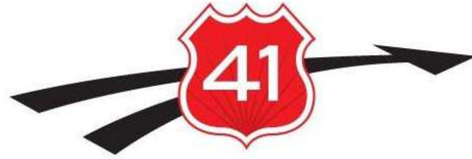

CONNECTING
WISCONSIN

Claims Manual

WISDOT US 41 Corridor Project

Owner Controlled Insurance Program (OCIP)

February 27, 2009

AON

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I. CLAIMS ADMINISTRATION TEAM

Insurance Carrier Claim Contacts

Workers Compensation
Victoria Marrs – Team Leader
ESIS Chicago WC
PO Box 31109
Tampa, FL 33631-3109
Telephone: 312-775-7860
Fax: 800-230-4866
Victoria.marrs@esis.com

General Liability
Maritza Castro – Team Leader
Chicago General Liability Claims
PO Box 31090
Tampa, FL 33631-3090
Telephone: 312-775-7809
Fax: 800-231-8506
Maritza.castro@esis.com

Builder's Risk
Bill Bartkowski
Claims Manager
Aon Risk Services
330 East Kilbourn Avenue
Milwaukee, WI 53202
Telephone: 414-225-5375
Cell Phone: 414-336-4843
Fax: 414-225-7413
Bill_bartkowski@ars.aon.com

RSUI Group, Inc.
Attn: Claims Department
945 E. Paces Ferry Road
Suite 1800
Atlanta, GA, 30326-1160
Fax: 404-264-7239
reportclaims@rsui.com

CLAIMS ADMINISTRATION TEAM - continued

Aon Contacts

Workers Compensation
Christine Green
Claims Manager
Aon Risk Services
200 East Randolph
Chicago IL 60601
Telephone: 312-381-2458
Cell Phone:
Fax: 312-381-0290
Christine_green@ars.aon.com

General Liability
Bill Bartkowski
Claims Manager
Aon Risk Services
330 East Kilbourn Avenue
Milwaukee, WI 53202
Telephone: 414-225-5375
Cell Phone: 414-336-4843
Fax: 414-225-7413
Bill_bartkowski@ars.aon.com

OCIP Safety Contacts

TBD Safety Manager
Highway 41 Field Office
2905 Universal Drive
Oskhosk, WI 54904
Telephone: TBD
Cell Phone: TBD
Fax: TBD

Rick Barton
Technical Services. Aon Risk Services
330 East Kilbourn Avenue
Milwaukee, WI 530202
Telephone: 414-225-5377
Cell Phone: 414-331-2938
Fax: 414-225-7413
rick_barton@ars.aon.com

WISDOT OCIP Claim Contacts

Damien Barr
Manager of Risk Management
Section Chief for Risk, Safety & Facilities
Wisconsin Department of Transportation
Telephone: 608-267-7722
Cell: 608-206-2634
Damien.Barr@dot.state.wi.us

Kevin Gehrmann
OCIP Project Manager
Department of Transportation
Cell Phone: 608-235-0622
Fax: 608-267-4892
Kevin.gehrmann@dot.state.wi.us

II. WORKER'S COMPENSATION CLAIM REPORTING INSTRUCTIONS/PROCEDURES:

1. The **EMPLOYER** of the injured worker must notify the OCIP Safety Manager:

   TBD
   Highway 41 Field Office
   2905 Universal Drive, Oshkosh, WI 549047
   Telephone: TBD
   Cell: TBD
   Fax: TBD

   of *any* on-site injury or occupation-related illness immediately following knowledge of the injury/illness. Any accidental injury and occupational illness needs to be reported regardless of how minor, including only first aid treatment cases. **Failure to report an injury/illness to the OCIP Safety Manager will be considered a violation of project safety rules and regulations, and as such, monetary penalties may be imposed on the EMPLOYER.**

   - **In an emergency situation**, contact the appropriate medical personnel and OCIP Safety Manager and stay with injured worker until help arrives.

2. The injured worker and his/her **EMPLOYER** must provide the OCIP Safety Manager with the factual information required to make the required notification to the insurer. See Exhibit C for a blank example of the Wisconsin Employer's First Report of Injury or Disease and Exhibit H for a fax cover sheet. **Each EMPLOYER needs to complete the Wisconsin First Report of Injury report and provide this form to the OCIP Safety Manager on a timely basis.**

3. **The Wisconsin Department of Transportation (WISDOT) is committed to a drug-free project. Drug testing will be performed on any accident or injury that occurs on the OCIP project.** Please refer to the separate drug policy in the Safety & Health Program Manual for specific details. A positive drug test will have adverse consequences to the involved employee. For example, if an employee has a positive drug test, for the first offense, he/she must be immediately removed from OCIP work and will be barred from any further work on this OCIP for a period of sixty (60) calendar days. Drug testing will be administered at a designated medical facility.

4. The OCIP Safety Manager will provide notification to the insurer ACE Insurance Company and the third party administrator (ESIS, Inc.). This relieves the **EMPLOYER** of its responsibility to notify ESIS.

WORKERS COMPENSATION CLAIMS – continued

5. For informational purposes, ESIS contracts with a third party, First Notice (FNS), to provide a toll-free telephone number dedicated to this OCIP for reporting injury/illness claims. The
FNS facility is operational daily, 24 hours per day. FNS electronically feeds the loss information to ESIS's claim handling system.

