

Grand River Insurance Agency



Workers' Compensation Claim Kit - Pennsylvania





Grand River Insurance Agency

GRIA Workers' Compensation | www.grandriverinsurance.com

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Dear Policyholder:

Thank you for placing your workers' compensation coverage with Grand River Insurance Agency (GRIA). We look forward to working with you to fulfill all your workers' compensation needs.

Enclosed you will find documentation necessary for the processing and administration of a claim in the event of a workplace injury, as well as important information regarding workers' compensation requirements for your state (i.e., posting notices, compliance laws, etc.).

Please utilize the documents included to collect valid information regarding the injured employee and incident and send the documents in when reporting the claim or upon request.

All new claims can be reported to claims@grandriverservices.com. Please email a completed first report of injury form ("Workers' Compensation Claim Form") along with a brief message describing the claim.

Pennsylvania state law recommends employers report every industrial injury or occupational disease claim to their workers' compensation carrier as soon as possible or within 5 days of employer knowledge of injury. State law also requires that employers authorize initial medical treatment within 24 hours of knowledge that an occupational injury or illness has been sustained or reported, regardless of the legitimacy of the claim. Failure to comply may result in the loss of "medical control" and a significant increase in the potential claim cost.

We will attempt to contact you and the injured worker within 24 hours of receiving the First Report of Injury.

Questions regarding your insurance policy or coverage should be directed to your Grand River agent. We thank you for choosing Benchmark Insurance Company as your workers' compensation carrier and look forward to providing you superior customer service and compassionate care for your injured workers.





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Workers' Compensation Posting Requirements

Workers' Compensation Notice Posters (LIBC-500 REV 09-22)

- Post in one or more conspicuous places at all business locations

To complete this form (LIBC-500 REV 09-22), please enter the following information in the spaces provided:

- Your company name
- Date you posted the notice
- Your agent's phone number



**REMEMBER: IT IS IMPORTANT TO TELL YOUR
EMPLOYER ABOUT YOUR INJURY**

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: _____ **Date Posted:** _____

IF INSURED:

(Complete all applicable spaces)

Name of Insurance Company:

Benchmark Insurance Company

Address: 150 Lake Street West, Wayzata, MN 55391

Telephone Number: _____

Insurer Code: 41394

**IF SOMEONE OTHER THAN INSURER IS
HANDLING CLAIMS:**

(Complete all applicable spaces)

Name of TPA (Claims administrator):

Grand River Services

Address: PO Box 1370 Marco Island, FL 34146

Telephone Number: (517) 290-7387

IF SELF-INSURED:

(Complete all applicable spaces)

Name of person handling claims at
the self-insured:

Address: _____

Telephone Number: _____

Insurer Code: _____

**IF SOMEONE OTHER THAN SELF-INSURER IS
HANDLING CLAIMS:**

(Complete all applicable spaces)

Name of TPA (Claims administrator):

Address: _____

Telephone Number: _____

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information
Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov



Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

**NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION
306 (f.1)(1)(i) OF THE PA. WORKERS' COMPENSATION ACT**

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.1)(1)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties
under Sec. 306 (f.1)(1)(i) and that I understand them
to the extent that they are explained above.

Print Name

Employee Signature

Date

See reverse for a complete text of Section 306 (f.1)(1)(i)
If you have any questions, ask your human resources office representative or call
The Bureau of Workers' Compensation at 1-800-482-2383

PENNSYLVANIA WORKERS' COMPENSATION ACT
SECTION 306 (f.1)(1)(i)

The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

Instructions: Complete the claim form and submit it to the agency workers' compensation service representative for entry to SAP (or the FROI system for independent agencies) and submission to Inservco Insurance Services, Inc., telephone number 800.356.0438. Codes are listed on the reverse side of this form.

Basic Data:

Date of Report	Date of Injury	Personnel or Soc Sec Number	Injury Type <input type="checkbox"/> Inj Leave <input type="checkbox"/> Heart&Lung <input type="checkbox"/> Act 632/534 <input type="checkbox"/> Other
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Employee Information:

Employee Last Name	Employee First Name	M.I.	Suffix	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Employee Home Address		City		State	Zip + 4
Residence County	Home Telephone Number	Married <input type="checkbox"/> Y <input type="checkbox"/> N	Number of Dependents	Employment Status	

Employer Information:

Agency Number	Agency Name	Job Classification	Date of Hire		
Org Code	Organization Name	Name of Supervisor	Work Telephone Number		
Work Location Address		City	State	Zip + 4	County

Injury Date Information (enter times as military time):

