

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

### Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than \$800 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than \$800 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than \$533.33 per week, not to exceed 350 weeks.
7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than \$533.33 per week for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to \$7,500 and two-thirds of your average weekly wage, but not more than \$800 per week. A widowed spouse with no children will be paid a maximum of \$320,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.
9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

### Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.
2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.
3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.
7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.
8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than \$10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: <https://www.sbwgc.georgia.gov>. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-334-6865.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <https://www.sbwgc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

**WC-BILL OF RIGHTS**

# JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

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## DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO

Según lo requiere la Ley O.C.G.A. §34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

### Derechos de los Empleados

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.
2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia medica temporaria de cualquier otro medico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.
3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo. Todas las lesiones que ocurren en o antes 30 de junio de 2013 se tendrá derecho a beneficios médicos de por vida. Si el accidente ocurrió en o 1 de julio del 2013 el tratamiento médico será limitado a un máximo de 400 semanas a partir de la fecha del accidente. Si su lesión es catastrófica en la naturaleza que puede tener derecho a beneficios médicos de por vida.
4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que faltó al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagara la primera semana.
5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en numero considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de \$800 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-0849.
6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no más de \$800 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted este incapacitado. Pero no más de 400 semanas si no esta trabajando y se determina que usted esta capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de \$533.33 por semana, que no excedan 350 semanas.
7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no más de \$533.33 por semana pero no más de 350 semanas.
8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro \$7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de \$800 por semana. Una esposa viuda sin niños se le pagara un máximo de \$320,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente cohabite con una persona del sexo opuesto.
9. Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

### Responsabilidades de los Empleados

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.
2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.
3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.
4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/ empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.
10. Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de \$10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: <https://www.sbwcc.georgia.gov>. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777 o al 1-800-334-6865.

### **WHAT IS WORKERS' COMPENSATION?**

Workers' compensation is an accident insurance program paid by your employer which may provide you with medical, rehabilitation and income benefits if you are injured on the job. These benefits are provided to help you return to work. It also provides benefits to your dependents if you die as a result of a job related injury.

### **HOW LONG DO I HAVE TO WORK TO BE COVERED UNDER WORKERS' COMPENSATION?**

You are covered from the first day on your job.

### **HOW DO I KNOW IF THE COMPANY I WORK FOR IS COVERED BY WORKERS' COMPENSATION?**

The law requires any business with three or more workers, including regular part-time workers, to have workers' compensation insurance. Coverage can be verified by going to [www.sbwgc.georgia.gov](http://www.sbwgc.georgia.gov) and click on "How Do I verify an employer's workers' compensation insurance coverage".

### **WHEN SHOULD I REPORT AN ACCIDENT THAT HAPPENED ON THE JOB?**

You should report any accident occurring on the job to your employer (boss, foreman, or supervisor) immediately. If you wait longer than 30 days, you may lose your benefits.

### **WHAT DO I DO ABOUT A DOCTOR?**

Your employer is required to post information identifying medical care providers. Your employer may satisfy this requirement in one of the following ways:

1. Post a Traditional Panel of Physicians consisting of a minimum of six doctors. You may choose any one of the six. However, the Board may grant exceptions to the required size of the panel where it is demonstrated that six physicians or groups of physicians are not reasonably accessible. The panel must include one orthopedic physician and not more than two industrial clinics. Where possible a minority physician must be included. You may make one

change to another doctor on the list without the permission of your employer.

2. Post the name of the Workers' Compensation Managed Care Organization (WC/MCO) certified by the Board which your employer has contracted with to provide medical services. Your employer must give you a notice of the eligible medical service providers and post a 24 hour toll free number for the managed care organization. A managed care representative will assist you in scheduling an appointment with the eligible medical provider of your choice. You may make one change to another eligible physician at any time, without the permission of your employer.

### **WHO PAYS FOR THE DOCTOR?**

Your company's workers' compensation insurance carrier will pay for your authorized medical treatment, if the treatment was for an on-the-job injury.

### **WHAT MEDICAL TREATMENT WILL BE PAID?**

All authorized doctor bills, hospital bills, physical therapy, prescriptions, and necessary travel expenses if the injury or illness was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum period of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.

### **WHEN DO I GET MY BENEFITS?**

You are entitled to weekly income benefits if you are unable to work for more than 7 days. Your first check should be mailed to you within 21 days after the first day you missed work. If you miss more than 21 consecutive days, you will be paid for the first week.

### **HOW MUCH WILL MY WEEKLY BENEFITS BE?**

You will receive two-thirds of your average weekly wage, but not more than \$575.00 per

week for an accident which occurred on or after July 1, 2016.