6. At the time of the initial report, the OCIP Safety Manager will report to FNS the location code assigned to the involved **EMPLOYER** so that loss experience may be properly tracked.

   - Aon provides each **EMPLOYER'S** location code along with the OCIP enrollment materials.

7. If an injured worker needs off-site medical care, the **EMPLOYER** will prepare the Site Treatment Authorization Form (Exhibit A) to accompany the injured worker to a designated medical facility. This form expedites the treatment process, providing pertinent information needed by the medical provider, and starts the tracking process regarding the worker's return to work. The treating doctor will complete this Site Treatment Authorization Form and advise the treated worker to return the form to the OCIP Safety Manager, along with pertinent comments.

8. WisDOT has **MANDATORY RETURN TO WORK** provisions for each enrolled **EMPLOYER.** Please refer to the separate Safety & Health Program Manual for specific details. Each **EMPLOYER** must provide an injured worker the opportunity to maximize rehabilitation and enable his/her early return to work by accommodating temporary alternate work assignments in compliance with medical restrictions**.** **Monetary penalties may be imposed upon an EMPLOYER for each violation of mandatory return to work provisions.**

9. Upon receipt of the claim-intake information from FNS, ESIS's Workers' Compensation team leader reviews the claim and assigns it to the Claim Representative. ESIS will further generate the first report of injury to the Wisconsin Department of Workforce Development, providing copies to the involved **EMPLOYER**, Aon and WisDOT.

10. On all lost time claims, ESIS's Claim Representative will attempt to make four-point contacts within 24 hours from date of claim receipt, involving the injured worker, the OCIP Safety Manager, off-site treating medical provider(s) and the **EMPLOYER**. The designated ESIS Claims Representative will manage the claim.

11. In the event of serious accident/injury, contact the OCIP Safety Manager. OCIP Safety Manager will contact ESIS's Workers' Compensation Team Leader to report the matter, along with WISDOT and the Wisconsin Department of Workforce Development.
    Examples of a serious injury include:

    - Fatalities
    - Catastrophic, disabling injuries to back or limbs
    - Serious fractures—compound fractures
    - Serious lacerations (dismemberment, amputation or disfiguring injuries)
    - Neck and/or spinal cord injuries with known, suspected or possible paralysis
    - Loss of consciousness or head trauma with possible brain damage
    - Serious burns
    - Major bleeding due to lacerations
    - Any injury for which an ambulance is called

12. On a monthly basis, the OCIP Administrator will make available copies of loss summaries to the prime contractors that have claim activity. Each prime contractor will be responsible for distribution of the claim activity of their sub-contractors. This information will enable each enrolled **EMPLOYER** to review losses associated with their work.

    - The claim summaries allow each enrolled **EMPLOYER** to timely review their claims and advise of any coding or other changes need to be made to avoid inaccurate reporting of claims to the National Council on Compensation Insurance (NCCI) impacting future Workers' Compensation experience ratings. Any coding or other data errors should be promptly reported to the on-site OCIP Administrator.

    - ACE Insurance Company will report all Workers' Compensation claims to NCCI in accordance with regulatory guidelines.

13. Like any insurance program, each **EMPLOYER** needs to cooperate with ESIS by providing information, documents and investigative files deemed necessary by ESIS to resolve a claim.

14. Any suspicious or questionable claim should immediately be brought to the attention of ESIS's designated Claim Representative, along with supporting facts and documentation. Take the time to provide the ESIS investigator with as much information as possible.

15. Medical providers should be instructed to directly bill ESIS for treatment:

ESIS Chicago WC
P.O. Box 31109
Tampa, FL 33631-3109

If a medical billing relating to a covered injury is directed to either the EMPLOYER or injured worker, the original medical bill including the Claim Number should be sent to the Highway 41 OCIP Administrator:

Highway 41 Field Office
2905 Universal Drive
Oshkosh, WI 54904
Telephone: TBD
Fax: TBD

Note: The following information should be put on every medical bill for prompt processing:

- WisDOT US 41 Corridor OCIP
- Claim Number & Policy Number
- Name & Social Security Number of INJURED WORKER (e.g., John Smith)
- Name of EMPLOYER (e.g. Concrete Inc.)

III. GENERAL LIABILITY CLAIM REPORTING INSTRUCTIONS/PROCEDURES:

1. The enrolled Party (**CONTRACTOR OR SUBCONTRACTOR**) who causes damage to a third-party or is aware of or suspects that a claim will be forthcoming as a result of activity on the project, must immediately notify the OCIP Safety Manager:

   TBD
   Highway 41 Field Office
   2905 Universal Drive, Oshkosh WI 54904
   Telephone: TBD
   Cell: TBD
   Fax: TBD

2. The **CONTRACTOR OR SUBCONTRACTOR** aware of, causes or is alleged to have caused any third-party damage or injury must assemble the necessary information for a General Liability claim **within 24 Hours following notice of any incident/accident**. Please complete the General Liability Acord form (Exhibit G) and provide this form to the OCIP Safety Manager.

3. The **CONTRACTOR OR SUBCONTRACTOR** must communicate the required information to both ESIS and the OCIP Safety Manager within the above time frame. **Telephonic notices are strongly recommended to avoid delays in claim processing / investigation.**

4. WisDOT is committed to a drug-free project. Drug testing will be performed on all employees of enrolled **CONTRACTOR OR SUBCONTRACTOR** involved in an accident/incident that produces or may produce a general liability claim. Post Accident drug screening will take place at a designated medical facility.