Time of Injury	Date of Death	Date Employer Knew	Shift Start Time	Type of Claim <input type="checkbox"/> Incident Only <input type="checkbox"/> Medical Only <input type="checkbox"/> Lost Time > 7 Days
Last Full Day Worked	Date Disability Began	Date Returned to Work	At Same Wages? <input type="checkbox"/> Y <input type="checkbox"/> N	Occur During Overtime? <input type="checkbox"/> Y <input type="checkbox"/> N

Injury Description Information:

Injury on Employer Premises? <input type="checkbox"/> Y <input type="checkbox"/> N	If not in PA, list state	If not on premises, list address of accident
Cause Code	Cause of injury additional information	
Injury Type Code 1	Injury Type Code 2	Type of injury additional information and severity
Body Part Code 1	Body Part Code 2	Body part affected additional information (example, left, right, upper, lower, etc.)

List all equipment, materials or chemicals employee was using when accident or illness occurred

Describe how injury or illness or abnormal health condition occurred. Describe the sequence of events and include any objects or substances directly responsible. Use abbreviations and short statements to include who, what, where, why and how. The what shall be the job assignment the employee was performing when injured.

Any tools involved? <input type="checkbox"/> Y <input type="checkbox"/> N	Any mechanical defect? <input type="checkbox"/> Y <input type="checkbox"/> N	Unsafe act? <input type="checkbox"/> Y <input type="checkbox"/> N	Unsafe condition? <input type="checkbox"/> Y <input type="checkbox"/> N	Amputation? <input type="checkbox"/> Y <input type="checkbox"/> N
Motor vehicle accident? <input type="checkbox"/> Y <input type="checkbox"/> N	Safeguards or safety equipment provided? <input type="checkbox"/> Y <input type="checkbox"/> N	Safeguards or safety equipment used? <input type="checkbox"/> Y <input type="checkbox"/> N		

Medical Information:

Panel of physicians? <input type="checkbox"/> Y <input type="checkbox"/> N	Initial treatment	Medical provider name and address
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Employer Comments and Signature

Agree/disagree with description of injury? Other information about injury, including names and telephone numbers of any witnesses.

Name of Supervisor completing form	Signature
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Injury Type Codes

0		3		6		76	VDT-Related Disease
1	No Physical Injury	4	Hernia	0	Dust Disease, NOC	77	Mental Stress
0		3		6	Asbestosis	78	Carpel Tunnel Syndrm
2	Amputation	6	Infection	1		79	Hepatitis C
0		3		6	Black Lung	80	Other Cumulative Inj
3	Angina Pectoris	7	Inflammation	2		90	Mltpl Physical Inj
0		4		6	Byssinosis	91	Mltpl Inj Phys/Psych
4	Burn	0	Laceration	6	Poison-Chem(non-mtls)	A	Animal Bite
0		4		6	Poisoning-Metal	1	Abrasion
7	Concussion	1	Myocardial Infarctn	8	Dermatitis	2	Human Bite
0		4		9	Mental Disorder	4	Insect Bite/Sting
8	Hearing Loss	2	Poisoning-General	0	Radiation	5	Lyme Disease
1		4		7	Othr Occ Dse Inj NOC	7	Stab Wound
0	Contusion	3	Puncture	7	Loss of Hearing	8	Gunshot Wound
1		4		3	Contagious Disease	9	
3	Crushing	6	Rupture	7	Cancer		
1		4		7	AIDS		
6	Dislocation	7	Severance	5			
1		4					
9	Electric Shock	9	Sprain				
2		5					
2	Enucleation/Removal	2	Strain				
2		5					
5	Foreign Body	3	Syncope/Fainting				
2		5					
8	Fracture	4	Asphyxiation				
3		5					
0	Freezing	5	Vascular				
3		5					
1	Hearing Loss/Imprmnt	8	Vision Loss				
3		5					
2	Heat Prostration	9	All Othr Spc Inj NOC				

