

Policy: AD-06-02

Policy Title: Worker's Compensation Reporting Policy

Policy Purpose: Set procedures for the reporting worker's compensation incidents

Implementation Date: 01/01/2006

Revision Date: NA

**TOWN OF WESTFIELD
PUBLIC WORKS DEPARTMENT
WORKER'S COMPENSATION REPORTING POLICY**

This policy will set forth guidelines regarding how associates within the department shall properly report incidents that qualify as a "*Worker's Compensation Incident*". Please find below a definition describing what a Worker's Compensation Incident is. This definition shall be utilized by department supervision in determining whether or not claim forms shall be filled out by the department regarding an incident.

Worker's Compensation Incident is defined as medical care to employees injured or disabled in the course of their employment (while on the job).

When an associate has been involved in a Worker's Compensation Incident as described above, the associate's immediate supervisor or responsible supervisor (supervisor responsible in absence of immediate supervisor) shall fill out the attached forms "Exhibit 1" **within 24 hours of the incident**. Once the forms have been completed by the supervisor, he/she must turn them into the department's administrative assistant for proper filing. The department's administrative assistant or designee shall forward the forms to the Town's Benefit Coordinator immediately upon receipt and review.

Should any supervisor question whether an incident qualifies as a Worker's Compensation Incident, they should consult with the Town's Benefit Coordinator and/or the Director of Public Works to make a determination.

Bruce A. Hauk, Director
Westfield Public Works



302 S. Reed Rd.
 P.O. Box 690
 Kokomo, IN 46903-0690
 1-800-382-8837

FOR WORKER'S COMPENSATION BOARD USE ONLY		
JURISDICTION	JURISDICTION CLAIM NUMBER	PROCESS DATE

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION					
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="radio"/> MALE <input type="radio"/> FEMALE <input type="radio"/> UNKNOWN	OCCUPATION/JOB TITLE	NCCI CLASS CODE	
LAST NAME	FIRST	MIDDLE	MARITAL STATUS <input type="radio"/> UNMARRIED <input type="radio"/> MARRIED <input type="radio"/> SEPARATED <input type="radio"/> UNKNOWN	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)			HRS/DAY	DAYS/WK	AVG WG/WK
PHONE	# OF DEPENDENTS		WAGE \$	PER <input type="radio"/> HR <input type="radio"/> DAY <input type="radio"/> WK <input type="radio"/> MO <input type="radio"/> YR <input type="radio"/> OTHER:	PAID DAY OF INJ SALARY CONTD <input type="checkbox"/>

EMPLOYER INFORMATION			
EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP)	EMPLOYER FEDERAL ID#	SIC CODE	INSURED REPORT NUMBER
LOCATION #	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		
PHONE #	CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
Actual Location of Accident/Exposure (if not on employer's premises):			

CARRIER/CLAIMS ADMINISTRATOR INFORMATION			
CLAIMS ADMINISTRATOR (NAME, ADDRESS, PHONE NO)	CARRIER FEDERAL ID#	CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE	
PHONE:	<input type="checkbox"/> INSURANCE CARRIER	POLICY/SELF-INSURED NUMBER	
AGENT NAME	<input type="checkbox"/> THIRD PARTY ADMIN	POLICY PERIOD FROM	TO
CODE NUMBER			

OCCURRENCE/TREATMENT INFORMATION					
DATE OF INJ/EXP	TIME OF OCCURRENCE ___M	DATE EMPLOYER NOTIFIED	TYPE OF INJURY/EXPOSURE	TYPE CODE	
LAST WORK DATE	TIME WORKDAY BEGAN	DATE DISABILITY BEGAN	PART OF BODY	PART CODE	
RTW DATE	DATE OF DEATH	INJURY/EXPOSURE OCCURRED ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	CONTACT NAME	PHONE NUMBER	
DEPARTMENT OR LOCATION WHERE ACCIDENT/EXPOSURE OCCURRED			ALL EQUIPMENT, MATERIALS, OR CHEMICALS INVOLVED IN ACCIDENT		
SPECIFIC ACTIVITY ENGAGED IN DURING ACCIDENT/EXPOSURE			WORK PROCESS EMPLOYEE ENGAGED IN DURING ACCIDENT/EXPOSURE		
HOW INJURY/EXPOSURE OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY RELEVANT OBJECTS OR SUBSTANCES					CAUSE OF INJURY CODE
NAME OF PHYSICIAN/HEALTH CARE PROVIDER				INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR: CLINIC/HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED >24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
WITNESSES (NAME, PHONE #)			DATE ADMINISTRATOR NOTIFIED		
DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER		



DOWNEY
INSURANCE
Protecting Those Who Serve™

INDIANA PUBLIC EMPLOYERS' PLAN, INC.
SUPERVISOR'S INCIDENT INVESTIGATION REPORT
(Please Complete All Sections)

1. Company or Location 2. Department 3. Date of Incident/Day of Week

4. Exact Location of Incident 5. Time of Occurrence (am/pm) 6. Date Reported

7. Name of Injured 8. Occupation 9. Body Part Affected (See Back)

10. Nature of Injury or illness (See Back) 11. Item Inflicting Injury/Illness 12. Type of Accident (See Back)

13. Person With Most Control of Item 11.

14. Description of the Incident

15. Direct Causes of Incident 16. Why Each Cause Exists

17. Actions Taken or Needed to Prevent Recurrence 18. Date Completed

19. Investigated By 20. Date 21. Reviewed By 22. Date

Please mail form to: IPEP
P.O. Box 690
Kokomo, Indiana 46903-0690

Toll free: 1-800-382-8837
Claims Fax: 1-765-868-3322
Local: 1-765-457-9161



Downey Insurance Inc.
P.O Box 1247
Kokomo, IN 46903-1247

Toll free: 1-800-382-8837
Local: 1-765-457-9161
Claims fax: 1-765-868-3310

Adjuster: _____

Claim No: _____

**AUTHORIZATION FOR RELEASE OF
MEDICAL, MILITARY, EDUCATION AND WAGE INFORMATION**

To any physician, dentist, hospital, health care practioner, military authority, education authority, employer or insurance carrier:

The requested information is needed to accurately evaluate, adjust and pay the patient's insurance claim.

I hereby authorize any health care professional (including health care physicians, medical practioners or other health care providers, hospitals, medical attendants, nurses, x-ray technicians, or any other person), military authority, education authority, employer or insurance carrier, to furnish to the insurance company named above or its authorized vendors and representatives, wage loss and individually identifiable health information regarding my injuries, payment, treatment rendered, or health care received or provided. I understand that this authorization is voluntary.

I agree that a photocopy or fax of the original authorization shall have the same force and effect as the original.

I understand that my health care records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that I may revoke this authorization at any time by notifying the health care professional(s) in writing, but if I do it will not have any affect on any actions taken before receipt of the revocation.

I understand that once disclosed, the information and documentation released may be re-disclosed and may no longer be subject to the HIPAA Privacy Rule.

This disclosure is made at the request of the individual named below for the purposes of evaluation, adjusting and paying an insurance claim.

Unless otherwise required by law, this authorization shall expire upon the final resolution of the insurance claim.

By signing below, the patient acknowledges that he/she has read the fraud statement printed below.

PATIENT OR REP SIGNATURE

PATIENT ADDRESS

PATIENT NAME OR REP (PLEASE PRINT)

CITY, STATE, ZIP

PATIENT PHONE NUMBER

REPRESENTATIVE'S RELATIONSHIP TO PATIENT

SOC SEC NUMBER

DATE OF BIRTH

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION COMMITS A FELONY.