pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: _____ **Date Posted:** _____

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company: BERKLEY INDUSTRIAL COMP

Address: PO BOX 660847, BIRMINGHAM, AL 35244

Telephone Number: (800) 844-5621

Insurer Code: 2190

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): _____

Address: _____

Telephone Number: _____

IF SELF-INSURED
(Complete all applicable spaces)

Name of person handling claims at the self-insured: _____

Address: _____

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): _____

Address: _____

Telephone Number: _____

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

Berkley INDUSTRIALCOMP
a Berkley Company

Named Insured	
Location Address	

NOTICE TO EMPLOYEES IN CASE OF WORK RELATED-INJURIES

1. If you suffer a compensable work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.

2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers. You must continue to visit one of the physicians listed below, if you need treatment for ninety (90) days from the date of your first visit.

3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.

4. After this ninety (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.

5. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety (90) days. Therefore, in this situation, the employee may be required to treat with an employer designated provider for up to 180 days.

6. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

7. The Commonwealth has no direct jurisdiction over out of state providers under PA Workers' Compensation Act. Treatment with out of state providers may result in you being billed for excess amounts over the PA Act 44 Fee Schedule. Your insurance company is not responsible for any fees over and above the fee schedule.

8. If you prefer to seek treatment with an out of state provider, you should discuss this possibility with your provider prior to initiating treatment.

Berkley INDUSTRIALCOMP
a Berkley Company

Named Insured	
Location Address	

AVISO A LOS EMPLEADOS EN CASO DEL TRABAJO RELATED-INJURIES

1. Si usted sufre lesión trabajar-relacionada compensable, su patrón o su compañía de seguros debe pagar los servicios y las fuentes quirúrgicos y médicos razonables, aplicaciones ortopédicas y prótesis, incluyendo el entrenamiento en su uso.

2. Para asegurar que su tratamiento médico será pagado para por su patrón o la compañía de seguros, usted debe seleccionar a partir del uno de los abastecedores siguientes del cuidado médico. Usted debe continuar visitando a uno de los médicos enumerados abajo, si usted necesita el tratamiento por noventa (90) días a partir de la fecha de su primera visita.

3. Si uno de los abastecedores abajo le refiere a otro especialista licenciado, su patrón o su asegurador pagará la cuenta estos servicios.

4. Después de este noventa (90) períodos del día, si usted todavía necesita el tratamiento y su patrón ha proporcionado una lista según lo dispuesto abajo, usted puede elegir ir a otro abastecedor del cuidado médico para el tratamiento. Usted debe notificar a su patrón de esta acción en el plazo de cinco días de su visita al abastecedor dicho.

5. Si un médico en la lista prescribe cirugía invasora, usted puede obtener una segunda opinión de cualquier médico de su opción. Si la segunda opinión es diferente que la opinión del médico mencionado, usted puede determinarse qué curso del tratamiento a seguir; sin embargo, la segunda opinión debe contener un plan específico y detallado del tratamiento. Si usted elige la segunda opinión, los procedimientos en que la opinión se debe realizar por uno de los médicos en la lista para los primeros noventa (90) días. Por lo tanto, en esta situación, el empleado puede ser requerido tratar con un patrón señalado abastecedor por hasta 180 días.

6. Si le hacen frente con una emergencia médica, usted puede asegurar ayuda de un hospital, de un médico, o de una salud cuide el abastecedor de su opción para su lesión trabajar-relacionada. Sin embargo, cuando se resuelve la emergencia, usted debe buscar el tratamiento de un abastecedor enumerado abajo.

7. La Commonwealth no tiene ninguna jurisdicción directa encima fuera de abastecedores del estado bajo acto de la remuneración de los trabajadores del PA. El tratamiento con fuera de los abastecedores del estado puede dar lugar a usted que es mandado la cuenta para exceso de las cantidades sobre el horario del honorario del acto 44 del PA. Su compañía de seguros no es responsable de ninguna honorarios superior al horario del honorario.