### **WHAT IF I AM ABLE TO RETURN TO WORK BUT CAN ONLY GET A LOWER PAYING JOB AS A RESULT OF MY INJURY?**

You will receive a reduced benefit based upon your earnings for a maximum of 350 weeks from the date of injury. This benefit will not exceed \$383.00 per week, if your accident occurred on or after July 1, 2016.

### **HOW LONG WILL I RECEIVE WEEKLY BENEFITS?**

If your accident occurred on or after July 1, 1992, you are entitled to benefits for up to 400 weeks. If your injury is catastrophic in nature you may be entitled to lifetime benefits. In certain circumstances, your benefits may be reduced after you have been released to return to work with limitations or restrictions, or suspended if you are released to return to work with no limitations or restrictions.

### **WHAT IF MY INJURY KEEPS ME FROM GETTING A JOB?**

Under the law, if you sustain a catastrophic injury, you are entitled to receive help in getting another job or learning to do another job. If you need help in this area, call the State Board of Workers' Compensation at (404) 656-0849.

### **WHAT KIND OF BENEFITS WILL I RECEIVE IF I HAVE A PERMANENT DISABILITY?**

You will receive weekly benefits based on the type and extent of your permanent disability. The authorized treating physician determines ratings based upon Guides to the Evaluation of Permanent Impairment fifth edition, published by the American Medical Association.

### **WHAT BENEFITS WILL I RECEIVE IF I LOSE A LEG, ARM OR OTHER PART OF MY BODY?**

You will receive benefits based upon an amount set by law. For example, if you lost an arm or leg you will receive benefits of 225 weeks.

### **CAN I BE COMPENSATED FOR LOSS OF SIGHT OR HEARING?**

Yes.

### **CAN I RECEIVE BENEFITS IF I HAVE LOST THE USE OF A PART OF MY BODY?**

Yes. Benefits are based upon the extent of loss of use of a part of your body as determined by the authorized treating physician.

### **IF I DIE AS THE RESULT OF AN ON-THE-JOB ACCIDENT, WHAT BENEFITS WILL MY DEPENDENTS RECEIVE?**

Your dependents will receive two-thirds of your average weekly wage or a maximum of \$575.00 per week for death on or after July 1, 2016. Your dependents are your surviving spouse, children or dependent stepchildren. A widowed spouse with no children is limited to a total amount of \$230,000.00, unless he or she remarries or cohabitates in a meretricious relationship.

### **CAN I BE PAID SOCIAL SECURITY AND WORKERS' COMPENSATION AT THE SAME TIME?**

Yes, but social security benefits may be reduced.

### **WHAT IF I DON'T RECEIVE MY WORKERS' COMPENSATION BENEFITS?**

You must file a claim to protect your rights within one year from the date of your accident. This is accomplished by filing Form WC-14 with the State Board of Workers' Compensation.

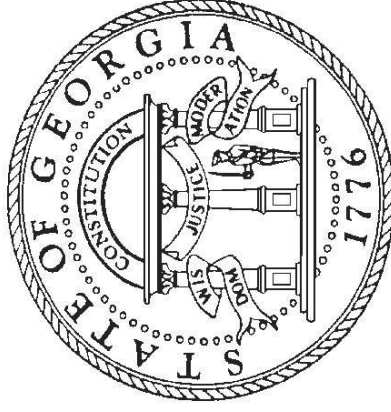
### **HOW DO I FILE A CLAIM?**

The State Board of Workers' Compensation will provide you with Form WC-14 to file a claim. In the metro Atlanta dialing area call (404) 656-3818 and outside the metro Atlanta area call 1-800-533-0882, or write the State Board of Workers' Compensation at:

State Board of Workers' Compensation  
270 Peachtree Street, NW  
Atlanta, GA 30303-1299

You may also obtain a Form WC-14 from the State Board of Workers' Compensation website [www.sbwgc.georgia.gov](http://www.sbwgc.georgia.gov).

# Questions & Answers About Georgia's Workers' Compensation Law



State Board of Workers' Compensation  
270 Peachtree Street, NW  
Atlanta, GA 30303-1299

TO: \_\_\_\_\_  
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purpose of obtaining or denying benefits or payment under the law may be assessed a civil penalty of not less than \$1,000.00 or more than \$10,000.00 per violation. The Board may assess a penalty of not less than \$500.00 nor more than \$5,000.00 per violation for an employer's failure to be insured for workers' compensation.

## CRIMINAL PENALTIES

In addition to civil penalties, a person, firm or corporation who makes false and misleading statements or representations may face criminal sanctions by imprisonment not to exceed 12 months.

Any employer who refuses or willfully neglects to have workers' compensation insurance shall be guilty of a misdemeanor.

