NORTH DAKOTA WORK INJURY REPORTING PROCEDURES

This Claim Kit is provided for your use in reporting all employee job related injuries. Copy the forms as needed.

Employer's First Report of Injury (FROI)

This form, numbered SFN 2828 (07/2014), 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 Berkley Industrial Comp. Maintain a copy for your records. Keep a separate file for each workers' compensation claim (do not maintain with other personnel records).

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the First Report of Injury. Maintain a copy for your records. If you utilize another version of a Supervisor's Report, it may be substituted for this form but please send it to us with the First Report of Injury.

Wage Statement

A Statement of Weekly Earnings form must be completed on any case where it is anticipated that the injured employee might lose work beyond the waiting period of more than three (3) days. The State requires reporting of gross wages for the 52 weeks prior to the accident. If the employee has not been employed for that amount of weeks, report all the wages available. We may inquire about wages for a similar employee of the same class and grade. Remember computation of wages may include, in addition to salary, hourly pay or tips, the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee if they constitute a financial benefit to the employee and are capable of monetary calculation. 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
If you have any questions, feel free to contact the claim department to assist you.

Please do not hold the 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. Equally important, you must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

FIRST REPORT OF INJURY

CLAIMS DIVISION
SFN 2828 (11/2017)

North Dakota Workforce Safety & Insurance

1600 E Century Ave, Ste 1
PO Box 5585
Bismarck ND 58506-5585
Telephone 800-777-5033
Toll Free Fax 888-786-8695
TTY (hearing impaired) 800-366-6888
Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

SECTION 1 - *Completion of this section is required*

Claim number	Worker's (First name)	(Last name)	Social Security number*
Date of birth	Gender ☐ Female ☐ Male	Marital status ☐ Single ☐ Married	Worker's telephone number
Worker's physical address (Street address)			
City		State	ZIP code
Worker's mailing address, if different than physical address (Street address, PO Box number)			
City		State	ZIP code
Date of injury	Time of injury ☐ AM ☐ PM	Nature of injury or illness (broken left leg, carpal tunnel left wrist, etc.)	
Body parts injured (Example: 2nd/middle finger, shoulder, ankle, etc.) ☐ Left ☐ Right ☐ NA			
How did the injury happen?			
Has this claim been filed in another state? ☐ Yes ☐ No If yes, which state?			
Where did the injury happen? (City)	(County)	(State)	
Treating doctor's name			Date of first treatment ☐ NA
Clinic/hospital name (If you have received treatment in more than one location, please provide the name of clinic/hospital, treating doctor(s), address and telephone number of all locations on page two or separate sheet of paper.)			
Clinic/hospital mailing address (Street address, PO Box number)			Clinic/hospital telephone number
City	State		ZIP Code
Employer's name			Employer's telephone number
Employer's mailing address	City	State	ZIP code
What is the worker's job?	Date hired (Month) (Year)		Last day worked in ND prior to injury

SECTION 2 – *Worker completion*

Date employer notified	Person you notified	Before this injury, have you had any problems, injuries, or treatment to the injured body parts? ☐ Yes ☐ No
Have you missed or will you miss 5 or more consecutive days of work due to the injury? **OR** Has a doctor taken you off work for 5 or more consecutive days? ☐ Yes ☐ No		
Witness to the injury (First name)	(Last name)	Telephone number

SECTION 3 – *Release of information/fraud warning/signature*

Release of information

I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including all prior records as well as those pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS-related illness. I authorize healthcare providers to respond to WSI regarding my injury, including request for conclusions and opinions not otherwise contained within existing medical records.

(Continued on page 2)

Claim number	Worker's (First name)	(Last name)

In addition, I authorize any education agency or institution to release to WSI any and all "educational records" as defined by 20 U.S.S 21 Sec. 1232g. This authorization continues while I have any claim open or pending before WSI. WSI is exempt from HIPAA regulations. I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.

Fraud warning
Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for workers' compensation benefits will forfeit any future benefits and may be guilty of a felony which is punishable by imprisonment, substantial fines, or both. These criminal penalties are applicable to all persons dealing with WSI, including injured workers, employers, medical providers, and attorneys.

Signature
By signing this form, I acknowledge that I have read and understand the release of information and fraud warning. I understand that falsifying this claim or making a false statement regarding this claim may be a felony, punishable by substantial fines and imprisonment. I authorize the release of information and agree that statements in this form are true and accurate.

Worker's signature	**Date signed**

In addition to myself, I authorize WSI to release information on my claim to (please print)
First name Last name Relationship

SECTION 4 - *Employer completion*

Employer's account number	Rate class	Is worker a corporate officer, owner, or family member? ☐ Yes ☐ No
Employer's name	Mailing address (Street address, PO Box number)	
City	State	ZIP code

Has the worker missed or will they miss 5 or more consecutive days of work due to the injury? **OR** Has a doctor taken the worker off work for 5 or more consecutive days? ☐ Yes ☐ No

Date employer notified	Person notified	Before this injury, are you aware of the worker having any problems, injuries, or treatment to the injured body part? ☐ Yes ☐ No ☐ Unknown

Do you have a Designated Medical Provider (DMP)? ☐ Yes ☐ No	Did the worker add another medical provider? ☐ Yes ☐ No If yes, which provider?	Do you question this claim? ☐ Yes ☐ No If yes, please explain in section 5.

