

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)

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

(Complete all applicable spaces)

Name of Insurance Company:

Normandy Insurance Company

Address: 4800 N. Federal Hwy Ste 302A

Boca Raton FL 33431

Telephone Number: 833-968-7462 compcare@normandyins.com

Name of TPA (Claims administrator):

Address: _____

Telephone Number: _____

Insurer Code: _____

IF SELF-INSURED

(Complete all applicable spaces)

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

(Complete all applicable spaces)

Name of person handling claims at
the self-insured:

Name of TPA (Claims administrator):

Address: _____

Address: _____

Telephone Number: _____

Telephone Number: _____

Insurer Code: _____

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

El nombre, la dirección y el número de teléfono de la compañía de seguros de compensación para trabajadores de su empleador, el administrador externo (TPA) o la persona que maneja las reclamaciones de compensación para trabajadores de su empresa se muestran a continuación.

Nombre del empleador: _____

Fecha de publicación: _____

SI ESTA ASEGURADO/A:

(Complete todos espacios que apliquen)

**SI ALGUIEN QUE NO SEA LA ASEGURADORA ESTÁ
MANEJANDO LOS RECLAMOS:**

(Complete todos los espacios que apliquen)

Nombre de la compañía de seguro: _____

Nombre del TPA (Administrador de reclamos): _____

Dirección: _____

Dirección: _____

Número de teléfono: _____

Número de teléfono: _____

Código del asegurador: _____

SI ESTA AUTO-ASEGURADO

(Complete todos los espacios que apliquen)

**SI ALGUIEN QUE NO SEA EL AUTO-ASEGURADOR ESTA
MANEJANDO LOS RECLAMOS:**

(Complete todos los espacios que apliquen)

Nombre de la persona que está manejando los reclamos
en el autoseguro: _____

Nombre del TPA (Administrador de reclamos): _____

Dirección: _____

Dirección: _____

Número de teléfono: _____

Número de teléfono: _____

Código del asegurador: _____

Cualquier individuo que presente información errónea o incompleta a sabiendas y con la intención de defraudar, infringe la Sección 1102 de la Ley de Compensación para Trabajadores de Pensilvania, 77 P.S. §1039.2, y también puede estar sujeto a sanciones penales y civiles según 18 Pa. C.S.A. §4117 (relacionado con el fraude de seguros).

**Servicios de
información para
empleadores**
717.772.3702

Servicios de información de reclamaciones
Número gratuito dentro PA: 800.482.2383
Local & fuera de PA: 717.772.4447

**Personas con
discapacidad auditive**
PA Relay 7-1-1

Correo electrónico
ra-li-bwc-helpline@pa.gov



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

EMPLOYEE WORKPLACE NOTICE PUBLIC SECTOR Pennsylvania Worker and Community Right To Know Act

The Pennsylvania Worker and Community Right to Know Act requires that information about hazardous substances in the workplace and in the environment is available to public sector employees and employees of private sector workplaces not covered by the Federal Occupational Safety and Health Administration (OSHA) Hazard Communication Standard and to all persons living or working in the state. Employee rights listed below are further defined in the Worker and Community Right to Know Act (P.L. 734, No. 159) and Regulations. For additional information, contact the Department of Labor & Industry, Bureau of Workers' Compensation, Health & Safety Division, 1171 S. Cameron Street, Room 324, Harrisburg, Pennsylvania 17104-2501; Phone: 717-772-1635; Fax: 717-783-6365; E-mail: RA-LI-BWC-SAFETY@pa.gov.

Employee Workplace Notice:

Public sector employers (including state and local government agencies and public schools and public universities) and private sector employers not covered by the OSHA Hazard Communication Standard must post this notice informing employees of their rights under the law. This notice must be posted prominently in the workplace at a location where employee notices are normally posted.

Training:

Public sector employers and private sector employers not covered by the OSHA Hazard Communication Standard must provide an annual education and training program to employees exposed to hazardous substances. The training program may be presented either in written form or in training sessions.