## ENFORCEMENT DIVISION

An Enforcement Division has been established at the State Board of Workers' Compensation. You may report fraud, including the failure to secure workers' compensation coverage, by calling (404) 657-7285.

If you still have questions, call (404) 656-3818 in the Atlanta area or 1-800-533-0682 outside the Atlanta area, or visit our website at [www.sbwcc.georgia.gov](http://www.sbwcc.georgia.gov).

## WHAT HAPPENS AFTER I FILE A CLAIM?

If you do not receive any benefits, you may request a hearing before the State Board of Workers' Compensation at the above address. A hearing is like a trial in the courts of Georgia. Your claim will be decided by an Administrative Law Judge who listens to both sides of the claim and determines what benefits, if any, you should receive. The judge's decision will be based on the law and the facts involved.

## WHEN WILL THE HEARING TAKE PLACE?

The hearing generally will be scheduled within 60 days from the time the judge receives the Form WC-14.

## WHERE WILL THE HEARING TAKE PLACE?

The hearing will generally be held in or near the county where you were injured.

## DO I HAVE TO HAVE A LAWYER REPRESENT ME AT THE HEARING?

Everyone has the right to represent him or herself. However, your employer may be represented at the hearing by a lawyer. You may need help from a lawyer in order to present your claim properly.

## WHAT IF I WANT TO HIRE A LAWYER BUT I DO NOT KNOW ONE?

You may call the Atlanta Bar Association Lawyer Referral Service by dialing (404) 521-0777. You may also call the Georgia Bar Association at 1-800-334-6865 or check your telephone directory for the number of a local lawyer referral service.

## HOW MUCH WILL MY LAWYER CHARGE ME?

The attorney fee will be based on an agreement between you and your lawyer, subject to the approval of the State Board of Workers' Compensation if the fee is greater than \$100.00. No fee greater than 25% of the employee's award of weekly benefits or settlement shall be approved.

## CIVIL PENALTIES

Any person who knowingly and intentionally makes a false or misleading statement for the

Rev. (7/16)

## **PURPOSE**

The Workers' Compensation Act defines the responsibility of the employer to provide prompt medical and disability benefits for injuries sustained on the job by workers, resulting in partial or total incapacity or death. In return, the employer is shielded from tort liability for these injuries.

## **EMPLOYER**

Every employer, individual, firm, association, or corporation, regularly employing three or more persons, part-time or full time, shall provide workers' compensation insurance coverage. Exempted officers of corporations or exempted members of limited liability companies shall not reduce the number of employees for this purpose.

## **EMPLOYEE**

"Employee" or "worker" shall include every person, including minors, working full-time or part-time under a contract of hire, written or implied.

## **CORPORATE OFFICERS/LIMITED LIABILITY COMPANY MEMBERS**

Corporate officers and limited liability company members are considered employees of the company. Any officer or member of a limited liability company (maximum of 5) may exempt themselves from coverage by filing a Form WC-10 with their insurance company. The exemptions shall not decrease the number of employees for purposes of determining the employer's obligations under the Workers' Compensation Act.

## **PARTNER/SOLE PROPRIETOR**

A partner or sole proprietor is not an employee of the business unless he or she wishes to be

included as an employee in the coverage provided and so advises his or her insurance company on Form WC-10.

## **CONTRACTOR**

A contractor who is subject to the Workers' Compensation Law, who sublets any part of his or her contract work to a subcontractor, may be liable for coverage for the employees of the subcontractor if the subcontractor has not obtained workers' compensation insurance coverage.

## **COVERAGE**

Every employer subject to the workers' compensation law must insure payment of benefits to injured workers by securing a policy of insurance or by qualifying and being approved as a self-insurer. Employers desiring insurance coverage should contact an insurance agency representing a company licensed to write workers' compensation insurance in this state.

## **RATES**

Employers having questions regarding insurance rates or premiums should contact the Office of Insurance and Safety Fire Commissioner, 2 Martin Luther King, Jr., Drive, Atlanta, GA 30334. The telephone number is (404) 656-2056.

## **SELF-INSURANCE**

Employers desiring to be self-insured must file an application with the Board and include three years of audited financial statements and a non-refundable \$500.00 application fee made payable to the Georgia Self-Insurers Guaranty Trust Fund. If the application is approved by the Board and the Trust Fund, a surety bond or letter of credit will be required. The amount of security that is required is determined after a

thorough review of the application and financial statements.

## **LIABILITY**

An employer failing to provide coverage, as required by law, shall be held responsible for compensable injuries in the same manner as an employer having coverage. In addition, the Board may assess attorney's fees, civil penalties, and a 10% increase in compensation to the employee, if the employer refuses or willfully neglects to secure insurance.