5. To the extent payments are made under the General Liability coverage of this OCIP, including court costs, attorney's fees, and costs of defense, which are attributable to a **CONTRACTOR'S OR SUBCONTRACTOR'S** work, acts or omissions, including any other entity for whom **CONTRACTOR OR SUBCONTRACTOR** may be responsible, WisDOT is due the sum of up to $10,000 per occurrence.

6. For informational purposes, ESIS contracts with a third party, First Notice (FNS), to provide a toll-free telephone number dedicated to this OCIP for reporting General Liability claims. The FNS facility is operational daily, 24 hours per day. FNS electronically feeds the loss information to ESIS's claim handling system.

7. Upon receipt of the claim-intake information from FNS, ESIS's General Liability Team Leader reviews the claim and then assigns it to the Claims Representative.

GENERAL LIABILITY CLAIM REPORTING – continued

8. ESIS's Claim Representative will attempt contact with the claimant within 24 hours from date of claim receipt. The ESIS Claims Representative will manage the claim.

9. No OCIP coverage is provided for Automobile Liability insurance and Automobile Physical Damage insurance. It is the sole responsibility of each **CONTRACTOR OR SUBCONTRACTOR** to report accidents/claims involving their own vehicles to their own insurers. However, all motor vehicle accidents within the footprint of the OCIP project must be immediately reported to the OCIP Safety Manager. Accident investigations will occur and focus upon liability issues arising out of ongoing construction activities that could result in claims being asserted (i.e., due to conditions of the roads, barricading, flagging, etc.). Each **CONTRACTOR OR SUBCONTRACTOR** must cooperate in the investigation of each such accident.

10. Never admit liability or responsibility to any third party in the accident investigation process.

11. In the event of serious damage and/or injury, immediately contact the OCIP Safety Manager.

    Examples of a serious injury and damage include:

    - Serious Bodily injury — same as the Workers' Compensation claim reporting instructions.
    - Water damage — flooding due to broken water/sprinkler lines, connections and pipes.
    - Structural damage to buildings or infrastructure caused by work means & methods of **CONTRACTOR'S OR SUBCONTRACTOR'S** operations.
    - Claims causing an exposure for business interruption or an unscheduled disruption of any public/private utility services.

12. Like any insurance program, each enrolled **CONTRACTOR OR SUBCONTRACTOR** needs to fully cooperate with ESIS in providing whatever information, documents and investigative files are deemed necessary by ESIS to resolve a claim.

13. Any suspicious or questionable claim should immediately be brought to the attention of ESIS's designated claim representative, along with supporting facts and documentation.

IV. BUILDER'S RISK CLAIM REPORTING/PROCEDURES:

(Note: The Builder's Risk coverage is not a part of the OCIP program; it is a separate insurance coverage.)

1. All risk of direct physical loss or damage to OCIP property, including flood and earthquake but excluding mold and defective workmanship, is generally covered by the Builder's Risk policy. There is a $25,000 per occurrence obligation (deductible) that applies to all Builder's Risk claims.

2. Any insured party having knowledge of such loss must immediately notify the OCIP Safety Manager:

   TBD
   Highway 41 Field Office
   2905 Universal Drive, Oshkosh WI 54904
   Telephone: TBD
   Cell: TBD
   Fax: TBD

   within 24 hours following knowledge of such loss. The initial report of such loss should include the following information:

   - The date of the loss?
   - How did insured first obtain knowledge/ information regarding the loss?
   - At what specific location or segment did the loss occur?
   - What event or accident may have caused or contributed to the loss?
   - Explain how the Incident occurred?
   - Provide the names, addresses, telephone numbers and other contact information for all persons who have firsthand knowledge of the loss. Loss investigators will need this information to further investigate the loss.

3. As soon as practicable, the involved party should complete the Acord form for property damage and fax such information to 404-264-7239. The attachment section below has the Acord Property Loss Notice form.

4. WisDOT is committed to a drug-free project. Drug testing will be performed on all employees of enrolled **CONTRACTORS OR SUBCONTRACTORS** involved in such loss. Drug testing will be administered at all designated medical facilities.

5. The carrier will use the provided information to notify the insurance carrier, RSUI, of the loss. Bill Bartkowski will be the primary contact person for the builder's risk carrier, RSUI.

V. CLAIM INVESTIGATION:

It is important to promptly conduct each investigation while the information is readily available. Memories will be fresh and pertinent facts will be readily visible and available. These efforts are critical to avoid or minimize potential liability. Litigation or claims may arise many years after an accident/injury.

Because accidents/injuries can occur for a variety of reasons, it is important to investigate occurrences and to use such efforts to prevent future occurrences. This allows needed revisions to be made to construction procedures and remedial actions to be taken. If the investigation is haphazard or incomplete, the future effects may be serious injury or death, not to mention economic losses.

Investigations should not be one-dimensional. A successful investigation is accomplished by utilizing several different tools simultaneously. As examples, one may wish to consider the following:

1. Secure the accident scene for serious injury/accident for possible investigation by outside investigators, including insurer personnel. The notice requirements necessitate such investigations.

2. Obtain the names and secure written statements from any witnesses who have firsthand information regarding an accident/injury. Any written report should be as thorough and descriptive as possible. Memories fade, people forget and recollections change. If you cannot obtain names, note who was present at the accident scene in written documentation.