Hazardous Substance Survey Form:

The Hazardous Substance Survey Form (HSSF) provides an inventory of the hazardous substances found in the workplace during the prior calendar year. All employers must complete a workplace HSSF annually. Public sector employers and private sector employers not covered by OSHA must post the HSSF prominently in the workplace and must provide a copy to any employee upon request.

Work Area List:

The Work Area List names the hazardous substances used or produced in a specific work area in the workplace. Public sector employers and private sector employers not covered by the OSHA Hazard Communication Standard must update a Work Area List at least annually, must provide a copy to any employee of the work area upon request, and must offer a copy to any employee newly assigned to that work area.

Material Safety Data Sheet/Safety Data Sheet:

The Material Safety Data Sheet (MSDS)/Safety Data Sheet (SDS) provides detailed information about a hazardous substance. In public sector workplaces and private sector workplaces not covered by the OSHA Hazard Communication Standard, an MSDS/SDS must be accessible in the work area where the hazardous substance it describes is used. MSDSs/SDS must be readily available to employees without the intervention or permission of management or supervisors, and any employee may obtain and examine an MSDS/SDS for any hazardous substance in the workplace. If an employee's request to obtain a copy of an MSDS/SDS is made to the employer

in writing and, after five working days from the date the request is made, the employer fails to furnish the employee with an MSDS/SDS in the employer's possession or fails to provide the employee with proof of the employer's effort to obtain the requested MSDS/SDS from the manufacturer, importer, supplier or distributor and from the Department of Labor & Industry, the requesting employee may refuse to work with the substance.

Environmental Hazard Survey Form:

The Environmental Hazard Survey Form (EHSF) provides information about any environmental hazards emitted, discharged or disposed off from the workplace. All employers are required to complete an EHSF when and if requested to do so by the Department of Labor & Industry. If an EHSF has been completed by a public sector employer or a private sector employer not covered by the OSHA Hazard Communication Standard, a copy must be provided to any employee upon request.

Labeling:

All containers and ports of pipelines of hazardous and non-hazardous substances in public sector workplaces and private sector workplaces not covered by the OSHA Hazard Communication Standard must be properly labeled. Employers must ensure that each label, sign, placard or other operating instruction is prominently affixed and displayed on the container or port of a pipeline system so that employees can easily identify the contents.

Health and Exposure Records:

Public sector employers and private sector employers not covered by the OSHA Hazard Communication Standard must maintain and allow employee access to records of employee chemical exposure to the extent required by OSHA (under 29 CFR 1910.1200) or by the Mine Safety Health Administration (under 30 CFR 70.210 and 71.210).

Non-discrimination:

If a public sector employee or an employee of a private sector workplace not covered by the OSHA Hazard Communication Standard believes that he or she has been discharged, disciplined or discriminated against by an employer for exercising his or her rights granted under the Pennsylvania Worker and Community Right to Know Act, that employee has 180 days from the date of the alleged violation to file a written complaint with the Department of Labor & Industry, Bureau of Workers' Compensation, Health & Safety Division.

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

**LA LEY DEL DERECHO A SABER
DEL TRABAJADOR Y
COMUNIDAD DE PENNSYLVANIA
AVISO PARA SER COLOCADO EN EL CENTRO
DE TRABAJO SECTOR PÚBLICO**

La Ley del Derecho a Saber del Trabajador y la Comunidad de Pennsylvania obliga a que la información sobre sustancias peligrosas en el centro de trabajo y en el medio ambiente esté disponible para los empleados del sector público y los del sector privado que no están cubiertos bajo los Estándares de OSHA (Administración Federal de Seguridad Ocupacional y Salud, por sus siglas en inglés) y para todos aquellos viviendo o trabajando en el Estado. Los derechos de los trabajadores mencionados abajo están aún más definidos en la Ley del Derecho a Saber del Trabajador y Comunidad (L. P. 734, nro. 159) y en la regulaciones relacionadas. Para mayor información contacte con el *Department of Labor & Industry, Bureau of Workers' Compensation, Health & Safety Division, 1171 S. Cameron Street, Room 324, Harrisburg, Pennsylvania 17104-2501*; teléfono 717-772-1635; fax 717-783-6365; email: RA-LI-BWC-SAFETY@pa.gov

Aviso en el centro de trabajo:

Los empleadores del sector público (incluidas las agencias gubernamentales locales y estatales y las escuelas y universidades públicas) y los empleadores del sector público que no están cubiertos por los Estándares de Comunicación de Peligros de OSHA deberán exhibir este aviso para informarles a los trabajadores de sus derechos bajo la ley en un lugar visible en el centro de trabajo donde los avisos son generalmente puestos.