## **CIVIL PENALTIES**

Any person who willfully fails to file any form or report required by the Board, fails to follow any order of the Board, or violates any rule or regulation of the Board shall be assessed a civil penalty of not less than \$100.00 or more than \$1,000.00 per violation.

Any person who knowingly and intentionally makes any false or misleading statements for the purpose of obtaining or denying benefits or payment under the law may be assessed a civil penalty of not less than \$1,000.00 or more than \$10,000 per violation.

The Board may assess a civil penalty of not less than \$500.00 or more than \$5,000.00 per occurrence for violation of an employer's duty to provide coverage under the Workers' Compensation Act.

## **CRIMINAL PROVISION**

Employers refusing or willfully neglecting to secure insurance coverage as required by law shall be guilty of a misdemeanor and upon conviction thereof shall be punishable by a fine of not less than \$1,000.00 or more than \$10,000.00 or imprisonment not to exceed 12 months, or both.

## **ENFORCEMENT UNIT**

The Enforcement Division investigates incidents of non-compliance and allegations of fraud. The number to call or report fraud, including failure to secure workers' compensation coverage, is (404) 657-7285.

## **NOTICE**

Employers must post a notice reflecting their compliance with the law and post the State Board of Workers' Compensation Bill of Rights for the injured worker, along with a Panel of Physicians (P1, P3), in a conspicuous place. These notices may be obtained by calling 404-656-3870.

The insurance company's name must be posted, or if self-insured the certificate of self-insurance must be posted in a prominent place.

## **REPORTING**

Immediately upon knowledge of an injury, an employer must complete and file with its insurer's or self-insurer's claims office, an Employer's First Report of Injury or Occupational Disease (Form WC-1). Injuries involving seven or more days of lost time must be reported to the Board within 21 days of the employer's knowledge of disability.

Failure to file timely reports with the Board and/or make timely payments of income or medical benefits will result in late payment penalties and may result in late filing penalties and the assessment of attorney's fees.

## **LAW AND RULES**

For \$57.00 prepaid, Lexis-Nexis, Matthew Bender, 1275 Broadway, Albany, N.Y. 12204-4024, 1-800-533-1637, will furnish a copy of Workers' Compensation Law and the Rules and Regulations of the Board.

# HOW THE WORKERS' COMPENSATION LAW APPLIES TO EMPLOYERS



**State Board of Workers Compensation**  
270 Peachtree Street, NW  
Atlanta, GA 30303-1299

## MEDICAL CARE FOR INJURED EMPLOYEES

Employers must select ONE of the following three options to provide medical care for injured employees. The choices will be known as Option 1, Traditional Panel of Physicians and Option 3, a panel listing a Workers' Compensation Managed Care Organization certified by the Board.

**Option 1.** The employer may maintain a Traditional Panel of Physicians that shall consist of at least six non-associated physicians, but is not limited to six. However, the Board may grant exceptions to the required size of the panel where it is demonstrated that more than six physicians or groups of physicians are not reasonably accessible. The minimum panel shall include an orthopedic physician and no more than two physicians shall be from industrial clinics. The panel shall include a minority physician, where feasible.

**Option 2.** The employer or workers' compensation insurer of an employer may contract with a Workers' Compensation Managed Care Organization certified by the Board. A "Workers' Compensation Managed Care Organization" means a plan certified by the Board that provides for the delivery and management of treatment to injured employees under the Georgia Workers' Compensation Act. The managed care organization must include minority providers.

The employer must post their Panel of Physicians in prominent places within the workplace. If the employer is using an MCO to provide medical care, the list of all network physicians must be available to the employee. An employee may select any physician on the panel and may make one change to another physician on the panel without approval from the employer. Further changes require approval of the employer/insurer or the Board. Employers must fully explain the purpose of the

panel to all employees and must assist employees in obtaining medical care when an injury occurs. Failure to comply with these rules may result in the employee having the freedom to select any physician he/she chooses to provide the employee with care for his/her injuries, and may result in an assessment of penalties and attorney's fees against the employer.

## SUBSEQUENT INJURY

The Official Code of Georgia Chapter 34-9-368 was amended by establishing June 30, 2006 as the last date of injury eligible for reimbursement by the Fund. For information, about the Subsequent Injury Trust Fund, write or call the Administrator, Subsequent Injury Trust Fund, Marquis II Tower, Suite 1250, 285 Peachtree Center Avenue, Atlanta, GA 30303, (404) 656-7000 or visit their website at [sift.georgia.gov](http://sift.georgia.gov).

## INFORMATION

For additional information, you may call (404) 656-3818 in the Atlanta area or 1-800-533-0682 outside the Atlanta area, or visit our website at [www.sbwcc.georgia.gov](http://www.sbwcc.georgia.gov).