Employer's signature	**Title**	**Date signed**

SECTION 5 – *Additional information or comments*

* In compliance with the Federal Privacy Act of 1974, disclosure of the Social Security number on this form is mandatory pursuant to N.D.C.C. § 65-05-02. The Social Security number is used for identification and verification purposes. Failure to provide this information may result in a delay in processing your request.

To report an instance of fraud, contact the ND Fraud and Safety Hotline at 800-243-3331.

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		

North Dakota
Workforce Safety
& Insurance
Putting Safety to Work

1600 E Century Ave, Ste 1 - PO Box 5585 - Bismarck ND 58506-5585
(701) 328-3800 1-800-777-5033 Hearing Impaired: 1-800-366-6888
Decision Review Office: (701) 328-9900 1-800-701-4932
Fraud & Safety HotLine: 1-800-243-3331
Filing a claim (3 methods):
Online: *www.WorkforceSafety.com* (Online Services Section), 24 hours/weekends/holidays
By hand: Complete the First Report of Injury (FROI) Form and submit to WSI
Telephonically: 1-800-777-5033, 8 a.m. - 5 p.m. on business days

Important Notice to Workers

The information contained in this poster is **effective August 1, 2011.** This poster is updated, reprinted, and distributed to employers every two years for them to post for their workers' reference. For a detailed explanation of the information contained in this poster, please contact WSI at the numbers listed above or visit our web site at *www.WorkforceSafety.com.*

When you are injured on the job:

1 **Notify your employer immediately of the accident and your injury. By law, you must give written or oral notice to your employer within seven days of an accident or after the general nature of your injury becomes apparent.** If you fail to notify your employer, Workforce Safety & Insurance (WSI) may consider that failure when deciding whether your claim will be accepted. ***NOTE: Even if you feel your injury is not serious enough to need medical treatment, it is important you report your accident to your employer so they are informed of the potential hazard.***

2 **Seek first aid or medical attention promptly after a workplace injury.** If your employer does not have a Designated Medical Provider (DMP), you may go to a doctor of your choice. If your employer does have a DMP, you are required to see your employer's DMP, UNLESS you informed your employer, in writing, of a different medical provider before any injury occurred. Contact your employer or WSI for more detailed information about this requirement. Emergency medical treatment is exempt from the DMP requirement. Inform the doctor that your injury is a workers' compensation injury. Also, inform the doctor of your work duties and ask if you can return to work within any work restrictions the doctor may impose. Follow restrictions, both on and off the job.

3 **File a claim with WSI immediately after a work-related injury occurs (within 24 hours of occurrence).** Use one of three methods: 1) online at *www.WorkforceSafety.com*, available 24 hours/weekends/holidays (follow online instructions); 2) by hand by completing the First Report of Injury (FROI) Form, or 3) telephonically by calling 1-800-777-5033, 8 a.m. - 5 p.m. on business days.

Whichever claim filing method is used, complete the FROI form with your employer, if possible. Answer all questions fully and honestly on the form. Be sure to have your employer complete the employer's portion of the FROI form. If you have received benefits for an injury and are now off work again for that same injury, you must reapply for benefits in writing. Contact WSI and request a Worker's Notice of Reapplication (C4) form.

4 WSI will inform you of your claim number, in writing, upon registering your claim. **Be sure to always inform the pharmacy and medical provider of your claim number.**

5 **Keep in touch with your employer and provide them with periodic updates on your condition.**

6 **Notify WSI immediately: 1) when you perform any type of work activity, whether you receive pay for it or not; 2) if you change your address or telephone number; or 3) if you apply for either Social Security disability or retirement benefits or are found to be eligible for these benefits.**

Types of benefits available:

Medical Benefits
On an accepted claim, WSI pays for reasonable and necessary work-related medical care and prescriptions in accordance with fee schedule limitations and administrative rule guidelines. Some medical procedures require prior authorization.

Pharmacy Benefits
On accepted claims, WSI will pay for prescriptions that are part of the necessary work-related medical care. All prescriptions must be obtained at pharmacies and medical facilities that are contracted with WSI's prescription benefit management company. WSI does not reimburse for prescriptions that are paid out-of-pocket by an injured worker. WSI will pay for a limited quantity for certain medications under a first fill program while awaiting a decision on the compensability of a claim.

Wage Replacement Benefits
An injured worker may be entitled to wage replacement benefits if their doctor orders them not to work for five or more calendar days in a row because of their work-related injury or illness.

Permanent Partial Impairment (PPI) Benefits
This benefit is for injured workers who suffer permanent physical loss of a body part or function because of a compensable work-related injury. PPI benefits are given only if the full-body impairment meets or exceeds the statutory minimum impairment. Once an injured worker reaches maximum medical improvement, a doctor will then determine the level of permanent impairment. This is a one-time, lump-sum payment that is tax free.

