Workers' Compensation Claim Filing Packet Cover Sheet

As part of the workers' compensation claim filing process, the forms below must be completed and returned to Human Resources.

Instructions: Please enter the fields below in order to pre-populate standard fields on the following forms. Enter remaining fields as appropriate.

Date of Injury:

First Name:

Last Name:

Date of Birth:

Employee ID:

Home Street Address:

City:

State:

Zip:

Phone:

Preferred Email:

Workers' Compensation Acknowledgement Letter

PLEASE READ THE IMPORTANT INFORMATION BELOW REGARDING YOUR CLAIM UNDER WORKERS'S COMPENSATION (WC)

**This letter must be signed and returned with the required forms provided in this process.*

Regarding your new workers' compensation claim or recurrence of an existing claim:

1. Notification: Notify your supervisor immediately of your injury.

2. Medical treatment, Initial Treatment Provider, Network Physician: If you need medical treatment, seek treatment from an approved Initial Treatment Provider (for new claims) or from your treating physician (for a recurrence of an existing approved claim). The medical provider must be listed in the Prime managed care network for the State's third-party administrator for workers' compensation claims (Gallagher Bassett). Be advised that your claim or medical treatment may be denied if you seek a physician outside the Prime network. Prime Network: https://ct.primehealthservices.com/Custom/CtIndex

3. Medical visit work status note: After receiving medical treatment, you will receive a Workers' Status report from the physician. If you are unable to return to work due to your injury you must contact and provide a copy of your workers status report to Human Resources immediately. If you are released to work with restrictions from your medical provider, you must also immediately contact your supervisor to discuss the restrictions and you must provide a copy of your workers status report to Human Resources.

4. Pharmacy Rx: A pharmacy benefit management program is in place to provide prescriptions ordered by the WC treating physician for a work-related injury. Please have your prescription filled by a network pharmacy and ask them to process your prescription through MyMatrixx. 1.877-804-4900. MyMatrixx: https://www.mymatrixx.com/injured-worker-resources

5. Forms required for WC processing: Please make sure the following forms have been completed, signed, and dated, and submit to Human Resources within 24 hours of your injury:

   NEW INJURY:

   - **DAS-WC 207**(First Report of Injury) and **DAS-WC 207-1** (Supervisor's Accident Investigation) need to be completed by the Supervisor of the injured employee, who will call in the claim to Gallagher Bassett, and forward the documents to Human Resources.
   - **DAS-715** (use of accrued leave). You must elect to use or not use accrued leave balances to supplement lost wage benefits on an approved WC claim. If the form is not completed and signed, your accrued time cannot be used, and may result in reduced pay. Once this form is completed and entered into our system, it cannot be changed until your disability period has ended. Use this form for new claims and recurrences.
   - **WCC-1A** (Filing Status and Exemption form). This form must agree with your IRS filing status for your 1040 Federal Income Tax Return. Use this form only for new injury claims.
   - **DAS-211** (Concurrent Employment and Third-Party Liability). Please be sure to answer all questions on each form completely, sign and date all forms. Use this form only for new injury claims.

6. *Fraud: Realize that injured workers who, while collecting temporary total disability benefits for their state job, work another job (including self-employment) either legally or "under the table" are committing fraud and can be prosecuted by the Chief States' Attorney. In Connecticut, workers' compensation fraud is a crime. If the benefits obtained through fraud exceed $2,000.00, the offense is a Class B felony punishable by up to twenty (20) years in prison and/or up to $10,000.00 in fines.*
7. *Fraud Hotline: Note that the Department of Administrative Services through Gallagher Bassett Special Investigation Unit maintains a Fraud Hotline to report potential workers' compensation fraud by state employees. All discovered material on reported fraud cases are reported to the State of Connecticut Chief State's Attorney Workers' Compensation Fraud Control Bureau for review.* ***If you suspect that workers' compensation fraud is being committed, you can call the Hotline anonymously any time at 1-(800) 927-0456. This number is available 24 hours a day, 7 days a week to file a report.***

Signature:

Please sign below and submit it with the other required forms in this process to Human Resources within 24 hours of the injury. Please be sure to keep a copy of all documents in this process for your records.