Capacitación:

Los empleadores de los sectores público y privado que no están cubiertos por los Estándares de Comunicación de Peligros de OSHA deberán proveer un programa anual de instrucción y capacitación a los empleados expuestos a sustancias peligrosas. El programa de capacitación podría ser por escrito o en sesiones de instrucción.

Hoja de datos sobre sustancias peligrosas:

El Formulario de informe de sustancias peligrosas (HSSF, en inglés) provee una lista de las sustancias peligrosas en existencia en el centro de trabajo en el año anterior. Todo empleador deberá llenar un HSSF anualmente. Los empleadores de los sectores público y privado que no están cubiertos por OSHA deberán exhibir el HSSF visiblemente en el centro de trabajo y proveer una copia de éste al empleado que lo pida.

Lista en el centro de trabajo:

Esta lista menciona las sustancias peligrosas usadas o producidas en un área específica en el centro de trabajo. Los empleadores del sector público o privado que no están cubiertos por los Estándares de Comunicación de Peligros de OSHA deberán actualizar una lista del área de trabajo como mínimo anualmente, deberán proveerle una copia de ésta al empleado de esa área que la solicite, y ofrecérsela a todo nuevo empleado asignado a esa área de trabajo.

Hoja de datos de seguridad (MSDS/SDS):

La Hoja de datos de seguridad de los materiales (MSDS/SDS, en inglés) provee información detallada sobre una sustancia peligrosa. En los centros de trabajo de los sectores públicos y privados que no estén cubiertos por los Estándares de Comunicación de Peligros de OSHA, una MSDS/SDS deberá estar accesible en el área de trabajo donde la sustancia peligrosa nombrada esté localizada. La MSDS/SDS deberá estar disponible para ser vista por los empleados sin la intervención o permiso del supervisor o gerente, y cualquier trabajador puede obtener y examinar una MSDS/SDS en cuanto a sustancias peligrosas localizadas en el centro de empleo. Si el pedido del trabajador de obtener una copia de

la MSDS/SDS es por escrito y después de cinco días laborales desde la fecha del pedido y el empleador no ha presentado el MSDS/SDS al trabajador o no le presenta al trabajador una prueba de que ha tratado de obtener dicha MSDS/SDS del fabricante, importador, abastecedor o distribuidor y del Departamento de Labor e Industria, el trabajador solicitante puede rehusar a trabajar con dicha sustancia.

Hoja de datos sobre peligros en el medio ambiente:

El Formulario de informe de peligros en el medio ambiente (EHSF, en inglés) le informa sobre peligros en el medio ambiente emitidos, descargados o desechados del centro de trabajo. Todos los empleadores están obligados a llenar el EHSF si la orden viene del Departamento de Labor e Industria. Si el EHSF ha sido llenado por un empleador del sector público o privado que no está cubierto por los Estándares de Comunicación de Peligros de OSHA, una copia deberá ser proveída al empleado que lo solicite.

Etiquetas o rótulos:

Todos los envases y entradas/salidas de tuberías de elementos peligrosos y no peligrosos localizados en los centros de trabajo de los sectores públicos y privados que no están cubiertos por los Estándares de Comunicación de Peligros de OSHA deberán estar debidamente etiquetados. Los empleadores deberán asegurar de que toda señal, rótulo, etiqueta u otras instrucciones se exhiban visiblemente en el envase o entrada/salida de la tubería para que los empleados puedan fácilmente identificar los elementos contenidos.

