ALABAMA WORK INJURY REPORTING PROCEDURES

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

Employer's First Report of Injury (WCC Form 2)

This form must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, Employer's First Reports of Injury (FROI's) may be submitted to us online at: **https://berkindcomp.com**. Online Reporting Instructions are enclosed. Maintain a copy of the FROI for your records. Keep a separate file for each workers' compensation claim.

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the FROI. If the FROI is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

Wage Statement

Wage statements must be completed on claims involving lost time from work. The employee's gross wages for the 52 weeks prior to the date of injury are required. If the employee has not been employed for 52 weeks, then report the available wages. In addition to regular pay, computation of wages may include overtime, tips, and the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee. If there are weeks with no wages, please explain the reason by coding as follows:

V= Vacation I= Illness L= Lay off P= Personal leave O= Other

Please contact our claims department with questions.

Do not delay reporting the Employer's First Report of Injury for completion of the wage statement.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2
Rev. 10/2012

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE

1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name
5. Physical Address 1
6. Physical Address 2
7. City 8. State 9. Zip

ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS
10. Mailing Address 1
11. Mailing Address 2
12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number	17. NAICS

INSURER / FILING OFFICE

18. Insurer Name
19. Insurer Federal ID Number
20. Type Insurer Ins Co ☐ Self-Insurer ☐ Group Fund ☐

21. Filing Office Name
22. Mailing Address 1
23. Mailing Address 2 or Telephone Number
24. City 25. State 26. Zip
27. Filing Office Federal ID Number

EMPLOYEE / WAGES

28. First Name
29. Middle Name
30. Last Name
31 Last Name Suffix (ie. Jr., Sr., III)

32. Employee ID Number
33. Type Employee ID Number
SSN ☐ Passport Number ☐ Green Card ☐
Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1
35. Mailing Address 2
36. City 37. State 38. Zip 39. Phone

40. Gender
Male ☐
Female ☐

41. Date of Birth
42.Nbr of Dependents

43. Marital Status
Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐

44. Date Hired

45. Occupation Description

46. Number of Days Worked Per Week

47. Wages $
48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐

49. Received Full Pay For Day of Injury? Yes ☐ No ☐
50. Did Salary Continue? Yes ☐ No ☐

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE

56. Site Address
57. City 58. State 59. Zip
60. County

61. Injury Occurred on Employer's Premises?
Yes ☐ No ☐

62. Date Employer Notified

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

67. Initial Treatment
First Aid By Employer ☐
Emergency Room ☐
Hospitalized > 24 Hours ☐
No Medical Treatment ☐
Minor Clinic / Hospital ☐
Hospitalized Overnight ☐
Outpatient Treatment ☐

68. Name of Treatment Facility
69. Address
70. City 71. State 72. Zip

73. Name of Physician or Other Health Care Professional

74. Has Injured Returned to Work
Yes ☐ No ☐

If so, 75. Date
76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name	79. Last Name	80. Title	81. Preparer's Telephone Number

WAGE STATEMENT

In order to determine with accuracy, the average weekly wages in accordance with the provisions of the Workmen's Compensation Law, please fill out and return.

This is to certify that I _____ am the _____
(Name of Person Certifying) (Name of Office or Position Held)

of _____ of _____
(Name of Employer) (Number, Street, City, Town)

employer of _____ injured on or about _____, _____
(Name of Injured Person) (Month, Day, Year)

"A" I have examined the payroll of said employer and the following table shows the days worked and the wages earned by said _____ employed as a _____ during the period stated therein.

"B" I have examined the payroll of said employer and find that _____ the injured employee, did not work for said employer a substantial portion of the year before the accident.

The following table shows the days worked and the wages earned by _____ another employee of the same class employed by the same employer who did work a substantial part of such year in the same or similar employment.

Official Position _____ Signed By _____

	WEEK ENDING			Days Worked	Amount Paid Including Overtime		WEEK ENDING			Days Worked	Amount Paid Including Overtime
	Month	Day	Year				Month	Day	Year		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					
			TOTAL PAID						TOTAL PAID		
									TOTAL GROSS		

STATE OF ALABAMA
WORKERS' COMPENSATION INFORMATION

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE CARRIER_____Berkley Industrial Comp_____

TELEPHONE NUMBER_____1-800-448-5621_____

ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS' COMPENSATION LAW INCLUDING MEDIATION SERVICE.
FOR INFORMATION CALL:
1-800-528-5166
Alabama Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131
CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED
IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

FORM WCC#1 10/12

WORKERS' COMPENSATION FRAUD

It could be a ticket to jail!

The Alabama Attorney General's Office and the Alabama Department of Industrial Relations

are working together to find and prosecute Workers' Compensation Fraud.

Workers' Compensation Fraud is STEALING!

W A N T E D

INFORMATION LEADING TO THE DISCOVERY AND OR CONVICTION OF WORKERS' COMPENSATION FRAUD.

Making a false statement to obtain workers' compensation benefits (Ala. Criminal Code, Section 13A-11-124) is a Class C Felony under Alabama law. False statements are punishable by up to $5,000 and up to 10 years in prison. Felony theft statutes may also apply.

FIVE TYPES OF WORKERS' COMPENSATION FRAUD

Agent ~ Employer ~ Employee ~ Medical ~ Legal

WORKERS' COMPENSATION FRAUD CAN BE:

* Reporting an off the job accident as an on the job accident.
* Reporting an accident that never happened.
* Complaints of accident injury symptoms that are exaggerated or non-existent.
* Malingering - to avoid work when injury is healed.
* Not reporting outside income from other work-related activities while drawing workers' compensation benefits from another employer.
* Making false or fraudulent statements for the purpose of obtaining workers' compensation benefits.

TO REPORT WORKERS' COMPENSATION FRAUD CALL

1-800-923-2533 or 334-242-7345