table.pdf
Block 65. Part of Body Codes http://dlr.alabama.gov/docs/forms/wcio_part_table.pdf
Block 66. Cause of Injury Codes http://dlr.alabama.gov/docs/forms/wcio_cause_table.pdf
Block 67 through Block 81. Self Explanatory

WAGE STATEMENT

EMPLOYEE _____ EMPLOYER: _____

DATE OF INJURY_____ CLAIM NO: _____

Please complete this table to show the weeks worked and the **gross** wages earned by this employee for the fifty-two (52) weeks **prior to the date of injury** in accordance with Alabama Workers' Compensation Law 25-5-57(b). If this employee did not work a sufficient number of weeks to complete this table, use the wages of a fellow employee of the same class and who was engaged in the same type work for the time period stated above.

	Week Ending			Days Worked	Gross Payroll		Week Ending			Days Worked	Gross Payroll
	Mo.	Day	Year				Mo.	Day	Year		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
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16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					
				Total	$					Total	$

Annual Total $

This report was prepared by _____ Date _____

(Please complete **fringe benefit information on page two.**)

FRINGE BENEFIT INFORMATION

EMPLOYEE _____ EMPLOYER: _____

DATE OF INJURY _____ CLAIM NO. _____

1. Please indicate if any of the following benefits are provided for this employee. If yes, list the cost (amount paid by you, the employer) for each benefit provided on behalf of this employee.

Health Insurance $_____

Life Insurance $_____

Disability Insurance $_____

2. Do you still provide the benefits? Yes or No.

3. If no, what date did you discontinue the benefits? _____

Verified by _____ Date _____

NOTE: Should you discontinue fringe benefits at a later date prior to resolution/closure of this employee's worker's compensation claim, notify Business Insurance Group, LLC immediately.

CHILD SUPPORT GARNISHMENT/LEVY

Have you, the employer, received an order/notice to withhold income for child support? YES or NO

If yes, provide us copy of the order.

AL DEPT OF CORRECTIONS WORK RELEASE PROGRAM

Is this employee a participant in the Work Release Program? YES or NO

If yes, provide employee's AL DEPT OF CORRECTIONS prisoner ID number. _____

Name (facility), address, and telephone number of the Work Release Program:

WAGE STATEMENT

EMPLOYEE _____ EMPLOYER _____

DATE OF INJURY _____ CLAIM NO: _____

Please complete this table to show the weeks worked and the **gross** wages earned by this employee for the fifty-two (52) weeks **prior to the date of injury** in accordance with Alabama Workers' Compensation Law 25-5-57(b). If this employee did not work a sufficient number of weeks to complete this table, use the wages of a fellow employee of the same class and who was engaged in the same type work for the time period stated above.

MILEAGE RECORD

Name: _____

ADDRESS: _____

_____

Date of Injury or Claim No: _____

DATE	DESTINATION	TOTAL MILEAGE

By endorsement of this form, the signee is attesting that he/she has received, understands and acknowledges the following statement: any person who, knowingly, and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided by law.

_____ _____

SIGNATURE DATE

MAIL TO: Business Insurance Group LLC, P.O. Box 243007, Montgomery, AL 36124

STATE OF ALABAMA
WORKERS' COMPENSATION
INFORMATION

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE CARRIER AlaCOMP
PO Box 243007
Montgomery, Al 36124

TELEPHONE NUMBER 1-888-661-7119

ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS' COMPENSATION LAW INCLUDING MEDIATION SERVICE.
FOR INFORMATION CALL:
1-800-528-5166
Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131
CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED
IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

FORM WCC#1 10/12

TREATMENT AUTHORIZATION FORM

Form to be presented to physician's office for treatment.

EMPLOYEE INFORMATION

(Valid identification is needed for all drug screens and breath alcohol tests)

Name: _____ **Position:** _____ **Date:** _____

SCREENS REQUIRED UPON TREATMENT: ____ **Breath Alcohol Test** _____ **Instant Drug Test**

EMPLOYER INFORMATION AND AUTHORIZATION

AUTHORIZED TREATMENT PROVIDER: _____

SUPERVISOR NAME: _____ **OFFICE:** _____ **FAX:** _____

CONTACT PERSONNEL: _____ **OR** _____

Please call** _____ **at** _____ **after treatment

AUTHORIZATION: This form, completed and signed by an authorized representative of _____, serves as authorization to treat the above named employee and to bill for services rendered. Please submit a first report of this injury to the company as soon as possible.

Authorized Signature: _____ **Date:** _____

BILLING INFORMATION

Billing Address: _____

Submit all billing to AlaCOMP

6-2-14