I,_____acknowledge that I have received the above Workers' Compensation Information and understand the information.

Employee Signature:_____Date:_____

TPA Reference No.	Agency use only Incident No.:	DAS WC-207 *First Report of Injury*
	Claim No.:	

The Supervisor must complete this form with the injured worker and then forward it along with the balance of the claim forms to the Human Resources/Workers' Compensation Office within 24 hours.

Rev 02/2017

1. Agency Location Code UOC67000	2. Division/Region			
3. SSN	4. Employee Number	5. Name of Injured Worker (First) (Last) (MI)		
6. Home Address (City or Town) (State) (Zip)		7. Home Telephone	8. Date of Birth	9. Sex
10. Job Classification (Title)		11. Date of Hire	12. Date of Incident	13. Time of Incident
14. Time Employer Notified	15. Date Employer Notified	16. Time Injured Worker Began Work _____ ☐AM ☐PM	17. Was Injury Fatal? ☐ YES ☐ NO	18. Date of Fatality

19. How Did the Injury Occur?

20. Type of Injury	21. Body Part(s) Affected
22. Did Injury Occur on Employer Premises? ☐ YES ☐NO	23. Location Injury Occurred
24. Injured Worker Seeking Medical Treatment ☐ YES ☐ NO If Yes Complete Questions 25-27	25. Medical Care Provided By: (Physician Name and Address)
26. Was Injured Worker Treated in an Emergency Room? ☐ YES ☐ NO	27. Was Injured Worker Hospitalized Overnight as an In-Patient? ☐ YES ☐ NO

28. Were There Any Witnesses to the Injury? ☐YES ☐NO (If yes, give name, address, and phone)

29. To What Supervisor Was Injury Reported? (Name) (Title)

30. Supervisor Contact Info Please Print	Name:
	Work Phone:
	Best Time to Contact:

31. **Signature of Supervisor** (or other Designated Authority) **PRINT NAME:** **DATE:**

32. **Date Injury Phoned In To 800-828-2717**

Supervisors Report All Injuries - Call 1-800-828-2717

Supervisor's Accident Investigation Report 207-1

The Supervisor must complete this form with the employee and then forward it to the Human Resources office, along with the 207 report, within 24 hours after the incident.

GENERAL INFORMATION

Employee Name	Date of Incident	Location of Incident
Job Title	Time of Incident	Medical Treatment? ☐ ER ☐ First Aid ☐ None ☐ Walk-In ☐ Ambulance ☐ Other
Nature of Injury		

INCIDENT DESCRIPTION: _____

_____

_____

TYPE OF INCIDENT: (check most appropriate, define other if checked)

- ☐ Assault by public
- ☐ Caught in/on/between
- ☐ Shoved by or against an object
- ☐ Contact with heat/cold/chemical
- ☐ Motor Vehicle Accident
- ☐ Slip/Trip/Fall
- ☐ Lifting/Material Handling
- ☐ Foreign body in eye
- ☐ Cumulative trauma
- ☐ Repetitive motion
- ☐ Cut/laceration/puncture
- ☐ Exposure (air quality, etc.)
- ☐ Other

CAUSES/CONTRIBUTING FACTORS *Check all that apply*

CONDITIONS

- ☐ Hazardous process
- ☐ Weather conditions
- ☐ Equipment not available
- ☐ Poor housekeeping
- ☐ Equipment malfunction
- ☐ Ergonomic set-up
- ☐ Floor/ground condition
- ☐ Poor lighting
- ☐ Poor design
- ☐ Carpet/mat
- ☐ Chemicals/cleaning agents
- ☐ Improper PPE
- ☐ Lack of training