3. Background facts and general information:

   - Who, what, where, when, how and why? Answer these questions regarding an accident/injury and its cause. Do not speculate - advise known facts only.

   - Involvement of **CONTRACTOR'S OR SUBCONTRACTOR'S** personnel before or during the accident/injury.

CLAIM INVESTIGATION – continued

4. What happened to cause the accident/injury?

- Describe the event, not just the damage.

- If the event is complicated, explain the specific steps that lead to the event. When explaining, assume that the people to you are communicating to are ignorant of the event and knows nothing about the location of the accident/injury.

- A diagram/field sketch can aid in showing what happened after a complex incident. The diagram can show the approximate location of the Project's facilities from the accident site; damage to the Project's facilities; geographic orientation; other facilities that may have contributed to accident/injury; approximate locations of witnesses; and identification of photographs. **The diagram/field sketch should be dated and signed by its preparer.**

- Photographs are very useful to document conditions, evidence locations, spatial arrangements and many other aspects related to investigations. Pictures should be taken from different angles. The photographer needs to record: (1) what each photograph is intended to show; (2) the direction from which each photograph was taken; and (3) numbering or coding system identifying the various photographs. **The photographs should be dated and signed by the photographer.**

VI. MEDICAL

THE BELOW INFORMATION WILL BE OCIP PROJECT SPECIFIC

1. **Occupational Medicine**:

   Aurora BayCare Health Center
   2253 W. Mason
   Green Bay, WI 54303
   Main Telephone Number: 920-327-7300

   Aurora BayCare Center
   1881 Chicago Street
   De Pere, WI 54115
   Main Telephone Number: 920-403-8000

   Aurora BayCare Medical
   2845 GreenBrier Rd
   Green Bay, WI 54311
   Main Telephone Number: 920-288-8100

   Aurora Health Center
   855 N. Westhaven
   Oshkosh, WI 54904
   Main Telephone Number: 920-303-8750

2. **Hospitals**:

   Aurora Medical Center
   855 N. Westhaven
   Oshkosh, WI
   Main Telephone Number: 920-456-6000

   Aurora BayCare Medical Center (Level Two Trauma)
   2945 Greenbrier
   Green Bay WI 54311
   Main Telephone Number: 920-288-8000

3. **Level One Trauma**:

   Froedtert Hospital
   9200 West Wisconsin Ave.
   Milwaukee WI 53226-3596
   Main Telephone Number: 414-805-3000
   Admissions: 414-805-5100

VII. LITIGATION

CONRACTORS OR SUBCONTRACTORS should immediately forward all summons, notice of hearings, and complaints to the proper insurer. Copies of such materials should also be faxed to the Aon contact identified in the CLAIMS ADMINISTRATION TEAM.

Contact information by line of coverage (insurer) is as follows:

1. **Workers' Compensation**:

ESIS Chicago WC
Attn: Victoria Marrs
Workers Compensation Team Leader
P. O. Box 31109
Tampa, FL 33631-3109
Direct Telephone Number: 312-775-7860
Fax Number: 800-230-4866

2. **General Liability**:

ESIS Chicago APL
Attn: Maritza Castro
General Liability Team Leader
P.O. Box 31090
Tampa, FL 33631-3090
Direct Telephone Number: 312-775-7809
Fax Number: 800-231-8506

3. **Builder's Risk:**

Bill Bartkowski
AON Risk Services
330 East Kilbourn Avenue
Milwaukee, WI 53202
Direct Telephone Number: 414-225-5375
Fax Number: 414-225-7413
Cell: 414-336-4843

VIII. APPENDIX

Exhibit A – Site Treatment Form

Exhibit B – Workers' Compensation Claim Form - ACE

Exhibit C – Work Comp: Employer's First Report of Injury - WI

Exhibit D – Medical Facilities

Exhibit E – Workers Comp Incident Investigation

Exhibit F – Flow Chart

Exhibit G – General Liability First Report of Injury

Exhibit H – Acord Property Loss Form

Exhibit I – Fax Cover Sheet

WisDOT US 41 Corridor
Site Treatment Authorization

Contractor Name: ____

Employee Name: ____

Project Contact Name & Phone #: ______________________________________

Date of Injury: ______________________ Time of Injury: ______________________

Type of Injury/Illness Sustained: _______________________________________

THIS COMPLETED FORM MUST BE RETURNED TO THE PROJECT BY THE **EMPLOYEE SO HE/SHE CAN RETURN TO WORK**

This certifies that the above named individual is employed on an Owner Controlled Insurance Program Project. Workers Compensation coverage is provided by **ACE USA.** Please provide appropriate evaluation and treatment, and bill to the address below. **Post-accident drug screening is required for all covered workers seeking medical evaluation/treatment. Return To Work Program in-place; employers expected to provide light/restricted duty work.**

Site Approval (Print): ______________________________Date: __________________

Site Approval Signature: ____

THIS SECTION MUST BE COMPLETED BY THE ATTENDING PHYSICIAN

Diagnosis: ____
____

1. Is the Employee able to return to work?
   Full Duty _____ Restricted Duty _____ Total Disability _____
   If restricted duty was selected, briefly describe restrictions: ______________________
   ____
2. Will employee require any follow up treatment? Yes _____ No _____
   If yes was selected, when is the next scheduled visit?
   Date: ____/____/____ Time __________ Est. # of follow up visits
3. I am aware of the restrictions placed on me by the treating Physician:

Employees Name (Please print): ____

Employees' Signature: ____

Physicians' Name (Please print): ____

Bills should be sent to:
ACE USA
RE: US 41 Corridor OCIP
P.O. Box 31109
Tampa, FL 33631-3109

Questions should be referred to:
312.775.7860
Victoria Marrs, Team Leader

WORKER'S COMPENSATION CLAIM FORM

Please fax to 866-300-8206 or email to esis_FNOL@firstnotice.com

WisDOT US 41 Corridor

Dedicated 800-Number -TBA

Date of Loss:	Time of Loss:	am ☐ pm ☐
Type: (select one)	Claim ☐	Record Only ☐
Employers Policy #:	Location/Site Code:	
Employers (Contractor) Name:		
Carrier Name: ACE USA	Policy Eff:	Exp:

Caller Information:

Name:		
Address:		
City/St/Zip:		
Work Phone#:	Cell Phone #:	
Fax #:	E-Mail:	
Job Title:	Department:	
☐ Insured	☐ Employee/Claimant	☐ Agent
☐ Attorney	☐ 3rd Party Representative of Claimant	
☐ First Script Referral	☐ Clinic Referral	☐ Other
Special Type of Claim:	☐ None	☐ Longshore
☐ **OCIP**	☐ Defense Based	☐ Continental Shelf
☐ Non-Appropriated Funds		☐ Foreign

Corporate Information:

Entity Name:	
Address:	
City/St/Zip:	
Work Phone#:	Fax #:

Employer Information: (injured workers direct employer)

Name:		
Address:		
City/St/Zip:		
Phone#:	Ext:	Fax #:
E-Mail :		
FEIN #:	State Unemployment ID #:	
SIC (Standard Industry Code):		

Loss Location:

Benefit State Applicable:
Project Name:
Address:
City/St/Zip:

WORKER'S COMPENSATION CLAIM FORM

Please fax to 866-300-8206 or email to esis_FNOL@firstnotice.com

WisDOT US 41 Corridor

Dedicated 800-Number -TBA

Employee Information:

First Name:	Last Name:	
Home Address:		
City/St/Zip:		
Home Phone #:	Work Phone#:	Ext:
Cell Phone #:	E-Mail Address:	
Social Security #:	Employee ID #:	
Gender: ☐ Male	☐ Female	☐ Unknown
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown		
Total Dependents:	Date of Birth: / /	Age:
Height:	Weight:	
Job Class Code:	Job Title:	Department:
Supervisor First Name:	Last Name:	
Supervisor Phone #:	Cell #:	
Supervisor E-Mail:		
Pre-Existing Conditions: ☐ High Blood Pressure ☐ Diabetes ☐ Obesity		
Do You Question the Validity of this Claim? ☐ **Yes** ☐ **No**		

Employment Information:

Hire Date: / /	Hire State:	State Hire Date: / /
☐ Full Time ☐ Part Time ☐ Apprenticeship Part Time ☐ Apprenticeship Full Time ☐ Disabled ☐ Laid Off ☐ Not Employed or Unemployed ☐ On Strike ☐ Other/Unknown ☐ Piece Worker ☐ Retired ☐ Seasonal ☐ Volunteer ☐ Terminated		
☐ Hourly Wage $________/hour ☐ Salary $ _________/year ☐ Variable Wage $ _________ Type of Variable: ________________		
Hours worked per day:	Days worked per week:	
Other Payments not reported as wages/salary:		
Was employee Drug Tested After Incident? ☐ No ☐ Yes		

Lost Time & Return to Work Information:

Did the Employee Miss Work Beyond Their Normal Shift:	
If Yes to LT answer these Questions:	
Last Date Worked: / /	Disability Date: / /
Paid in Full for the Day of Injury:	☐ No ☐ Yes
Did the Salary Continue After the Injury:	☐ No ☐ Yes
Last Date Employee Paid Through: / /	
Did the Employee Return to Work:	☐ No ☐ Yes
If Yes to RTW answer these Questions:	

WORKER'S COMPENSATION CLAIM FORM

Please fax to 866-300-8206 or email to esis_FNOL@firstnotice.com

WisDOT US 41 Corridor

Dedicated 800-Number -TBA

Number of Lost Days:

Does EE have Release to Return to Work: ☐ No ☐ Yes
If Yes, Release Date: / /

Return to Work Date: / / Return to duty at: ☐ Full ☐ Light

If Light Duty, Paid Full Wages: ☐ No ☐ Yes

Return to Work at Regular Occupation: ☐ No ☐ Yes
If No, Return to Work Occupation: ______________________________

Return to Work at Same Wage: ☐ No ☐ Yes
If no, Return to Work Wage: $__________________ Per: ______________
Wage Period: ______________________________

Incident Information:

Time Employee Began Work: : : ☐ am ☐ pm
Scheduled Quit Time: : : ☐ am ☐ pm

Employer Notified Date: / /
Date Employer Knowledge of Disability: / /

Department Where Injury Occurred:

Activity Engaged in:

Work Process:

Accident/Injury Description:

Were there any Witnesses: ☐ No ☐ Yes

Objects or Material Causing the Injury:

Was Injury Caused by a Product: ☐ No ☐ Yes
Material Secured: ☐ No ☐ Yes

Safeguards/Safety Equipment:
Provided ☐ No ☐ Yes Used ☐ No ☐ Yes Modified ☐ No ☐ Yes