**Rev. (7/16)**

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury
-----------------	--------------------	---------------------	------	-------------------------	----------------

### A. IDENTIFYING INFORMATION

<b>EMPLOYEE</b>	<input type="checkbox"/> Male	Birthdate	Phone Number	Employee E-mail	
	<input type="checkbox"/> Female				
Address			City	State	Zip Code
<b>EMPLOYER</b>	Name		NAICS Code	Nature of Business (Trade, Transport, Mfg., etc.)	
	Address		Phone Number	Employer FEIN	
City		State	Zip Code	Employer E-mail	
<b>INSURER / SELF-INSURER</b>	Name		Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #	
<b>CLAIMS OFFICE</b>	Name		Claims Office FEIN #	Claims Office Phone	Claims Office E-mail
SBWC ID# (five digit no.)		Address	City	State	Zip Code
<b>EMPLOYMENT/WAGE</b>	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: <input type="checkbox"/> per Hour <input type="checkbox"/> per Day <input type="checkbox"/> per Week <input type="checkbox"/> per Month	
	Insurer Type Code <input type="checkbox"/> - Insurer <input type="checkbox"/> S-Self-insurer <input type="checkbox"/> Group Fund		List Normally Scheduled Days Off		
<b>INJURY/ILLNESS &amp; MEDICAL</b>	Time of Injury <input type="checkbox"/> am <input type="checkbox"/> pm	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day	
	Did Employee Receive Full Pay on Date of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did Injury/Illness Occur on Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred					
Treating Physician (Name and Address)		Initial Treatment Given: <input type="checkbox"/> None <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinical/Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)		If Returned to Work, Give Date:  Returned at what wage _____ per Week  If Fatal, Enter Complete Date of Death
Report Prepared By (Print or Type)			Telephone Number	Date of Report	

### ☐ B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only <input type="checkbox"/> Yes <input type="checkbox"/> No	Average Weekly Wage: \$ _____ Weekly benefit: \$ _____	Date of disability: _____
Date of first Payment: _____ Compensation paid: \$ _____ or Date salary paid: _____ Penalty paid: \$ _____		
BENEFITS ARE PAYABLE FROM _____ FOR:		
<input type="checkbox"/> Temporary total disability <input type="checkbox"/> Temporary partial disability <input type="checkbox"/> Permanent partial disability of _____ % to _____ for _____ weeks.		
UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.		

### ☐ C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:
------------------------------------

### ☐ D. MEDICAL ONLY ☐ No disability paid or controverted

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Phone and Ext.	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.
2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY.**  
Do not send this form to the State Board of Workers' Compensation.
3. If you need additional help, call your insurance company or self-insurer claims office.
4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

## NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.  
This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be sent to the claimant(s) and all counsel of record. Form W-6 must be filed if weekly benefits are less than the maximum.

## NOTICE TO EMPLOYEE

1. This form is provided for your information only.

If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682

In Atlanta: (404) 656-3818

<http://www.sbwc.georgia.gov>

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwc.georgia.gov>

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Georgia  
State Board of Workers'  
Compensation  
270 Peachtree Street, N.W.  
Atlanta, Georgia 30303-1299

# **Georgia State Board of Workers' Compensation Enforcement Division**



## **WORKERS' COMPENSATION FRAUD AND INSURANCE NON-COMPLIANCE**

**Everyone pays the price for W.C. Fraud!**

**Contact the Workers' Compensation Enforcement Division.**



**Toll Free Fraud Hotline: 1-800-533-0682**

**Office: (404) 657-7285**

**Fax: (404) 651-7390**

**Visit our Website at [www.sbwc.georgia.gov](http://www.sbwc.georgia.gov)**

**WORKERS' COMPENSATION FRAUD WILL BE PROSECUTED**



Georgia  
State Board of Workers'  
Compensation  
270 Peachtree Street, N.W.  
Atlanta, Georgia 30303-1299

# **Junta Estatal de Compensación al Trabajador de Georgia**

## **División de Cumplimiento**



### **FRAUDE DE COMPENSACIÓN AL TRABAJADOR**

¿Conoce usted a alguien que esté defraudando al sistema?

**¡Todos pagan el precio por fraude de compensación al trabajador!**

**Llame a la División de Cumplimiento de Compensación al Trabajador**



**Línea Gratuita contra el Fraude: 1-800-533-0682**

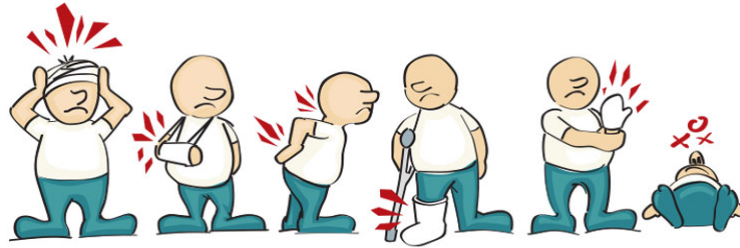
**Oficina: (404) 657-7285**

**Fax: (404) 651-7390**

Visite nuestro sitio web [www.sbwc.georgia.gov](http://www.sbwc.georgia.gov)

**EL FRAUDE DE COMPENSACIÓN AL  
TRABAJADOR SERÁ ENCAUSADO**

**No matter how large or how small,  
You must remember to report them all.**



**Report ALL work-related incidents IMMEDIATELY to your supervisor.**

Report every injury that occurs, even if you don't need medical attention.