BEHAVIORS

- ☐ Failure to follow safety procedure
- ☐ Failure to use PPE
- ☐ Improper technique
- ☐ Using equipment unsafely
- ☐ Inappropriate dress or footwear
- ☐ Failure to obtain assistance
- ☐ Working at unsafe speed
- ☐ Performing task without knowledge/failure to ask
- ☐ Failure to recognize unsafe condition
- ☐ Not in scope of duties
- ☐ Unsafe body mechanics
- ☐ Employee attitude on safety
- ☐ Horseplay
- ☐ Failure to use lookout/tagout
- ☐ Inattention/disfunction
- ☐ Poor judgement responding to unsafe condition
- ☐ Other

ACTION PLAN TO PREVENT RECURRENCE

- ☐ Reinforce employee accountability for safety
- ☐ Monitor work practices
- ☐ Work orders written
- ☐ Maintenance work order written
- ☐ Procedures revised
- ☐ Referrals made
- ☐ Apply OSHA program and manuals
- ☐ Additional training
- ☐ Hepatitus B vaccine
- ☐ Renew bloodborne training
- ☐ Renew hazmat training
- ☐ Ergonomic set-up evaluation
- ☐ Air quality consultation
- ☐ MVA= ☐ Local or ☐ State Investigation
- ☐ Other

MANAGER SIGNATURE:	**PRINT NAME:**	**DATE:**
SUPERVISOR SIGNATURE:	**PRINT NAME:**	**DATE:**

white copy - Agency pink copy - Agency Human Resources yellow copy - DAS Human Resources

Request for Use of Accrued Leave with Workers' Compensation

DAS WC-715

3-10

This form covers an employee election to utilize or not utilize accrued leave (existing balances and additional accruals as credited) during the interim period and/or to supplement lost wage benefits on an approved workers' compensation claim. The Agency Section shall be completed with the initial agency processing of the **LOST TIME** claim and provided to the injured employee with instruction to make an election and ***RETURN WITHIN 10 BUSINESS DAYS***. This form is to be maintained in the injured worker's agency workers' compensation file.

AGENCY SECTION

Agency Name	Department ID
University of Connecticut	UOC67000

Employee Name	Employee ID

Date of Injury	Daily Pay Rate	**LEAVE BALANCES** As of date of injury Denoted in Hours	Sick	Vacation	Personal	Holiday Comp	Comp

EMPLOYEE ELECTION SECTION - Please check your choice of the options available to you then sign and return to your agency Workers' Compensation office **within ten business days.** Failure to return the completed form to the agency will be administered as an election **not** to utilize accrued leave during the interim period and **not** to supplement the approved workers' compensation lost wage benefit.

USE OF ACCRUED LEAVE FOR INTERIM PERIOD

☐ I elect NOT to use accrued leave during the interim period (after the first day of my incapacity and continuing until such time as a determination of compensation is made).

☐ I elect to use accrued leave during this interim period. By choosing this option I will receive my full base pay while a determination of compensation is being made. I understand that, once a compensation award has been made, I must repay the State an amount equal to the net pay I would have received during such interim period in order for my leave balances to be restored. I further understand that sick leave must be used first, followed by my designated choice of vacation, personal, holiday compensatory time and/or compensatory leave, as designated below.

Indicate the order in which you wish to use leave balances (if any), upon the exhaustion of your sick leave, by entering the number 2,3,4,5 in each box:	Sick 1	Vacation	Personal	Holiday Comp	Compensatory

USE OF ACCRUED LEAVE WHILE RECEIVING WORKERS' COMPENSATION

☐ I elect NOT to use any of my accrued leave while I am receiving Workers' Compensation lost wage benefits.

☐ I elect to use accrued leave, which in addition to the lost wage benefits awarded to me under Workers' Compensation, will result in my receiving the equivalent of my full base pay while I am receiving Workers' Compensation lost wage benefits. I further understand that sick leave must be used first, followed by vacation and/or personal leave, as designated below.

