

# WORKERS' COMPENSATION



is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

## IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

**1. GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation, the PPP counts as one of your two choices of providers.

**2. NOTIFY YOUR EMPLOYER.** You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.

**3. LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.

**4. KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033      Chicago: 312/814-6611      Peoria: 309/671-3019      Springfield: 217/785-7087  
 Web site: [www.iwcc.il.gov](http://www.iwcc.il.gov)      Collinsville: 618/346-3450      Rockford: 815/987-7292      TDD (Deaf): 312/814-2959

**BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE  
IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.**

Party handling workers' compensation claims	Berkley Industrial Comp		
Business address	P.O. Box 660847, Birmingham, AL 35266-0847		
Business phone	800-448-5621		
Effective date		Termination date	
Policy number		Employer's FEIN	

# COMPENSACION A LOS TRABAJADORES



es un sistema de beneficios que por ley se provee a la mayoría de trabajadores que se han enfermado o accidentado en el trabajo. Los beneficios son pagados por lesiones que son causadas en parte o completamente por el trabajo del trabajador. Esto puede incluir el agravante o una condición pre-existente, lesiones causadas por uso repetitivo de una parte del cuerpo, ataques cardiacos, o cualquier otro problema físico causado por el trabajo. Los beneficios son pagados sin importar la causa.

## SI USTED SUFRE DE UNA LESION O ENFERMEDAD RELACIONADA AL TRABAJO, USTED DEBE TOMAR LAS SIGUIENTES MEDIDAS:

- 1. OBTENGA AYUDA MEDICA.** Por ley, su empleador debe pagar por todos los servicios médicos necesarios que se requieran para aliviar los síntomas de lesión o enfermedad. Si es necesario, el empleador debe pagar por rehabilitación física, mental o profesional dentro de los límites establecidos. El trabajador puede escoger dos doctores, cirujanos u Hospitales. Si el empleador le notifica que tiene un programa de proveedor preferido (PPP) aprobado para la compensación de trabajadores, el PPP cuenta como una de las dos opciones de proveedores.
- 2. NOTIFIQUE A SU EMPLEADOR.** Usted debe notificar a su empleador del accidente o enfermedad dentro de 45 días, ya sea por escrito o verbalmente. Para evitar posibles demoras, es recomendable que la nota incluya su nombre, dirección, número telefónico, número de Seguro Social, y una breve descripción de la lesión o enfermedad.
- 3. CONOZCA SUS DERECHOS.** Su empleador por ley debe reportar accidentes que resulten en más de tres días de ausencia al trabajo, a la Comisión de Compensación para Trabajadores. Una vez que el accidente es reportado, usted recibirá un manual que explica la ley, beneficios y procedimientos. Si necesita un manual, por favor llame a la Comisión o visite nuestra red.

Si usted tiene que faltar al trabajo para recuperarse de la lesión o enfermedad, usted tiene derecho a recibir pagos semanales y atención médica necesaria hasta que este capacitado para regresar a trabajar y que el trabajo este de acuerdo a sus capacidades.

Es contra la ley que el empleador moleste, despidas o se niegue a reemplazar o de alguna manera discrimine contra un trabajador por ejercitar sus derechos de conformidad con las leyes que rigen el seguro de accidentes de trabajo de enfermedades profesionales. Si usted hace una demanda fraudulenta, podrá ser castigado por la ley.

- 4. MANTENGASE DENTRO DEL LIMITE DE TIEMPO.** Usualmente, las quejas deben ser presentadas dentro de los primeros tres años del accidente o incapacidad de una enfermedad profesional, o dentro de dos años del último pago de compensación de trabajo, lo que sea más reciente. Quejas por neumoconiosis, exposición radiológica, asbestos, o enfermedades similares tienen requerimientos especiales.

Los trabajadores accidentados tienen derecho para volver a abrir su caso dentro de 30 meses después que la Comisión haya otorgado una decisión y la incapacidad haya incrementado, pero en casos resueltos por una suma global aprobada por la Comisión no pueden volver a abrirse. Únicamente las decisiones aprobadas por la Comisión son obligatorias.

Para mas información, visite la Red de la Comisión de Compensación para Trabajadores o llame a nuestras oficinas:

Toll-free: 866/352-3033 Chicago: 312/814-6611 Peoria: 309/671-3019 Springfield: 217/785-7087  
Web site: www.iwcc.il.gov Collinsville: 618/346-3450 Rockford: 815/987-7292 TDD (Sordo): 312/814-2959

### LOS EMPLEADORES DEBEN EXHIBIR ESTE AVISO EN UN LUGAR VISIBLE PARA TODOS LOS TRABAJADORES Y LLENAR LA INFORMACIÓN REFERENTE A LA COMPAÑIA DE SEGUROS.

Nombre:	Berkley Industrial Comp		
Dirección de la Compañía:	P.O. Box 660847, Birmingham, AL 35266-0847		
Teléfono de la Compañía:	800-448-5621		
Fecha efectiva:		Fecha de terminación:	
Número de Póliza:		FEIN del Empleador:	

## **ILLINOIS 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 (IC45)**

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).

# ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

*Please type or print.*

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? Yes      No
Employer's name		Doing business as	
Employer's mailing address			Employer's email address
Nature of business or service			SIC code
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? Yes      No
Employee's full name			Birthdate
Employee's mailing address			Employee's e-mail address
Gender Male      Female	Marital status Married      Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? Yes      No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? Yes      No		Was the employee hospitalized overnight as an inpatient? Yes      No	
Report prepared by	Signature	Title and telephone #	Email address

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD SPRINGFIELD, IL 62703**  
 By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any way. This information is confidential. IC45 8/12

# 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				