8. Si usted prefiere buscar el tratamiento con fuera de abastecedor del estado, usted debe discutir esta posibilidad con su abastecedor antes de iniciar el tratamiento.

El ********** considera la PÁGINA DOS

PENNSYLVANIA 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 Report of Occupational Injury or Disease (LIBC-344)

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 Reports of Occupational Injury or Disease may be submitted to us online at: www.berkindcomp.com. Online Reporting Instructions are enclosed. Maintain a copy of the Employer's Report of Occupational Injury or Disease 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 Report of Occupational Injury or Disease. If the Employer's Report of Occupational Injury or Disease 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.

Statement of Wages (LIBC-494C)

The Statement of Wages must be completed on claims involving lost time from work.

Please contact our claims department if you have questions about completing the Statement of Wage Information.

Do not delay reporting the Employer's Report of Occupational Injury or Disease for completion of the Statement of Wages.

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).

WORKERS' COMPENSATION INFORMATION

To all employees:

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of insured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer.

Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a Workers' Compensation Judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone No. within Pennsylvania: 800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY-800-362-4228 (for hearing and speech impaired only);
www.state.pa.us Pa keyword: workers' comp

I, _____, employee of _____ (employer), Certify that I have been provided with, read and understood the information set Forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Date:_____ **Signature**:_____

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

The Pennsylvania Workers' Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising in the course of his/her employment and causally related thereto. Pursuant to the Act, your employer will provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

If you require emergency medical treatment, you may seek it from any provider; however, any subsequent non-emergency treatment shall be obtained from one of the designated health care providers whose names appear on the list posted on your employer's premises. If you are faced with a medical emergency, you may secure assistance from a hospital or physician/health care provider of your choice. However, once the emergency no longer exists, the injured employee must treat with a listed provider for the remainder of the ninety (90) day period.

During the initial ninety (90) days from the date of your first visit, you have the right to switch from one health care provider on the list to another, and your employer will pay for that treatment.

If a designated health care provider refers you for treatment to another health care provider whose name is not on the list, your employer will pay for the treatment rendered by the provider to whom you were referred.

Naturally, you have the right to seek treatment or medical consultation from a non-designated health care provider during the initial ninety (90) day period following the first visit, but you are personally responsible for payment for those services.

You have the right to seek treatment from any health care provider at the expiration of the ninety (90) day period from the date of first visit. Your employer will pay for this treatment unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the Workers' Compensation Act.

Your employer will be responsible for the cost of that treatment after the initial ninety (90) day period has ended but only if you notify the employer that you are receiving treatment from non-designated health care provider and only if that notice is provided to your employer within five (5) days of the first visit to that provider. If you provide notice to your employer of treatment by a non-designated provider more than five (5) days after the first visit to that provider, the employer will not be responsible to pay for treatment rendered by that non-designated provider until it receives notification from you that you are receiving such treatment.

Should a designated health care provider prescribe invasive surgery, your employer will pay for an additional opinion from a health care provider of your choice. If the additional opinion differs from the opinion of the designated health care provider and if the additional opinion provides a specific and detailed course of treatment, you will then determine which course of treatment to follow. If you choose to follow the procedures recommended in the additional opinion, your employer will pay to have such procedures performed by one of its designated health care providers and will not be responsible for payment for treatment provided by a non-designated provider for a period of ninety (90) days from the date of your visit to the health care provider from whom you obtained the additional opinion.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND MY RIGHTS AND DUTIES UNDER THE PENNSYLVANIA WORKERS' COMPENSATION ACT AS SET FORTH HEREIN.

Employee Name	Employee Signature	Date

EMPLOYEE RE-NOTIFICATION AT OR NEAR THE TIME OF THE CLAIMED WORK INJURY

I hereby acknowledge that I have been informed again and that I understand my rights and duties under the Pennsylvania Workers' Compensation Act. I have received a copy of this workers' compensation employee notification form.

