



Policy for Reporting Work Related Injuries

When an injury occurs, please notify DecisionHR immediately at (888) 828-5511, Ext. 4272 or 4101. Then complete the following DecisionHR TeleClaim Workers' Compensation Form and fax it to (855) 204-4169. All Employers are required to notify OSHA within 8 hours to report an employee fatality on the job or suffers a work-related hospitalization, amputation, or loss of an eye. Call OSHA's 24 Hour Hotline 1-800-321-6742.

- **If an injury is life threatening:**

1st – Dial 911 or seek the nearest hospital

2nd – Notify DecisionHR immediately at the numbers listed above (*)

- **Information needed when reporting an injury:**

1. Employee name and date of injury

2. How injury occurred and specific body part injured

3. Please fax the DecisionHR TeleClaim Workers' Compensation Form to DecisionHR-immediately

- **If treatment is needed:**

1. Direct the injured worker to one of the approved treatment facilities found in the DHR Client Packet or at talispoin.com/aig/obn. For assistance in locating a facility, please contact DecisionHR at the phone numbers listed above.

2. DecisionHR's claims personnel will work with you to determine whether a post-accident drug screen is necessary. Post-accident drug screens will only be administered when it was influenced or caused by a drug related activity. LabCorp offices in your area can be found at www.labcorp.com.

3. Complete the temporary prescription card and give it to the injured worker to provide to the pharmacy.

() After Hours: If an injury occurs after hours, leave a message for DecisionHR and include the injury details, your company name, contact person and phone number. Then proceed with necessary medical care and fax the DecisionHR TeleClaim Workers' Compensation Form as explained above. If you need assistance after hours, please call (727) 512-0139.*

Important: All injuries are to be reported to DecisionHR within 24 hours of occurrence. Failure to report timely may jeopardize employee benefits and subject employer to penalties by the Division of Workers' Compensation.



DecisionHR TeleClaim Workers' Compensation Form

WITHIN 24 HOURS OF NOTICE FROM INJURED EMPLOYEE: COMPLETE THIS FORM and CONTACT DECISIONHR AT

(888) 828-5511 ext. 4272 or 4101

Client Company Name: _____

Date of Loss: _____ State in which loss occurred: _____

Employee Information:

1. Employee's Full Name: _____

2. Employee's Social Security Number: _____

Accident/Incident Information:

1. Date and time of accident: _____

2. Date and time reported to employer: _____

3. Who was the accident reported to: _____

4. Employee Supervisor: _____

5. Shift begin and end time: _____

6. Address where accident/incident occurred (street, city, state, zip code and county): _____

7. Is the above address the employer's premises? ___ Yes ___ No

8. Full description of accident/incident (include what employee was doing, work process, cause, injury and body part): _____

9. Is the accident/incident questionable to the employer? ___ Yes ___ No

10. Was the employee permanently disabled as a result of the accident/incident? ___ Yes ___ No

11. Does the employer suspect drug and/or alcohol use at time of accident/incident? ___ Yes ___ No

12. Date of death (if accident resulted in a fatality): _____

13. Number of days employee is expected to miss (if applicable): _____

14. Last date worked and time employee left work: _____

15. First date missed: _____

16. Was the employee's salary continued? ___ Yes ___ No

17. Has employee returned to work? ___ Yes ___ No If yes, what date: _____

If no, is there an expected return to work date? ___ Yes ___ No Date: _____

18. Does employee have a previous claim? ___ Yes ___ No If yes, is the status ___ Open ___ Closed

If yes, please list previous claim body part affected and date of loss: _____

Accident/Incident Information:

1. Was any safety equipment provided? Yes No If yes, was it used? Yes No
2. Was an unsafe act being performed? Yes No
If yes, describe: _____
3. Was a machine part involved? Yes No
If yes, describe part: _____
4. Was the machine part defective? Yes No
If yes, in what way? _____
5. Was a third party responsible for the accident/incident? Yes No
If yes, please list third party name, address and phone: _____
6. Was the accident/incident witnessed? Yes No
If yes, please list witness name, address and phone: _____
7. Name, address and phone of person to contact regarding additional loss information: _____

Provider Information:

1. Was first aid given onsite? Yes No If yes, what medical treatment was received? _____
2. Clinic/Doctor – Doctor name, specialty (i.e.: family prac, chiro, etc.) address, city, St, zip & phone: _____
3. Hospital name, address, city, St, zip & phone: _____
4. Was employee hospitalized? Yes No If yes, on what date? _____
5. Was employee: treated-outpatient received for emergency treatment transported by _____
6. Name of person reporting this claim, including title and phone number: _____

PLEASE have the Employee sign and date below as an acknowledgement that at this time the Employee has chosen to decline medical treatment:

Employee Signature

Date