Any unsafe work conditions should also be reported to your supervisor so that they may be corrected.

## How to report a work-related injury



Online • [www.normandyins.com](http://www.normandyins.com)



App • [www.normandyins.com/claim-app](http://www.normandyins.com/claim-app)



Search: Normandy - Claims Reporting



Email • [compcare@normandyins.com](mailto:compcare@normandyins.com)



Call • 833-968-7642 (833-YOURNIC)



Fax • 833-770-1220

You do not need to wait until the incident report form is completed. Simply report the injury to Normandy Insurance right away with whatever information you have.

Questions?  
Call 866-688-6442  
Visit us at [www.normandyins.com](http://www.normandyins.com)



**NORMANDY**  
INSURANCE COMPANY



## REPORTING A CLAIM

- Once an employee reports an injury, provide the employee instructions on how to obtain medical care
  - **In an emergency, dial 911** or get the employee to the closest hospital, emergency room or medical facility. In a non-emergency situation, the employee should be directed to an urgent care or walk-in clinic you have selected
  - Contact the medical provider/facility to let them know that an employee is being sent over for treatment and that a drug test should be completed on the injured employee
- To report a claim, **notify Normandy Insurance IMMEDIATELY (within 24 hours) via:**
  - Phone at **833-968-7642 (833-YOURNIC)** (this is the preferred method of reporting a claim), or
  - Email the completed First Notice of Injury form (DWC-1) to [compcare@normandyins.com](mailto:compcare@normandyins.com), or
  - Online at [www.normandyins.com](http://www.normandyins.com), or
  - Fax the completed First Notice of Injury form (DWC-1) to 833-770-1220
  - Immediate notification of a claim may help reduce the cost of the claim
  - Your company could be fined by the state for failure to report a claim to your insurance carrier
- If there is a job-related death or hospitalization of 1 or more employees you must notify OSHA **within 8 hours**, and each work-related inpatient hospitalization, as well as amputations and losses of an eye must be reported to OSHA **within 24 hours**. The reporting regulations affect all employers covered by OSHA, even those who are partially exempt from maintaining injury and illness records
  - The Occupational Safety and Health Administration (OSHA) in your state by telephone to the OSHA toll-free central telephone number, 1-800-321-OSHA (1-800-321-6742). Or by electronic submission using the reporting application located on OSHA's public Web site at [www.osha.gov](http://www.osha.gov).
- Have the injured employee and supervisor and/or witnesses complete an Accident Investigation Report form
  - **NOTE: If you do not agree with the description of the accident or believe that an accident did not occur, you are still required to report the incident to Normandy. It is imperative that a claim be reported, even if it is questionable.**
- Maintain continuous contact with the injured employee to let them know that you are concerned about their well-being and that work is available. If an employee is released by their treating physician to return to work in an alternate duty capacity, you should attempt to make the necessary accommodations to bring the injured employee back into the workplace
- You can expect to hear from your adjuster within 24 hours of reporting a claim and also throughout the duration of the claim, but it is important that you also keep in touch with your adjuster.
- Provide your adjuster with any pertinent information that you may have with regard to your claims
- If an employee needs further medical treatment for the same injury or is having problems with claims payments, instruct them to contact their adjuster at 866-688-6442.
- Please visit [www.normandyins.com](http://www.normandyins.com) for more information.



## Claim Reporting Instructions

### To Report A Claim:

**Phone:** 833-968-7642 (833-YOURNIC)

**Online:** [www.normandyins.com](http://www.normandyins.com)

**Email:** [compcare@normandyins.com](mailto:compcare@normandyins.com)

**Fax:** 833-770-1220

### PHONE REPORTING:

If reporting by **PHONE**, the operator that answers the phone will ask question in regards to the accident. S/he will also obtain some personal information about the injured worker that is required in order to file a workers' compensation claim.

If necessary that operator will either connect the caller with the adjuster in order to obtain physician information in regards to where to treat. If the call is placed after hours that operator will provide the physician information.