Medical Treatment:

Medical Treatment: ☐ None ☐ Minor by Employer ☐ Minor by Clinic/Hospital
☐ Medical Services other than First Aid ☐ Injuries Beyond First Aid
☐ Emergency Care Hospitalized > 24 hours ☐ Future Major Med/Lost Time

Admitted to Hospital: ☐ No ☐ Yes Still in Hospital: ☐ No ☐ Yes

Transported Via Airlift or Emergency Vehicle: ☐ No ☐ Yes

History Work Related Injuries: ☐ No ☐ Yes Attorney Involved: ☐ No ☐ Yes

Additional Treatment: ☐ No ☐ Yes
If Yes, What Specialty: ______________________________
More than two visits with Primary Care Physician: ☐ No ☐ Yes

WORKER'S COMPENSATION CLAIM FORM

Please fax to 866-300-8206 or email to esis_FNOL@firstnotice.com

WisDOT US 41 Corridor

Dedicated 800-Number -TBA

Physician & Hospital Information:

Physician Name:	
Address:	
City/St/Zip:	
Phone#:	Ext
Hospital Name:	
Address:	
City/St/Zip:	
Phone#:	Ext

Witness Information:

Name:		
Address:		
City/St/Zip:		
Work Phone#:	Ext:	Cell Phone #:
Fax #:	E-Mail:	

Additional Remarks/Information

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

An employer subject to the provisions of ch. 102, Wis. Stats., shall, within one day after the death of an employee due to a compensable injury, report the death to the Department of Workforce Development (DWD) and to the employer's insurance carrier, if insured. In cases of permanent disability or where temporary disability results beyond the 3-day waiting period, an insured employer shall also notify its insurance carrier of a compensable injury or illness wthin 7 days after the injury or beginning of a disability from occupational disease related to the employee's compensable injury.

Insurance carriers and self-insured employers must report all compensable claims to DWD on this form, the EDI system, or the internet format within 14 days of the date of injury.

The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)]. **(Please read the instructions on page 2 for completing this form)**

EMPLOYEE

Employee Name (First, Middle, Last) | Social Security Number: - - | Sex: ☐ M ☐ F | Employee Home Telephone No.: ( ) -

Employee Street Address | City | State | Zip Code: - | Occupation

Birthdate | Date of Hire | County and State where accident or exposure occurred

EMPLOYER

Employer Name	WI Unemployment Insurance Account No.	Self-Insured?	Nature of Business (specific product)
UW-Milwaukee	6911180002	☒ Yes ☐ No	Higher Education

Employer Mailing Address	City	State	Zip Code	Employer FEIN
P.O. Box 413	Milwaukee	WI	53201-0413	39 - 1805963

Name of Worker's Compensation Insurance Co. or Self-Insured Employer: UW system OSLIP (State of WI) | Insurer FEIN: 39 – 1805963

Name and Address of Third Party Administrator (TPA) used by the Insurance Company or Self-Insured Employer: N/A | TPA FEIN: - N/A

WAGE INFORMATION

Wage at Time of Injury: $ | Specify per hr., wk., mo., yr., etc. | In Addition to Wages, Check Box(es) if Employee Received: ☐ Meals No. of Meals/wk. ☐ Room No. of Days/wk ☐ Tips Avg. Weekly Amt. $

Is worker paid for overtime? ☐ Yes ☐ No If yes, after how many hours of work per week?

For the 52 week period prior to the week the injury occurred, report below the number of weeks worked in the same kind of work, and the total wages, salary, commission and bonus or premium earned for such weeks.

No. of Weeks: | Gross Amount Excluding Tips: $ | If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	☐ AM ☐ PM			
Employer's Usual Full-Time Schedule For This Type of Work At Time of Employee's Injury:				

Part-Time Employment Information: | Are there other part-time workers doing the same work with the same schedule? ☐ Yes ☐ No If yes, how many? | Number of **full-time** employees doing the same type of work:

INJURY INFORMATION

Injury Date | Time of Injury: AM PM | Last Day Worked | Date Employer Notified | ☐ Date Returned to Work ☐ Estimated Date of Return

Did injury cause death? ☐ Yes ☐ No | Date of Death | Was this a lost time or other compensable injury? ☐ Yes ☐ No | Did injury occur because of: ☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to Obey Rules

Was employee treated in an emergency room? ☐ Yes ☐ No Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Name and Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe activities of employee when injury or illness occurred and what tools, machinery, objects, chemicals, etc. were involved.

What happened to cause this injury or illness? (Describe how the injury occurred)

What was the injury or illness? (State the part of body affected and how it was affected)

Report Prepared By | Work Phone Number: ( ) - | Position | Date Signed

WKC-12-E (R. 02/2002) SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

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

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

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

MANDATORY INFORMATION

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

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

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

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

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

MEDICAL FACILITIES:

1. Occupational Medicine:

   Aurora BayCare Health Center
   2253 W. Mason
   Green Bay, WI 54303
   Main Telephone Number: 920-327-7300

   Aurora BayCare Center
   1881 Chicago Street
   De Pere, WI 54115
   Main Telephone Number: 920-403-8000

   Aurora BayCare Medical
   2845 GreenBrier Rd
   Green Bay, WI 54311
   Main Telephone Number: 920-288-8100

