

Grand River Insurance Agency



Workers' Compensation Claim Kit - Wisconsin





Grand River Insurance Agency

GRIA Workers' Compensation | www.grandriverinsurance.com

Table of Contents

Page 3 – WI Claims Kit Introductory Letter

Page 4 – GRIA Requirements for WI Posting Notices

Page 5 – Workers' Compensation Notice

Page 6 – WI First Report of Injury





Grand River Insurance Agency

GRIA Workers' Compensation | www.grandriverinsurance.com

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 (WKC-12) along with a brief message describing the claim.

Wisconsin 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.





Grand River Insurance Agency

GRIA Workers' Compensation | www.grandriverinsurance.com

Workers' Compensation Posting Requirements

Workers' Compensation Notice Posters (WC 7618a)

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

To complete this form (WC 7618a), please enter the following information in the spaces provided:

- Your company name
- Signature of company representative and date



NOTICE

The undersigned, an employer within the meaning of the Workers' Compensation Law of the State of Wisconsin, hereby gives notice to employees that the employer has secured the payment of Compensation to its employees and their dependents in accordance with the provisions of said law, by insuring with

Employer

Dated _____ By _____

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

**Department of Workforce Development
Worker's Compensation Division**
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
http://www.dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.

Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.

Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to (608) 267-0394.

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

(Please read the instructions on page 2 for completing this form)

| | | | | | | | | |
|--|---|---|---|--|--|--|---------------|--|
| EMPLOYEE | Employee Name (First, Middle, Last) | | Social Security Number* | | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Employee Home Telephone No. () - | | |
| | Employee Street Address | | | City | State | Zip Code | Occupation | |
| | Birthdate | Date of Hire | | County and State Where Accident or Exposure Occurred? | | | | |
| EMPLOYER | Employer Name | | WI Unemployment Ins. Acct No. | Self-Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Nature of Business (Specific Product) | | |
| | Employer Mailing Address | | | City | State | Zip Code | Employer FEIN | |
| | Name of Worker's Compensation Insurance Co. or Self-Insured Employer | | | | | | Insurer FEIN | |
| | Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer | | | | | | TPA FEIN | |
| WAGE INFORMATION | Wage at Time of Injury | Specify per hr., wk., mo., yr., etc. | | In Addition to Wages, Check Box(es) if Employee Received: | | No. of Meals/wk. No. of Days/wk. Avg. Weekly Amt. \$ | | |
| | \$ | Per: | | <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Tips | | | | |
| | Is Worker Paid for Overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, After How Many Hours of Work Per Week? | | | | | | | |
| | For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks. | | | | | | | |
| | No. of Weeks: | Gross Amount Excluding Tips: \$ | | | If Piece-Work, No. of Hrs. Excluding Overtime: | | | |
| | Employee's Usual Work Schedule When Injured: | | Start Time | | Hours Per Day | Hours Per Week | Days Per Week | |
| | | : <input type="checkbox"/> AM <input type="checkbox"/> PM | | | | | | |
| Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury: | | | | | | | | |
| INJURY INFORMATION | Part-Time Employment Information: | Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many? | | | Number of Full-Time Employees Doing the Same Type Of Work: | | | |
| | Injury Date | Time of Injury | Last Day Worked | Date Employer Notified | <input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return | | | |
| | : AM : PM | | | | | | | |
| | Did Injury Cause Death? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of Death | Was This a Lost Time or Other Compensable Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Did Injury Occur Because of: <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Failure to Use Safety Devices <input type="checkbox"/> Failure to Obey Rules | | | |
| | Was Employee Treated in an Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No Was Employee Hospitalized Overnight as an In-Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Name and Address of Treating Practitioner and Hospital: | | | | | | | | |
| Case Number from the OSHA Log: | | | | | | | | |
| Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved. | | | | | | | | |
| What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred) | | | | | | | | |
| What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected) | | | | | | | | |
| Report Prepared By | | Work Phone Number () - | | Position | | Date Signed | | |

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.