### FAX OR EMAIL REPORTING:

If reporting by **FAX** or **EMAIL**, claims should be reported on the **State Form DWC-1, First Report of Injury or Illness**. The following information is required for claim entry:

- Full name, address, telephone number of injured employee
- Occupation, date of birth, sex of injured employee
- The injured employee's Social Security number
- Date and time of accident
- Employee's description of accident
- Injury/illness that occurred, part of body injured
- Company name, phone, address; and policy number, if known
- Employer's location address is different from above
- Did the employee return to work? If so, note the date.
- Do you (the employer) agree with the accident?
- Name of physician or hospital where employee was sent by you for treatment
- Place/address accident occurred\*
- Employee date of hire\*

*\*Not required, but preferred*

A PDF version of the DWC-1 form that can be completed electronically is available for your convenience if you choose to report a claim via email or fax. Please contact your adjuster at **866-688-6442** to get a copy of this form.



## First Fill Form

Client Name: Normandy Insurance

### 1. Instructions for the **EMPLOYER**:

- Provide this form to your injured worker to have any prescription filled for up to **7 Days**, and please fill out the information below:

**Injured Worker Name:**

**SS#:**

**Injured Worker DOB:**

**Injured Worker Phone:**

**Injured Worker Employer:**

**Date of Injury:**

**Injured Worker Address:**

**City:**

**State:**

**Zip:**

### 2. Instructions for the **INJURED WORKER** / Instrucciones para el **TRABAJADOR LESIONADO**:

- **You, the injured worker, will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work related injury/illness**
- **Usted, el trabajador lesionado, deberá llevar este formulario y entregarlo en la farmacia junto con sus recetas relacionadas con el tratamiento de su lesión/enfermedad laboral.**

### 3. Instructions for the **PHARMACY**:

- Please submit workers' compensation claims to **S1 Medical** using the following information:

<b>BIN</b>	<b>PCN</b>	<b>Group Id</b>	<b>Member Id</b>
610237	123119	NOR001	Injured Worker SS#

- Prescription(s) will fill for up to **7 Days**. If there is a remaining balance on the script after it is filled, S1 Medical will call back if and when the balance has been approved. If you need assistance, please call **S1 Medical** at (888) 356-3332.

Representative's on-call 24 hours/7 days a week.

**FOR ALL REJECTIONS OR QUESTIONS CALL: (888) 356-3332**



## COMO REPORTAR UNA RECLAMACIÓN

- Una vez que un empleado reporta una lesión o una enfermedad, dele instrucciones sobre cómo obtener atención médica.
  - **En caso de emergencia, marque el 911** o lleve al empleado al hospital, sala de emergencias o centro médico más cercano  
En una situación que no sea de emergencia, el empleado debe ser dirigido a una clínica de atención urgente (urgente care) o ambulatoria (walk-in) que usted haya seleccionado.
  - Contacte al proveedor/centro médico para informarles que se va a enviar a un empleado para que reciba tratamiento y que se debe realizar una prueba de drogas al empleado lesionado
- Para informar de un accidente, **notifique a Normandy Insurance INMEDIATAMENTE (en un plazo de 24 horas) a través de:**
  - Por teléfono, llamando **al 833-968-7462 (833-YOURNIC)** (este es el método preferido para notificar un accidente), o
  - Envíe por correo electrónico el Formulario de Primera Notificación de Lesión diligenciado a **compcare@normandyins.com** , o
  - En línea en **www.normandyins.com**,o
  - Envíe por fax el Formulario de Primera Notificación de Lesión (DWC-1) diligenciado al 833-770-1220
  - La notificación inmediata de un accidente puede ayudar a reducir el costo del mismo
  - Su empresa podría ser multada por el Estado por no comunicar un accidente a su aseguradora
- Si se produce una muerte u hospitalización relacionada con el trabajo de uno o más empleados, debe notificar a la OSHA **en un plazo de 8 horas**, y cada hospitalización relacionada con el trabajo, así como las amputaciones y pérdidas de un ojo deben notificarse a la OSHA **en un plazo de 24 horas**. La normativa de notificación afecta a todos los empleadores cubiertos por la OSHA, incluso a los que están parcialmente exentos de mantener registros de lesiones y enfermedades
  - La Administración de Seguridad y Salud Ocupacional (OSHA) de su estado llamando al número de teléfono central gratuito de la OSHA, 1-800-321-OSHA (1-800-321-6742). O bien mediante el envío electrónico a través de la aplicación de notificación que se encuentra en el sitio web público de la OSHA en **www.osha.gov**.
- Hacer que el empleado lesionado y el supervisor y/o los testigos completen un formulario de Informe de Investigación de Accidentes
  - **NOTA: Si no está de acuerdo con la descripción del accidente o cree que no se ha producido un accidente, usted sigue estando obligado a informar del incidente a Normandy. Es imperativo que se reporte un accidente, aunque éste sea dudoso.**
- Mantenga un contacto continuo con el empleado lesionado para hacerle saber que se preocupa por su bienestar y que el trabajo está disponible. Si el médico tratante autoriza a un empleado a volver al trabajo en una capacidad de trabajo alternativo, usted debe intentar hacer los ajustes necesarios para que el empleado lesionado vuelva a su lugar de trabajo.



