TOWER GROUP
COMPANIES

RE: Workers Compensation Claims Kit

Welcome to the Workers Compensation Insurance Program offered through Tower Group Companies. While we hope that your company never has to experience a workers compensation loss, we want you to have everything that you will need to ensure that if a loss occurs you can get your employee taken care of quickly and that you have access to the people and resources that can provide assistance.

Attached you will find the Workers Compensation Reporting Kit which contains the Oregon state-mandated forms, and a step-by-step process to follow in case an employee sustains an injury.

For claims handling, we have selected Pinnacle Risk Management as our claims servicing administrator. If you report claims, your claims adjusting team at Pinnacle's Lake Oswego, Oregon office will make contact with you to get additional information about the injury and your employee to answer any questions that you might have regarding the Oregon workers compensation process.

We thank you for your business, and look forward to providing you with the necessary protection and care for your business and employees.

The following forms have been included with your claims kit and will assist in the filling and handling of any workers compensation claim:

1. ***Oregon Form 801- Report of Job Injury or Illness-*** Employers must report the claim to their insurers no later than five days after notice or knowledge of any accident which may result in a compensable injury. There can be penalties for late reporting of claims.
2. ***Oregon Form 440-3283, "A Guide for Workers Recently Hurt on the Job-*** Insurer's on behalf of the employer must send information to the injured worker upon receipt of a claim/at initial processing.
3. ***Wage Statement-*** Please complete and send a copy of employees Wage Statement to Pinnacle Risk Management at the time of injury.
4. ***Medical Authorization-*** Please have the injured employee fill out and sign this form and send to Pinnacle Risk Management at the time of an injury.

Very truly yours,

Tower Group Companies

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How to file a work injury or Illness Claim

Worker's compensation claims can be reported in several different ways, you can:

- Complete and submit the ***Oregon Form 801- Report of Job Injury or Illness*** - and submit the form via one of the following:

- E-mail the completed form to 3772towernat@york-claims.com. T**his is the preferred method of reporting an injury**.

- Fax to York Risk Management Services Inc. at 800-393-8104.

- Call the York Risk Management Services Inc Reporting Hotline at 1-888-INS-YORK**.**

- By contacting your broker directly and providing the appropriate first report information.

- Your claim will be handled by York Risk Management Services Inc:

  Office Location and Mailing Address:

  York Risk Management Services Inc
  10220 SW Greensburg Road, Ste 610
  Portland, OR 97223

  Main Number: 503 246-1377
  Fax: 503 246-2235

Insert self-insured employer and insurer name, address, phone number, and service company, if any.

Report of Job Injury or Illness

Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give it to your employer. **If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.

Date of injury or illness:	Date you left work:	Time you began work on day of injury: ☐ a.m. ☐ p.m.	Regularly scheduled days off: ☐☐☐☐☐☐☐ M T W T F S S	**DEPT USE:** Emp
Time of injury or illness: ☐ a.m. ☐ p.m.	Time you left work: ☐ a.m. ☐ p.m.	Check here if you have more than one job: ☐		Ins
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☐Left ☐Right				Occ / Nat
What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)				Part / Ev / Src / 2src

Information ABOVE this line; date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.

Your legal name:	Language preference:	Birthdate:	Gender: M ☐ F ☐
Your mailing address:		Home phone:	
Social Security no. (see Form 3283):	Occupation:	Work phone:	
Names of witnesses:			
Name and phone number of health insurance company:		Name and address of health care provider who treated you for the injury or illness you are now reporting:	
Were you hospitalized overnight? ☐ Yes ☐ No			
Were you treated in the emergency room? ☐ Yes ☐ No			

By my signature, I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.

Worker signature:	Completed by (please print):	Date:

Employer

Complete the rest of this form and give a copy of the form to the worker. Notify your workers' compensation insurance company within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

Employer legal business name:		Phone:		FEIN:
If worker leasing company, list client business name:				Client FEIN:
Address of principal place of business (not P.O. Box):				Insurance policy no.:
Street address from which worker is/was supervised:		ZIP:		Nature of business in which worker is/was supervised:
Address where event occurred:				
Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No				
Were other workers injured? ☐ Yes ☐ No			OSHA 300 log case no:	
Date employer knew of claim:	Date worker returned to work:	Worker's weekly wage: $	Date worker hired:	If fatal, date of death:
Employer signature:		Name and title (please print):		Date:

OSHA requirements: On-the-job fatalities and catastrophes must be reported to Oregon OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to Oregon OSHA. Call 800-922-2689, 503-378-3272, or Oregon Emergency Response, 800-452-0311, on nights and weekends.

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

A Guide for Workers Recently Hurt on the Job

How do I file a claim?

- Notify your employer and a health care provider **of your choice** about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims,"** available from your health care provider.

How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
  - Authorized nurse practitioners
  - Chiropractic physicians
  - Medical doctors
  - Naturopathic physicians
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatric physicians
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

Are there limitations to my medical treatment?

- **Health care providers may be *limited* in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

What if I have questions about my claim?

- The insurance company or your employer should be able to answer your questions.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

Ombudsman for Injured Workers:
An advocate for injured workers
Toll-free: 800-927-1271
E-mail: oiw.questions@state.or.us

Workers' Compensation Compliance Section
Toll-free: 800-452-0288
E-mail: workcomp.questions@state.or.us

Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for? You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

440-3283 (07/10/DCBS/WCD/WEB)

WAGE STATEMENT

Employer: _____

Employee: _____

Please provide the **52 weeks** of wages prior to the date of injury of _____

Date employee ceased to work: _____ Date Hired _____

Number of Hours employee is scheduled to work per week: _____ Claim Number _____

Is employee paid by hour, day, week or month _____ At what rate: _____

Does Employee work Overtime ☐ Yes ☐ No If yes, is Overtime mandatory ☐ Yes ☐ No

State the date and amount of any pay increases during the past 52 weeks

Date _____ Amount _____ Date _____ Amount _____

Date _____ Amount _____ Date _____ Amount _____

	Dates Incl of each Week Pd			Hrs Wkd	Regular Pay		Overtime Pay			Dates Incl of each Week Pd			Hrs Wkd	Regular Pay		Overtime Pay	
	From	To	Yr							From	To	Yr					
1									27								
2									28								
3									29								
4									30								
5									31								
6									32								
7									33								
8									34								
9									35								
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16									42								
17									43								
18									44								
19									45								
20									46								
21									47								
22									48								
23									49								
24									50								
25									51								
26									52								
SUBTOTAL										**SUBTOTAL**							
										GRAND TOTAL							

This is a correct statement of Employee's earnings as actually taken from Payroll Records

Employer's Signature _____ Title _____ Date _____

WORKERS COMPENSATION
INJURY MEDICAL AUTHORIZATION

Authorization for Medical Records
And Communication Release

By this form or copy thereof, I _____ , hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other related medical or medically related facility, insurance company or other organization, institution, or person, that has any records or knowledge of my mental, physical health, history, condition or well being, to supply such information to my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment and as to any other issues including but not limited to diagnosis, prognosis, causal connection of care and treatment to my work injury or duties and ability to work. In conjunction with this, I authorize any treating physician or medical provider to review any additional medical records provided to them.

I understand that by signing this authorization for medical records and communication release that my applicable medical provider will be releasing information subject to the HIPPA restrictions. I specifically waive any rights or protections that I may have under the HIPPA regulation and request that the medical providers release the requested information.

A photo copy of this authorization shall be valid as the original. This release shall remain valid for the length of my claim.

_____
Name (Please Print)

_____
Address (Street, City/Town, Zip Code)

_____
Signature

_____
Date Signed