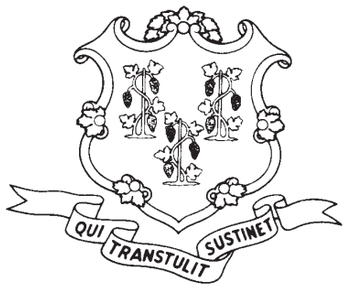
NOTICE
TO EMPLOYEES



State of Connecticut Workers' Compensation Commission **Revised 10-01-2017**

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,

_____

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the commissioner may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name BERKLEY INDUSTRIAL COMP

Address 3490 INDEPENDENCE DRIVE **Telephone** 800-448-5621

City/Town BIRMINGHAM **State** AL **Zip Code** 35266

Approved Medical Care Plan ☐ **Yes** ☐ **No**

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.

If your employer has listed a location below, you MUST file your compensation claim there.
When filing your claim, you are also required – by law – to send it by certified mail.

If blank below, ask your employer where to file your claim.

Employer Name _____

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted: _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).

CONNECTICUT 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 Occupational Injury or Illness (FRI)

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 Occupational Injury or Illness 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 Employer's First Report of Occupational Injury or Illness. If the Employer's First Report of Occupational Injury or Illness 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 Occupational Injury or Illness 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).

State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Date filed in Chairman's Office

(for WCC use only)

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Employer *(Name, Address & Zip)* | Phone #

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

SIC Code | FEIN

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ☐ Check, if Self-Insured | Policy Period *(MM/DD/YY)* FROM: TO:

Employee: Last Name First Name Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender ☐ Male ☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ _____ . _____ per ☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ☐ a.m. ☐ p.m.

Time of Occurrence ☐ cannot be determined ☐ a.m. ☐ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Contact Name

Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ☐ Yes ☐ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

If provided, were they used? ☐ Yes ☐ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

☐ No Medical Treatment ☐ Emergency Care

☐ Minor — by Employer ☐ Hospitalized More Than 24 Hours

☐ Minor — by Clinic / Hospital ☐ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

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		