Récords médicos y de exposición:

Los empleadores del sector público o privado que no están cubiertos por los Estándares de Comunicación de Peligros de OSHA deberán mantener y permitir a los empleados acceso a récords de exposición de los empleados a sustancias tal como es requerido por OSHA (bajo el 29 CFR 1910.1200) o por la Administración de la Protección de la Salud en las Minas (bajo 30 CFR 70.210 y 71.210).

No discriminación:

Si un empleado del sector público o el centro de trabajo de un empleado del sector privado no cubierto por los Estándares de Comunicación de Peligros de OSHA piensa que ha sido despedido, sancionado o discriminado por un empleador al haber hecho uso de sus derechos de acuerdo a la Ley del Derecho a Saber del Trabajador y la Comunidad de Pennsylvania, dicho empleado tiene hasta 180 días -desde la fecha de la alegada acción- para presentar una queja por escrito ante el Department of Labor & Industry, Bureau of Workers' Compensation, Health & Safety Division.

*Ofrecemos asistencia y servicios adicionales a las personas discapacitadas que los soliciten.
Empleador/programa de apoyo a la igualdad de oportunidad*

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of 6 or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted at _____ for you to view. Also, you may get a copy of this list from _____.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.1)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- ☞ You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- ☞ You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- ☞ You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- ☞ You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- ☞ If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- ☞ You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- ☞ If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

IMPORTANT: The requirements your employer must meet to have a valid list of at least 6 providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- ☞ You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- ☞ You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

Your signature on this form indicates that you have been informed of and you understand these rights and duties. **If you have questions, be sure you have your rights and duties explained to you before signing this form.**

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one):

☐ TIME OF HIRE

☐ WHEN I WAS INJURED

☐ OTHER

EMPLOYEE: _____ DATE: _____

EMPLOYER REPRESENTATIVE: _____ DATE: _____

(OVER)

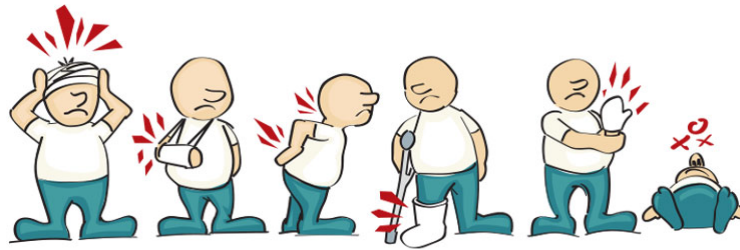
**REQUIREMENTS FOR EMPLOYER'S LIST OF
HEALTH CARE PROVIDERS**

1. There must be at least 6 health care providers on the list, but there may be more than 6 listed.
2. At least 3 of the health care providers on the list must be physicians.
3. No more than 4 of the health care providers on the list may be coordinated care organizations (CCOs).
4. The names, addresses, phone numbers and areas of medical specialties of all health care providers must be included on the list.
5. The health care providers on the list must be geographically accessible and must have specialties that are appropriate based on the anticipated work-related medical problems of the employees.
6. Your employer must specify on the list if any of the health care providers on the list are employed, owned or controlled by your employer or its workers' compensation insurance company.

NOTE: Your employer's list of health care providers must meet all of the above requirements. If the list does not meet all of these requirements, you do not have to choose a provider from the list. Instead, you have the right to seek medical treatment with any health care provider of your choice.

BUREAU OF WORKERS' COMPENSATION
HELPLINE INFORMATION CENTER
1-800-482-2383 (long-distance calls inside PA)
(717) 772-4447 (local and calls outside PA)

**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



App • www.normandyins.com/claim-app



Search: Normandy - Claims Reporting



Email • 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





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, or
 - Online at 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.
- 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 for more information.



Claim Reporting Instructions

To Report A Claim:

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

Online: www.normandyins.com

Email: 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:

BIN	PCN	Group Id	Member Id
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** .



Instrucciones para reporte de reclamaciones

Para Reportar un Accidente:

Teléfono: 833-968-7462 (833-YOURNIC)

En línea: www.normandyins.com

Email: 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:

BIN	PCN	Group Id	Member Id
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