Return-to-Work Services
These services may be assigned to an injured worker to assist in coordinating medical treatment or return-to-work planning. Different types of return-to-work services include return-to-work case management, medical case management, vocational rehabilitation services, and the Preferred Worker Program.

Reimbursement for Personal Expenses
On accepted claims, WSI will reimburse an injured worker (upon their request) for mileage, meals, and other out-of-pocket costs that are necessary for their medical care, within the limits of the law. Original, itemized, and dated receipts are required (certain conditions apply). Injured workers can download the appropriate form (C40a) from our web site or request it from our office.

Death Benefits
WSI pays death benefits to the survivors of workers killed in work related accidents. Survivors must file a claim within two years of the worker's date of death. Survivors receive 2/3 of the deceased worker's gross weekly wage, up to a maximum of 125% of the state's average weekly wage. Total benefits may not exceed $300,000. Funeral expenses are payable up to $10,000.

March 2012

IMPORTANT NOTICE TO WORKERS

The information contained in this poster is effective August 1, 2013 and available online for printing at ***http://www.workforcesafety.com/library/LibrarySearchResults.asp***.

For a detailed explanation of the information contained in this poster, please contact WSI at the numbers listed below or visit our website at ***www.WorkforceSafety.com.***

When You Are Injured On The Job:

Notify your employer immediately of the accident and your injury. By law, you must give written or oral notice to your employer within seven days of an accident or after the general nature of your injury becomes apparent. If you fail to notify your employer, Workforce Safety & Insurance (WSI) may consider that failure when deciding whether your claim will be accepted. **NOTE: Even if you feel your injury is not serious enough to need medical treatment, it is important you report your accident to your employer so they are informed of the potential hazard.**

Seek first aid or medical attention promptly after a workplace injury. If your employer does not have a Designated Medical Provider (DMP), you may go to a doctor of your choice. If your employer does have a DMP, you are required to see your employer's DMP, UNLESS you informed your employer, in writing, of a different medical provider before any injury occurred. In order to effectively select a DMP, your employer is required to give written notice of the identity and the terms of the preferred provider program:

(1) To the employer's employees when the employer makes an initial selection of a preferred provider.
(2) To the employer's employees when the employer changes the selection of the preferred provider.
(3) To an employee at the time of hire.
(4) To the employer's employees at least annually after the initial notice.

An employer that has selected a preferred provider shall display notice of the identity of the preferred provider and the terms of the preferred provider program in a conspicuous manner at fixed worksites, and wherever feasible at mobile worksites, and in a sufficient number of places to reasonably inform employees of the identity of the preferred provider and the terms of the preferred provider program. Failure to give written notice, to properly post notice, or to reasonably inform employees of the terms of the preferred provider programs as required under this subsection invalidates the selection.

Contact your employer or WSI for more detailed information about this requirement. Emergency medical treatment is exempt from the DMP requirement. Inform the doctor that your injury is a workers' compensation injury. Also, inform the doctor of your work duties and ask if you can return to work within any work restrictions the doctor may impose. Follow restrictions, both on and off the job.

File a claim with WSI immediately after a work-related injury occurs (within 24 hours of occurrence). Use one of three methods:

1) online at www.WorkforceSafety.com, available 24 hours/weekends/holidays (follow online instructions);
2) by hand by completing the First Report of Injury (FROI) Form, or
3) telephonically by calling 1-800-777-5033, 8 a.m. - 5 p.m. on business days.

Whichever claim filing method is used, complete the FROI form with your employer, if possible. Answer all questions fully and honestly on the form. Be sure to have your employer complete the employer's portion of the FROI form. If you have received benefits for an injury and are now off work again for that same injury, you must reapply for benefits in writing. Contact WSI and request a Worker's Notice of Reapplication (C4) form.

WSI will inform you of your claim number, in writing, upon registering your claim.
Be sure to always inform the pharmacy and medical provider of your claim number.

Keep in touch with your employer and provide them with periodic updates on your condition.

Notify WSI immediately:

1) when you perform any type of work activity, whether you receive pay for it or not;
2) if you change your address or telephone number; or
3) if you apply for either Social Security disability or retirement benefits or are found to be eligible for these benefits.

Types of Benefits Available:

- **Wage Replacement**
- **Medical Benefits**
- **Pharmacy Benefits**
  WSI will pay for prescriptions that are part of the necessary work-related medical care when obtained at pharmacies and medical facilities that are contracted with WSI's prescription benefit management company. WSI does not reimburse for prescriptions that are paid out-of-pocket by an injured worker.
- **Reimbursement for Personal Expenses**
- **Return-to-Work Services**
- **Death Benefits**

Scan here to learn more on the types of benefits.

November 2013

Our/Your Designated Medical Provider (DMP) selection is:

_____ _____ _____

WSI
North Dakota Workforce Safety & Insurance

1600 E Century Ave, Ste 1 - PO Box 5585 - Bismarck ND 58506-5585
(701) 328-3800 1-800-777-5033 Hearing Impaired: 1-800-366-6888
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