Employee Name	Employee Signature	Date

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY
MONTH DAY YEAR

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY PHONE NUMBER

EMPLOYEE:
MALE ☐ MARRIED ☐
FEMALE ☐ SINGLE ☐

NUMBER OF DEPENDENTS

DATE OF BIRTH
MONTH DAY YEAR

OCCUPATION OR JOB TITLE

NCCI CLASS CODE (IF KNOWN)

EMPLOYMENT STATUS

FT = Full time
PT = Part-time
SL = Seasonal
VO = Volunteer
ZZ = Other

EMPLOYER

STREET ADDRESS

CITY STATE ZIP CODE

SIC CODE EMPLOYER FEIN PHONE NUMBER

COUNTY NAICS CODE

FULL PAY FOR DAY OF INJURY?
YES ☐
NO ☐

TIME EMPLOYEE BEGAN WORK
AM ☐ PM ☐

TIME OF OCCURRENCE
AM ☐ PM ☐

344 1197-1

LAST DAY WORKED
MONTH DAY YEAR

DATE DISABILITY BEGAN
MONTH DAY YEAR

DATE EMPLOYER NOTIFIED
MONTH DAY YEAR

DATE RETURNED TO WORK
MONTH DAY YEAR

DATE OF HIRE
MONTH DAY YEAR

CONTACT FIRST NAME CONTACT PHONE NUMBER

CONTACT LAST NAME

NOTICE: Report should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee and insurer.

LIBC-344 REV 1-01

(OVER)

TYPE OF INJURY CODE

PART OF BODY AFFECTED CODE

CAUSE OF INJURY CODE (ENTER CODES, IF KNOWN)

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES?
YES ☐
NO ☐

IF OUT OF STATE, SPECIFY STATE OF INJURY

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?
YES ☐
NO ☐

WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?
YES ☐
NO ☐

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING 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 DIRECTLY RESPONSIBLE.

IF FATAL, GIVE DATE OF DEATH
MONTH - DAY - YEAR

INITIAL TREATMENT:
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYEE
- ☐ CLINIC / HOSPITAL
- ☐ PANEL PHYSICIAN
- ☐ EMPLOYEE PHYSICIAN
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED MORE THAN 24 HOURS

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME: LAST NAME:
STREET
CITY STATE ZIP

HOSPITAL NAME:
STREET
CITY STATE ZIP

POLICY PERIOD FROM:
MONTH - DAY - YEAR

POLICY PERIOD TO:
MONTH - DAY - YEAR

POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:
NAME:
TITLE:
PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)
NAME: Berkley Industrial Comp
STREET P.O. Box 660847
CITY Birmingham STATE AL ZIP 35266
BUREAU CODE: 2190 FEIN: 63-0866690

DATE PREPARED
MONTH - DAY - YEAR

344 1197-2

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.

PA Employers Workers Compensation Medical Providers Panel information

The PA Workers Compensation Act allows employers to post a panel of physicians to provide medical care for their injured employees during the first 90 days of treatment following an injury. The American Mining Insurance Co. strongly recommends that our insureds establish a panel in order to mitigate losses, provide prompt and appropriate medical care to their employees and assist in a more timely return to work.

If you already have a panel posted and wish to continue to use that panel, please provide a copy to American Mining Insurance Co. so we can ensure that your employees are compliant should an injury occur. If you wish to make changes to an existing panel or do not have one posted and wish to, we can assist you in that process. Please contact your agent or a representative at your servicing claims office (refer to business cards in the claims packet) to request that a panel be established.

In order to be enforceable, the panel must be posted and be compliant with the guidelines for required medical specialties per the PA W.C. Act. Once a panel is posted, all employees must sign an acknowledgement both at the time they are hired, or when the panel is posted, as well as at the time they are injured and go to seek treatment. They may seek and receive non panel emergency care, but must return to panel providers after the initial emergency treatment. The injured employee should be provided with a copy of the posted panel at the time they report an injury and go for treatment.