   Aurora Health Center
   855 N. Westhaven
   Oshkosh, WI 54904
   Main Telephone Number: 920-303-8750

2. Hospitals:

   Aurora Medical Center
   855 N. Westhaven
   Oshkosh, WI
   Main Telephone Number: 920-456-6000

   Aurora BayCare Medical Center (Level Two Trauma)
   2945 Greenbrier
   Green Bay WI 54311
   Main Telephone Number: 920-288-8000

3. Level One Trauma:

   Froedtert Hospital
   9200 West Wisconsin Ave.
   Milwaukee WI 53226-3596
   Main Telephone Number: 414-805-3000
   Admissions: 414-805-5100

SUPERVISOR'S WORKERS' COMPENSATION INCIDENT INVESTIGATION REPORT

Incident Date:______________ Time: ___________ Place:________________________________

EMPLOYEE INFORMATION (Complete one report for each employee involved)

Name: ____DOB: _________________________
Address: ____
Social Security #: _________________________ DL#: ______________________________________
Home Telephone: _____________________ Occupation: ______________________________________
How long was Employee performing this operation/job? ______________________________________
Employer: ____

INCIDENT INFORMATION

Describe in detail how incident occurred:

____

____

What was the employee doing at time of incident?

____

____

Were activities part of the job? YES/NO (If NO, describe further)

____

Were photos taken? Yes _____ No _______ By whom? ______________________________________
Name, address and phone number of all witnesses to the incident (use separate sheet if necessary):

____

____

Any contributing factors to incident, i.e., equipment/tools, unsafe acts of employee, or others:

____

Did the incident result in an injury? Yes ___ No______ (If No, skip Injury Information section)

INJURY INFORMATION

Describe nature and extent of injury: ____

Was first aid given? Yes ___ No ____ When and by whom? ________________________________

Was injured transported via ambulance? Yes___ No ____ Where taken?_______________________

I decline medical treatment at this time:____
(Employee's Signature)

Comments: ____

____

Supervisor's Name (Please print.): _______________________________
Supervisor's Signature: _______________________________
Date: _______________________________

esis

Workers' Compensation Claim Administration Process

Injury Occurs

Report Claim to Employer

Report Claim to ESIS

Review by TEAM LEADER

Routine Medical Only ?

Yes

Medical Only File Set-up

Review Medical Bills, Issue Payments, Monitor for Indemnity Conversion

END

No

Time Loss? Meds Over $5000?

Yes

Indemnity or Enhanced Med File Set-up

Initial Employer Contact

Initial Claimant Contact
* Rapport
* Expectations

Initial Contact w/ Doctor:
* Treatment Plan
* Estimated RTW

Initial Contacts Within 24-Hours

Refer to INTRACORP TCM/Medical Mgmt. Nurse if Appropriate

Determine Compensability

Set Initial Reserve

Review for Subrogation/ Recovery

Review for Special Investigation Unit Potential

Issue TTD Payments

Ongoing Contact With:
* Employee
* Employer
* Doctors

Return to Work: Action Plans
* Light Duty
* Rehabilitation
* IME/OME

Status Change? Reserve, etc

Yes

Take Appropriate Action

No

Litigation Management: Identify Disputed Issues

Settlement Discussions: MMI
* Impairment

Settlement Complete ?

No

Yes

File Resolution: CLOSE CLAIM

END

Exhibit F

ACORD GENERAL LIABILITY NOTICE OF OCCURRENCE/CLAIM

DATE (MM/DD/YYYY)

PRODUCER | PHONE (A/C, No, Ext):

NOTICE OF OCCURRENCE | NOTICE OF CLAIM | DATE OF OCCURRENCE AND TIME | AM | PM | DATE OF CLAIM | PREVIOUSLY REPORTED | YES | NO

EFFECTIVE DATE | EXPIRATION DATE | POLICY TYPE: OCCURRENCE | CLAIMS MADE | RETROACTIVE DATE

COMPANY | NAIC CODE: | MISCELLANEOUS INFO (Site & location code)

CODE: | SUB CODE: | POLICY NUMBER | REFERENCE NUMBER

AGENCY CUSTOMER ID:

INSURED

NAME AND ADDRESS | SOC SEC # OR FEIN:

RESIDENCE PHONE (A/C, No) | BUSINESS PHONE (A/C, No, Ext)

CONTACT

CONTACT INSURED

NAME AND ADDRESS | WHERE TO CONTACT | WHEN TO CONTACT

RESIDENCE PHONE (A/C, No) | BUSINESS PHONE (A/C, No, Ext)

OCCURRENCE

LOCATION OF OCCURRENCE (Include city & state) | AUTHORITY CONTACTED

DESCRIPTION OF OCCURRENCE (Use separate sheet, if necessary)

POLICY INFORMATION

COVERAGE PART OR FORMS (Insert form #s and edition dates)

GENERAL AGGREGATE	PROD/COMP OP AGG	PERS & ADV INJ	EACH OCCURRENCE	FIRE DAMAGE	MEDICAL EXPENSE	DEDUCTIBLE	PD / BI

UMBRELLA/ EXCESS | UMBRELLA | EXCESS | CARRIER: | LIMITS: | AGGR | PER CLAIM/OCC | SIR/ DED

TYPE OF LIABILITY

PREMISES: INSURED IS | OWNER | TENANT | OTHER: | TYPE OF PREMISES

OWNER'S NAME & ADDRESS (If not insured) | OWNERS PHONE (A/C, No, Ext):

PRODUCTS: INSURED IS | MANUFACTURER | VENDOR | OTHER: | TYPE OF PRODUCT

MANUFACTURER'S NAME & ADDRESS (If not insured) | MANUFACT PHONE (A/C, No, Ext):

WHERE CAN PRODUCT BE SEEN?

