Benchmark
INSURANCE COMPANY

7710 INSURANCE
Built by first responders, for first responders.
a Trean Company

Claims Kit

What to do when an injury occurs:

1. MEDICAL TREATMENT immediately refer injured worker to closest directed care medical clinic or emergency room!

CAUTION!!!

In the event that an injured employee appears or seems to be unable to drive himself to a clinic, for any reason, the supervisor or another employee should assist that injured worker and inform another employee to call 911.

2. REPORT YOUR WORK-RELATED INJURY TO SUPERVISOR
3. Supervisor completes "EMPLOYERS REPORT OF INDUSTRIAL INJURY" - Individual State Form
4. Employee completes "WORKERS COMPENSATION INJURY NOTICE" - Form B
5. Supervisor completes "SUPERVISOR'S REPORT OF INJURY" - Form C
6. Witness completes "WITNESS STATEMENT" – Form D
7. Employee completes "AUTHORIZATION TO DISCLOSE, RELEASE AND USE PROTECTED HEATH INFORMATION – HIPAA" – Form E
8. Employee completes "MEDICAL TREATMENT PROVIDER LIST" – Form F
9. Supervisor to scan and email the above completed forms to: 7710-claims@Trean.com

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Dear Policyholder:

Thank you for placing your workers' compensation coverage with 7710 Insurance. We greatly appreciate your business and look forward to assisting your company in the future.

Your new policy and claims kit are enclosed. Please review and retain for future reference. As you review this information, please feel free to contact your insurance professional or us directly with any questions you may have.

7710 Insurance management team is committed to providing you with personalized service to meet your workers' compensation insurance needs.

Welcome

7710 Insurance/Benchmark Insurance:

1 North Cantey Street, Suite 106, PO Box 207

Summerton, SC 29148

Claims Processing Benchmark Administrators:

3737 S. Elizabeth St. #101 Independence, MO 64057

Report a claim via phone (866) 337-0891

Telephone: (312) 216-2800 or (844)200-7710

Email: 7710-claims@trean.com

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How to use this kit:

STEP #1: Display Posting Notices in area accessible to ALL employees

- ☑ Employee Safety Health Protection Poster
- ☑ Notice of state Workers' Compensation Law
- ☑ Notice of Work Exposure to Bodily Fluids

STEP #2 Report job-related injuries when it occurs:

- ☑ Seek medical treatment for injured worker
- ☑ Report work-related injury either by email to 7710-claims@Trean.com

Or by phone (866)337-0891

STEP #3 Provide the injured worker with the following:

- ☑ Medical Provider List (provided by employer)
- ☑ Authorization to Release Protected Health Information form

IA-1 WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)

Carrier/Administrator Claim Number | Report Purpose Code

Jurisdiction | Jurisdiction Claim Number

Insured Report Number

Employer's Location Address (if different) | Location No.

Sic Code | Employer FEIN | Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)

Policy Period

To

☐ Check if self insured

Claims Admin (Name, Address & Phone Number)

Carrier FEIN | Policy Number or Self-Insured Number | Administrator FEIN

Agent Name & Code Number

Employee/Wage

Legal Name (Last, First, Middle) | Date of Birth | Social Security Number | Date Hired | State of Hire

Address (Incl. Zip)

Sex: ☐ Male ☐ Female ☐ Unknown

Marital Status: ☐ Unmarried/Single/Div. ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

Phone | No. of Dependents | NCCI Class Code

Wage Rate $ ☐ Day ☐ Week ☐ Month ☐ Other

Days Worked/WK

Hrs Worked per Day

Full Pay for Date of Injury? ☐ Yes ☐ No

Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM | Date of Injury or Illness | Time Occurred ☐ AM ☐ PM | Last Work Date | Date Employer Notified | Date Disability Began

Employer Contact Name/Phone Number | Type of Illness/Injury | Part of Body Affected

Did Injury/Illness Exposure Occur on Employer's Premises? ☐ Yes ☐ No | Type of Illness/Injury Code | Part of Body Affected Code

Department or location where accident or illness exposure occurred

All Equipment, Materials, or Chemicals Employee was using when accident or illness exposure occurred.

Specific Activity the Employee was engaged in when the accident or illness exposure occurred.

Work Process the Employee Was Engaged in when accident or illness exposure occurred.

How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill. | Cause of Injury Code

Date Returned to Work | If Fatal, Date of Death

Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No

Were they used? ☐ Yes ☐ No

Treatment

Physician/Health Care Provider (Name & Address)

Hospital (Name & Address)

Initial Treatment

0 ☐ No Medical Treatment
1 ☐ Minor: By Employer
2 ☐ Minor Clinic/Hosp
3 ☐ Emergency Care
4 ☐ Hospitalized > 24 hr.
5 ☐ Future Major Medical/Lost Time Anticipated

Other

Witness to Accident (Name & Phone Number)

Date Administrator Notified | Date Prepared | Preparer's Name & Title | Preparer's Phone Number

IA-1 (2/95)

SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE

Applicable in Alaska

A person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception.