Attached is copy of the Worker's Compensation Employee Notification form, as well as a sample panel for your review.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

STATEMENT OF WAGES (FOR INJURIES OCCURRING ON OR AFTER JUNE 24, 1996)

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

___ - ___ - ____ ____________

DATE OF INJURY

__ - __ - ____
MM DD YYYY

WCAIS CLAIM NUMBER

EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____ Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

Contact _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

CONCURRENT EMPLOYMENT ONLY

Check if Primary employer OR

__ Concurrent employer

INSTRUCTIONS

The Statement of Wages must be clearly completed in accordance with the Pennsylvania Workers' Compensation Act and uploaded in accordance with the provisions of the EDI Implementation guide when submitting certain EDI transactions. A copy must be sent to the injured employee.

The "average weekly wage" is used to determine the amount of weekly compensation wage-loss benefits payable under the Pennsylavania Workers' Compensation Act. A chart is available from the Bureau of Workers' Compensation to aid in determining the weekly compensation rate, online at www.dli.state.pa.us

CONCURRENT EMPLOYMENT

If the employee had more than one employer at the time of injury, a separate Statement of Wages form must be completed for each employer. Submit these forms together. Using #8 on the Primary Employer's form **only** (employer with whom the injury occurred): show the addition of the average weekly wages from all employers, show the combined average weekly wage to the right of the equal sign and show the appropriate workers' compensation rate. Check the Primary employer box for the Primary employer and the Concurrent employer box for all other employers.

Computation: Compute the appropriate items below for the employee to determine the average weekly wage.

	Wage		Weekly Board/ Lodging		Weekly Federal Reported Gratuities		Annual Bonus, Incentive or Vacation		Average Weekly Wage
1. If wages are fixed by the week:	_____	+	_____	+	_____	+	_____	= $	_____
2. If wages are fixed by the month:	_____	x 12 ÷ 52 +	_____	+	_____	+	_____	= $	_____
3. If wages are fixed by the year:	_____	÷ 52 +	_____	+	_____	+	_____	= $	_____

4. If paid in another manner, then complete the following for each of the last four consecutive periods of 13 calendar weeks preceding the injury.

	From	Through	Wages		Board/Lodging		Federal Reported Gratuities		Period Weekly Wage
1st Period	_____	_____	_____	+	_____	+	_____	÷ 13 = $	_____
2nd Period	_____	_____	_____	+	_____	+	_____	÷ 13 = $	_____
3rd Period	_____	_____	_____	+	_____	+	_____	÷ 13 = $	_____
4th Period	_____	_____	_____	+	_____	+	_____	÷ 13 = $	_____
							(Sum of three highest periods)	= $	_____

Annual bonus, incentive and vacation $ _____ ÷ 52 = $ _____ (Weekly bonus, etc)

Average Weekly Wage

Sum of the highest three period weekly averages = $ _____ ÷ 3 + $ _____ (Weekly bonus, etc) = $ _____

5. If the employee has not been employed by the employer for at least three consecutive periods of 13 calendar weeks in the 52 weeks preceding the injury, use #4 above and put in the wages for any completed periods(s) of 13 weeks immediately preceding the injury and average the total amounts ..... = $ _____

6. If the employee worked less than a complete period of 13 calendar weeks and does not have fixed weekly wages: hourly wage rate $ _____ x the number of hours the employee was expected to work per week under the terms of employment _____ =$ _____ + weekly board/lodging of $ _____ + weekly federal reported gratuities $_____ + (annual bonus, incentive or vacation pay ÷ 52) $ _____ ..... = $ _____

7. For seasonal occupations, the average weekly wage is one-fiftieth of the total wages earned from all occupations during the 12 months immediately preceding the injury. Twelve months prior earnings $_____ ÷ 50 = $ _____ + weekly board/lodging $_____ + weekly federal reported gratuities $_____ ..... = $ _____

8. If the calculation in #7, or any other calculation above, does not fairly ascertain the earnings of the employee, the period of calculation is extended to give a fair calculation of their average weekly wage. Show this calculation here **OR** use the space below to show calculations for concurrent employment. = $ _____

_____

COMPENSATION PAYABLE PER WEEK: = $ _____

_____ _____

Employer/Defendant Representative's signature | Employer/Defendant Representative's name (typed/printed)

_____

Telephone

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program