Indicate the order in which you wish to use leave balances (if any), upon the exhaustion of your sick leave, by entering the number 2 or 3 in each box:	Sick 1	Vacation	Personal

STATEMENT OF APPLICANT

I have read and understand the above explanation of the choices available to me as a result of my application for workers' compensation. Once made, this election cannot be revoked and will remain in effect until all accrued leave (including any future accruals that may be credited to me) is exhausted or until I return to my pre-injury number of scheduled work hours. **I agree to the conditions applicable to the choices I have checked above.**

SIGNATURE OF EMPLOYEE **DATE SIGNED**

State Of Connecticut Workers' Compensation Commission

Please Type or Print in Ink

Rev. -13-2009

1A

wcc File #

Date filed in District

(for Wcc use only)

Filing Status and Exemption

This form must be executed in every case of compensable disability for injuries occurring

ON OR AFTER October 1,1991, and must be completed in its entirety

EMPLOYEE

Name _____ Date of birth *(required)* _____

Address _____

City/Town _____ State _____ Zip Code _____

DATE OF INJURY: _____

FILING STATUS AND EXEMPTIONS – In order to determine your weekly benefit rate as per Sec. 31-310 C.G.S., we need the following information

1. Select your federal tax filing status based upon your **Actual filing 1 us 1 of the date of injury listed at right:**

(MUst match yoUr tax retUrn, as if yoU were filing with the IRS on the date of your injury)

☐ Single ☐ Head of household ☐ married filing jointly ☐ married filing separately

2. Number of exemptions *(including* yourself as of date of injury listed at right _____

3. Fica withheld for the above-named employee _____ ☐ YES _____ ☐ NO 2 ***If NO insurer must manually calculate weekly benefit rate***

4. Check all appropriate boxes

☐ Employee 65 years of age or older ☐ Employee legally blind ☐ spouse 65 years of age or older ☐ spouse legally blind

5. list name *(yourself first, date* of birth and relationship to you for all exemptions included in question 2 above

Name	*Date of Birth*	Relationship
		SELF1

CONCURRENT EMPLOYMENT - To be certain you receive the benefit to which you are entitled provide the following information *if you were working for more than one employer on the date of injury indicated above*:

Name of Employer	Address	Date of Hire

NOTE: Wage information for each concurrent employer must be supplied by the claimant

SIGNATURE OF INJURED WORKER OR REPRESEN TATIVE

I hereby attest that the above information is correct to the best of my knowledge

Employee Signature _____ Date _____

DAS Concurrent Employment Third Party Liability Form

Per WC-211 Rev. 2/05

EMPLOYEE TO COMPLETE

Employee Name (last) (First) (MI)	Social Security Number
Address (No. and Street)	Telephone Number
City or Town	Date of Injury
Employing State Agency University of Connecticut	Date of Birth
Address of Employing Agency (No. and Street) Zip 9 Walters Ave, U-5075 Storrs, CT 06269	Date First Employed by State

EMPLOYEE INSTRUCTIONS

The information requested on concurrent employment below is necessary to determine your Workers' compensation benefit rate:

1. You must complete this form for every Workers' Compensation claim you file.
2. You must keep the information contained in this form current while you are receiving Workers' Compensation benefits.
3. You must return this form to your personnel office within three days.

Note: If your claim is for Temporary Total or Temporary Partial disability benefits, you must advise your employer of any other earnings while receiving these benefits. Failure to do so may result in civil and/or criminal liability.

CONCURRENT EMPLOYMENT CHECK IF ANY OF THE FOLLOWING APPLY: ☐ NONE

☐ Employed by Another State Agency ☐ Employed Outside State Government

Name of Other Employer	Supervisor's Name	Telephone Number of Employer
Address of Employer (No. and Street)	City or Town	State Zip

THIRD PARTY LIABILITY INFORMATION

1. Was the cause of your accident/injury the result of the actions of a party other than you or your employer?

   Yes ☐ No ☐

   If you checked yes, please describe the facts.

   Name the Third Party _____

   Address _____

   Insurance Carrier of Third Party _____

2. Were there any witnesses?

   Yes ☐ No ☐

   Name of witnesses _____

3. Have you initiated a claim against this responsible Third party?

   Yes ☐ No ☐ Date _____

I DECLARE THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I AM AWARE THAT PROVIDING FALSE INFORMATION MAY RESULT IN CIVIL, OR CRIMINAL LIABILITY.

Signature _____ Date _____