- Usted puede esperar tener noticias de parte de su ajustador dentro de las 24 horas de haber reportado un accidente y también durante la duración de la reclamación, pero es importante que usted también se mantenga en contacto con su ajustador.
- Proporcione a su ajustador cualquier información pertinente que pueda tener con respecto a sus reclamaciones
- Si un empleado necesita más tratamiento médico por la misma lesión o tiene problemas con los pagos de las reclamaciones, indíquele que se ponga en contacto con su ajustador en el 866-688-6442.
- Para más información, por favor visite **[www.normandyins.com](http://www.normandyins.com)** .



## Instrucciones para reporte de reclamaciones

### Para Reportar un Accidente:

Teléfono: 833-968-7462 (833-YOURNIC)

En línea: [www.normandyins.com](http://www.normandyins.com)

Email: [compcare@normandyins.com](mailto:compcare@normandyins.com)

Fax: 833-770-1220

### REPORTAR POR VÍA TELEFÓNICA:

Si se reporta por vía **TELEFÓNICA**, la operadora que contesta el teléfono hará preguntas en relación con el accidente. También obtendrá algunos datos personales del trabajador lesionado que son necesarios para presentar una reclamación de indemnización por accidente de trabajo.

Si es necesario, ese operador pondrá en contacto a la persona que llama con el ajustador para obtener información respecto del médico y lugar de tratamiento. Si la llamada se realiza fuera del horario de atención al público, el operador proporcionará la información del médico.

### REPORTE POR FAX O CORREO ELECTRÓNICO:

Si se reporta por **FAX** o **EMAIL**, los accidentes deben notificarse en el **formulario estatal DWC-1, First Report of Injury or Illness** form. La siguiente información es necesaria para presentar la reclamación:

- Nombre completo, dirección y número de teléfono del trabajador lesionado
- Ocupación, fecha de nacimiento, sexo del empleado lesionado
- Número de Seguridad Social del trabajador lesionado
- Fecha y hora del accidente
- Descripción del accidente por parte del empleado
- Lesión/enfermedad ocurrida, parte del cuerpo lesionada
- Nombre de la empresa, teléfono, dirección y número de póliza, si se conoce
- La dirección del empleador es diferente a la anterior
- ¿El empleado volvió a trabajar? Si es así, anote la fecha.
- ¿Está usted (el empleador) de acuerdo con el accidente?
- Nombre del médico u hospital al que fue enviado el empleado para su tratamiento
- Lugar/dirección donde ocurrió el accidente\*
- Fecha de contratación del empleado\*

*\*No es necesario, pero sí preferible*

Para su comodidad, existe una versión en PDF del formulario DWC-1 que puede diligenciar electrónicamente si decide reportar un accidente por correo electrónico o fax. Por favor, póngase en contacto con su ajustador en el **866-688-6442** para obtener una copia de este formulario.



## First Fill Form

Client Name: Normandy Insurance

### 1. Instructions for the **EMPLOYER**:

- Provide this form to your injured worker to have any prescription filled for up to **7 Days**, and please fill out the information below:

**Injured Worker Name:**

**SS#:**

**Injured Worker DOB:**

**Injured Worker Phone:**

**Injured Worker Employer:**

**Date of Injury:**

**Injured Worker Address:**

**City:**

**State:**

**Zip:**

### 2. Instructions for the **INJURED WORKER** / Instrucciones para el **TRABAJADOR LESIONADO**:

- **You, the injured worker, will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work related injury/illness**
- **Usted, el trabajador lesionado, deberá llevar este formulario y entregarlo en la farmacia junto con sus recetas relacionadas con el tratamiento de su lesión/enfermedad laboral.**

### 3. Instructions for the **PHARMACY**:

- Please submit workers' compensation claims to **S1 Medical** using the following information:

<b>BIN</b>	<b>PCN</b>	<b>Group Id</b>	<b>Member Id</b>
610237	123119	NOR001	Injured Worker SS#

- Prescription(s) will fill for up to **7 Days**. If there is a remaining balance on the script after it is filled, S1 Medical will call back if and when the balance has been approved. If you need assistance, please call **S1 Medical** at (888) 356-3332.

Representative's on-call 24 hours/7 days a week.

**FOR ALL REJECTIONS OR QUESTIONS CALL: (888) 356-3332**