Applicable in Arkansas

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding worker's compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

Applicable in California

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Applicable in Connecticut

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Applicable in Delaware and Oklahoma

Any person who, knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. *Delaware Statutes Regulation: Del #C Section 913(B)

Applicable in Florida

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Applicable in Idaho

Any person who Knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company, Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kentucky and New York

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Michigan

Any person who knowingly and with intent to injure or defraud any insurer submits a claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to $5,000.00.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Pennsylvania

Any person who knowingly and with intent to injure or defraud any insurer files a claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years or payment of a fine of up to $50,000.

Applicable in Utah

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

EMPLOYEE SIGNATURE: _____

IA-1 (2-95)

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WORKERS COMPENSATION INJURY NOTICE

(To be handwritten by employee)

Injured Worker's Name: _____

Best Contact Number: _____ Social Security Number: _____

Date of Birth: _____ Marital Status: _____

Number of Children Under 18: _____ Salary: _____

Date of Hire: _____ Job Title: _____

Date of Injury: _____ Time of Injury:_____

Location Where the Injury Occurred: _____

To Whom Was the Injury Reported:_____

When Was Injury Reported: _____

Names of Witnesses (if any): _____

Which Body Part(s) Injured: _____

Description of Incident (Explain in Detail How Incident Occurred): _____

_____

_____

_____

_____

_____

_____

Did you seek medical attention and, if so, where? _____

_____

I, the undersigned injured worker, or legal representative of the injured worker named above, do hereby certify that the information provided is complete, true and correct to the best of my knowledge and that I have provided that information in order to obtain the benefits provided for by all applicable codes and rules. I hereby authorize any physician, chiropractor, practitioner, or other person, any hospital, including Veteran's Administration or other governmental hospital, any medical service organization, any insurance company, or other entity or organization, governmental or private, to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or any other disabilities or injuries. A photocopy of this authorization shall be as valid as the original.

Signature: _____ Date: _____

PRIOR HISTORY
(Initial correct box)

□ I have NO prior conditions, injuries, or disabilities, of which I am aware, that might affect the disposition of the claim referenced above. If you checked this box, no further information is needed at this point.

□ I have a prior condition, injury, or disability that could affect the disposition of the claim referenced above (this can include birth defects, prior surgeries, injuries, etc. whether work related or not). If you checked this box, indicating a pre-existing condition, please explain in detail in the space below. Please attach additional sheets of paper to this form if necessary.

_____

_____

_____

_____

_____

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SUPERVISOR'S REPORT OF INJURY

Supervisor's Name:_____ Title: _____

Email Address: _____ Best Contact Number:_____

Injured Worker's Name:_____

Injured Worker's Date of Hire: _____ Injured Worker's Salary: _____

Who reported the accident:_____

When was injury/illness reported:_____

Where did the accident take place: _____

If you witnessed the accident, please describe what you saw. If you were told about the accident by the injured employee, what did he or she say to you about it? _____

_____

_____

_____

Were there any witnesses: ☐Yes ☐ No. IF YES, Who_____

Did employee seek medical attention: ☐ Yes ☐ No. If so, where: _____

Do you have any reason to believe this was NOT an on-the-job injury ☐ YES ☐ No

If Yes, Please Explain in detail:_____

_____

_____

Did the employee miss any time from work as a result of this injury? ☐ YES ☐ No

Has the employee returned to work? ☐ YES ☐ No If Yes, Date of Return:_____

_____ _____

Supervisor Signature Date

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WITNESS STATEMENT

Date of Injury:_____ Time of Injury:_____

Witness Name:_____

Best Contact Number:_____ Job Title:_____

Injured Worker's Name:_____

Where did the injury occur:_____

Please describe the accident in detail. (Include events leading up to the injury and any objects or substance involved.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What did the injured worker do/say after the accident:_____

_____

_____

Were there any other witnesses: ☐ YES ☐ No

If "YES" please provide names:_____

_____

_____

I understand that falsification of this statement, or any misrepresented information contained in this statement, can result in disciplinary action.