OTHER LIABILITY INCLUDING COMPLETED OPERATIONS (Explain)

INJURED/PROPERTY DAMAGED

NAME & ADDRESS (Injured/Owner) | PHONE (A/C, No, Ext)

AGE | SEX | OCCUPATION | EMPLOYER'S NAME & ADDRESS | PHONE (A/C, No, Ext)

DESCRIBE INJURY | FATALITY | WHERE TAKEN | WHAT WAS INJURED DOING?

DESCRIBE PROPERTY (Type, model, etc) | ESTIMATE AMOUNT | WHERE CAN PROPERTY BE SEEN? | WHEN CAN PROPERTY BE SEEN?

WITNESSES

NAME & ADDRESS	BUSINESS PHONE (A/C, No, Ext)	RESIDENCE PHONE (A/C, No)

REMARKS

REPORTED BY | REPORTED TO | SIGNATURE OF INSURED | SIGNATURE OF PRODUCER

ACORD 3 (2002/01) NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE © ACORD CORPORATION 1986

PROPERTY LOSS NOTICE

DATE (MM/DD/YYYY)

AGENCY	PHONE (A/C, No, Ext):	MISCELLANEOUS INFO (Site & location code)	DATE OF LOSS AND TIME	AM / PM	PREVIOUSLY REPORTED YES / NO

POLICY TYPE	COMPANY AND POLICY NUMBER	NAIC CODE	POLICY DATES
PROP/ HOME	CO:		EFF:
	POL:		EXP:
FLOOD	CO:		EFF:
	POL:		EXP:
WIND	CO:		EFF:
	POL:		EXP:

FAX (A/C, No): E-MAIL ADDRESS:

CODE: SUB CODE:

AGENCY CUSTOMER ID

INSURED

NAME AND ADDRESS OF INSURED	DATE OF BIRTH
	SOC SEC # OR FEIN:
RESIDENCE PHONE (A/C, No)	BUSINESS PHONE (A/C, No, Ext)
NAME AND ADDRESS OF SPOUSE (IF APPLICABLE)	DATE OF BIRTH
	SOC SEC # OR FEIN:

CONTACT

CONTACT INSURED

NAME AND ADDRESS OF INSURED	
RESIDENCE PHONE (A/C, No)	BUSINESS PHONE (A/C, No, Ext)
WHERE TO CONTACT	WHEN TO CONTACT

LOSS

LOCATION OF LOSS	POLICE OR FIRE DEPT TO WHICH REPORTED

KIND OF LOSS: FIRE / THEFT / LIGHTNING / HAIL / FLOOD / WIND / OTHER (explain)

PROBABLE AMOUNT ENTIRE LOSS

DESCRIPTION OF LOSS & DAMAGE (Use separate sheet, if necessary)

POLICY INFORMATION

MORTGAGEE

NO MORTGAGEE

HOMEOWNER POLICIES SECTION 1 ONLY (Complete for coverages A, B, C, D & additional coverages. For Homeowners Section II Liability Losses, use ACORD 3.)

A. DWELLING	B. OTHER STRUCTURES	C. PERSONAL PROPERTY	D. LOSS OF USE	DEDUCTIBLES	DESCRIBE ADDITIONAL COVERAGES PROVIDED
					ON

COVERAGE A. EXCLUDES WIND

SUBJECT TO FORMS (Insert form numbers and edition dates, special deductibles)

FIRE, ALLIED LINES & MULTI-PERIL POLICIES (Complete only those items involved in loss)

ITEM	SUBJECT OF INSURANCE	AMOUNT	% COINS	DEDUCTIBLE	COVERAGE AND/OR DESCRIPTION OF PROPERTY INSURED
	BLDG / CNTS				
	BLDG / CNTS				
	BLDG / CNTS				

SUBJECT TO FORMS (Insert form numbers and edition dates, special deductibles)

FLOOD POLICY	BUILDING:	DEDUCTIBLE:	ZONE	PRE FIRM	DIFF IN ELEV	FORM TYPE	GENERAL	CONDO
	CONTENTS:	DEDUCTIBLE:		POST FIRM			DWELLING	

WIND POLICY	BUILDING	DEDUCTIBLE	CONTENTS	ZONE	FORM TYPE	GENERAL / DWELLING	CONDO

REMARKS/OTHER INSURANCE (List companies, policy numbers, coverages & policy amounts)/NY ONLY: PREVIOUS ADDRESS OF INSURED & WIFE'S MAIDEN NAME

CAT #	FICO #	ADJUSTER ASSIGNED	ADJUSTER #	DATE ASSIGNED

REPORTED BY	REPORTED TO	SIGNATURE OF INSURED	SIGNATURE OF PRODUCER

 NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE © ACORD CORPORATION 1988

FACIMILE TRANSMITTAL

Number of pages: ________________

Date: ________________

To: TBD – OCIP SAFETY MANAGER
Fax #: TBD

From: ____

Telephone: ____

Fax Number: ____

E-Mail: ____

RE: (Circle One) Workers Compensation Notification

General Liability Notification

Other ____

____