Body Part Codes

1		2		4		5	
0	Multiple Head Injury	4	Larynx	1	Upr Bck Area(Thrcic)	5	Ankle
1		2		4		5	
1	Skull	5	Neck - Soft Tissue	2	Lw Bck Area(Lbr&Lbo)	6	Foot
1		2		4		5	
2	Brain	6	Trachea	3	Back/Disc	7	Toe(s)
1		3		4		5	
3	Ear(s)	0	Mltple Upr Extrmtes	4	Chest(Ribs&Sft Tsue)	8	Great Toe
1		3		4		6	
4	Eye(s)	1	Upr Arm(Clvcl-Scpla)	5	Sacrum and Coccyx	0	Lungs
1		3		4		6	
5	Nose	2	Elbow	6	Pelvis	1	Abdomen incl Groin
1		3		4		6	
6	Teeth	3	Lower Arm	7	Back - Spinal Cord	2	Buttocks
1		3		4		6	
7	Mouth	4	Wrist	8	Internal Organs	3	Lumbar/Sacral Vertbr
1		3		4		6	
8	Head - Soft Tissue	5	Hand	9	Heart	4	Artificial Appliance
1		3		5		6	
9	Facial Bones	6	Finger(s)	0	Mltple Lwr Extrmtes	5	Insf Info 2 Prop Id
2		3		5		6	
0	Neck - Multiple Inj	7	Thumb	1	Hip	6	No Physical Injury
2		3		5		9	
1	Vertebrae	8	Shoulder	2	Upper Leg	0	Multiple Body Parts
2		3		5		9	
2	Neck - Disc	9	Wrist(s) and Hand(s)	3	Knee	1	Bdy Sys/Mtpl Bdy Sys
2		4		5			
3	Neck - Spinal Cord	0	Multiple Trunk	4	Lower Leg		

Cause Codes

Burn, Heat Or Cold Expos. 15 Cut/Inj By-Brkn Glas 57* Str/Inj By-Push/Pull 80* Strk-Obj Hndl by Oth

Workers' Compensation Claim Form

2*	Burn-Cntct w/ Object	17	Cut-Obj Liftd/Handld	58*	Strain/Inj By-Reach	86	Inj By-Explosion
3*	Burn-Temp Extremes	Fall or Slip		60*	Strain/Inj By-Misc	Rubbed or Abraided	
1*	Burn-Acid Chem	25*	Fall/Slip-Diff Level	54	Strain/Inj By-Jump	94*	Rept Motn
84*	Electrical Current	29*	Fall/Slip-Same Level	59	Str/Inj By-Tool/Mach	95*	Rub/Abraid-Misc
A3*	Heat Exhaust/Stroke	33	Fall/Slip-On Stairs	61	Strain/Inj By-Throw	Miscellaneous	
4	Burn-Fire or Flame	26	Fall/Slip-Ladder	97	Strain-Repitv Motion	A6*	Human Bite
5	Burn-Steam/Hot Fluid	28	Fal/Slp-Into Opening	53	Strain/Inj By-Twist	90*	Othr than Phys Caus
11	Burn-Cold Obj/ Subst	32	Fall/Slip-Ice/Snow	Strike Against or Step On		52*	Strain/Inj By-Noise
7	Burn-Welding	27	Fall/Slip-Liquid	70*	Step On/Strike-Misc	85*	Inj By-Anmal/Insct
8	Burn-Radiation	30	Slip-Did Not Fall	65	Step/Strik-Machine	89*	Misc-Person/Crime
6	Burn-Dst/Gas/Fms/Vpr	31	Fall/Slip-Misc	66	Step/Strk-Obj Handld	B1*	Microbiological Exp
14	Brn-Abnml Air Presur	Motor Vehicle		67	Step/Strik-Scraping	82*	Misc-Absorb/Ingest
9	Burn-Miscellaneous	50*	Motr Veh-Misc	68	Step/Strk-Statnry Ob	A2*	Exp Misc Viral Infec
Caught In or Between		46	Motr Veh-Hit Fxd Obj	69	Step/Strik-Sharp Obj	A4*	Exp to Skin Irritant
13*	Caught In/Betwn-Misc	45	Motr Veh-Veh Colison	Struck By		87*	Forgn Matter in Eye
10	Caught In-Machinery	48	Motr Veh-Veh Upset	74*	Struck-Cowrker/Other	98	Misc-Cumulative
12	Caught In-Obj Handld	41	Motr Veh-Train	75*	Struck-Fall/Fly Obj	A5	Gunshot Wound
20	Caught In-Collapse	47	Motr Veh-Airplane	76*	Struck-Tool/Machine	A7	Exposure to TB
Cut, Puncture or Scrape		40	Motr Veh-Water Veh	81*	Struck/Inj By-Misc	A8	Exp to Hepatitis B
16*	Cut/Inj By-Hand Tool	Strain or Injury By		77	Struck-Motor Veh	A9	Exposure to HIV
18*	Cut/Inj By-Powr Tool	55*	Strn/Inj-Hold/Carry	78	Struk-Machine In Use	99	Misc-Other**
19*	Cut/Inj By-Misc	56*	Strain/Inj By-Lift	79	Struck-Obj Handled		

* Recommended cause code

** Code should rarely be used