_____ _____

Witness Signature Date

AUTHORIZATION TO DISCLOSE, RELEASE AND USE
PROTECTED HEALTH INFORMATION
(HIPAA COMPLIANT)

To:

This authorization permits you to release a copy of ***any and all*** records in your possession regarding any medical treatment and/or hospitalization of:

Name of Claimant:_____ **Date of Birth:**_____

Social Security Number:_____

Date(s) of Injury/Occupational Disease:_____

By execution of this Authorization I consent that my employer, anyone acting on their behalf including, but not limited to, their insurance carrier, attorney or other representative, shall be permitted to examine and obtain copies of all hospital, medical, educational and vocational records of every sort and kind, review records of any insurance company, interview all doctors, rehabilitation professionals, venders, and all former and subsequent employers regarding all matters relating to any issue relevant my Workers' Compensation Claim.

I AUTHORIZE you to disclose any information and records regarding the above named individual in your possession. This includes but is not limited to, your medical findings, diagnosis, treatment, treatment summaries, psychological or psychiatric evaluations, prognosis, clinic notes, diagnostic reports or radiology films, physical therapy records, pharmacy records, or any other heath information in your records. I understand that based on the information released it may include information related to any substance abuse.

I UNDERSTAND that the information furnished may be used to evaluate and verify my claim for benefits for a work related injury or occupational disease. The information obtained is relevant to a workers' compensation claim(s) and may be used by persons or organizations performing a service related to, or adjudicating the claim(s).

THIS AUTHORIZATION will expire 90 days following a resolution of the workers' compensation claim(s) but may be revoked by signator in writing to the requesting party. Revocation of this authorization will not be valid if the requesting party has taken action in reliance upon such authorization. Please note that the information disclosed or used pursuant to this authorization may be subject to re-disclosure and would, therefore, no longer be protected under the terms of the HIPAA privacy rule.

A PHOTOSTATIC COPY of this authorization shall be deemed to have the same authority as the original.

I hereby certify that I have read the provisions in this authorization. I understand and agree to its terms, and authorize disclosure of the information described above.

_____ _____

Claimant Date

Form E

MEDICAL TREATMENT PROVIDER LIST

(for injured employee to complete)

Claimant Name:_____ Social Security Number:_____
Address:_____ Date of Injury:_____
_____ Employer:_____
Telephone Number:_____ Cell Number:_____

"Notification to the Workers' Compensation Claimant"
We are asking that you please fill out this form to help expedite the Workers' Compensation claim filed.
Please list all the medical providers for industrial injury first.

Please list any other medical providers who have treated you for any medical problems within the past years (up to 15 years)

_____ _____
_____ _____
_____ Zip_____ _____ Zip_____
Telephone Number_____ Telephone Number_____
_____ _____
_____ _____
_____ Zip_____ _____ Zip_____
Telephone Number_____ Telephone Number_____
_____ _____
_____ _____
_____ Zip_____ _____ Zip_____
Telephone Number_____ Telephone Number_____
_____ _____
_____ _____
_____ Zip_____ _____ Zip_____
Telephone Number_____ Telephone Number_____

Please attached additional pages, if necessary

Requesting Party:
Address:
Phone Number:
Fax:
Relationship to the Claimant: Adjuster

Failure to return this form to the requester may result in a delay or denial of your claim Form F

Pathogens - Exposure Incident Report

Employee Instructions
You are completing this form because you have experienced an actual or a potential exposure to blood or other potentially infectious material. An evaluation of this exposure is required by regulation.

Please complete all the information below. Take this form with you when you go to a physician or other healthcare provider for the evaluation of the exposure. The information contained on this form is crucial to a proper evaluation of the exposure. Please take the time and care in completing the form to insure that the information is clear and accurate. If you need information on where to have this medical evaluation performed, please contact your supervisor.

Employee's Statement: (Please Print)

Name: _____

Job Title: _____ Work Location: _____

Work Phone: _____ Supervisor: _____

Description of Exposure Incident

Incident or response number: _____

Date: _____ Time: _____ am / pm

City/Town: _____ State: _____

Describe Incident (Please include the type of infectious material to which you were exposed and the circumstances of the exposure – response to the call – protocols followed or breached due to circumstances uncontrollable):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Supervisor's Statement: (Please Print)

Employee's Name: _____

Supervisor Identification.

Name: _____

Work Phone: _____

Description of Incident
(Please describe the employee's duties as they relate to the exposure incident):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Hepatitis B Status

The employee named above has / has not (circle one) received a three dose series of hepatitis B Vaccine.
If yes, the series was completed on _____ (date).

Investigation of Source
Please describe what information is known about the source of the exposure (the incident number, person's name, address, telephone number, or other contact point), the result(s) of the blood testing of the source person (if known), or why blood testing of the source person is not feasible. Also, if the source person is known to have or test positive for hepatitis B or human immunodeficiency virus (HIV), please indicate this fact. The source person must be tested for these agents unless such testing is not legally possible.

_____

_____

_____

_____

_____

_____