*Safety's intention is*

# ACCIDENT PREVENTION

*Be a part of the safety*

**T**ogether
**E**veryone
**A**ccomplishes
**M**ore

# LA SEGURIDAD EN


# EVITE LO PEOR

## SEA PARTE DEL EQUIPO DE SEGURIDAD ...

# SOUTH 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 DLR-LM-101, 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).

# GENERAL INSTRUCTIONS

**EMPLOYEE**

1.

# South Dakota Employer's First Report of Injury

## EMPLOYEE

SSN: _____ Date of Birth: _____ Gender: M ◯ F ◯ Dependents: _____

Name: (Last) _____ (First) _____ ( Middle initial) ___

Mailing Address: _____

City: _____ State: _____ Zip: _____ Telephone No.: _____

Employee signature: (X) _____ Date _____

**Education:**

- ☐ Less than High School
- ☐ GED or High School
- ☐ Beyond High School

## INJURY/TREATMENT

Date of Injury: _____ Time of Injury: _____ a.m. ☐ p.m. ☐ Fatality Date (if applicable): _____

County Where Injury Occurred _____ Was Safety Equipment Provided? Yes ☐ or No ☐

Time Work Day Began on Date of Injury: _____ a.m. ☐ p.m. ☐ Was Safety Equipment Used? Yes ☐ or No ☐

Date Returned to Work (if applicable): _____ Did Injury Occur on Employer Premises? Yes ☐ or No ☐

Address or Location of Injury: _____

Description of Injury:

(See Codes on Second Page)

Body Part Injured

(If code 90, Multiple Injury, please specify body part codes for each body part injured.)

Nature of Injury

Cause of Injury

Date Employer Notified of Injury: _____

Injury Reported to: _____ Witness: _____

**Type of Treatment (please check one)**

- ☐ No Treatment
- ☐ On-Site Treatment
- ☐ Clinic
- ☐ Emergency Room
- ☐ Hospitalization

**If treatment sought, please specify provider of treatment:**

Medical Practitioner, Clinic or Hospital Name: _____

Mailing Address: _____

City: _____ State _____ Zip _____

Telephone No. : _____

## EMPLOYER/EMPLOYMENT INFORMATION:

Federal ID No.: _____ # Employees: _____

Employer Name (DBA): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone No. : _____ County Where Employer Located: _____

Employer signature: _____ Date _____

Employment Type: ☐ Regular or ☐ Temporary

Emp. Status: ☐ FT ☐ PT ☐ Seasonal ☐ Volunteer

Date Employee Hired: _____

Employee's Position: _____

Employee's Time in Current Position: _____

Employee's Hours Per Week: _____

Employee's Current Wage:

$ _____ per _____

## CLAIM OFFICE INFORMATION

NAICS for Employer Being Insured (Nature of Business): _____

Carrier Code _____ FEIN (Claim Office) _____

Claim Office _____

Claim Office Address _____

City _____ State _____ ZipCode _____

Telephone _____

Email Address _____

Claim Office Claim # _____

Date Notified _____ Date to DOL _____

☐ Check if Claim Office is same as Insurance Provider

If not, you must complete the following

UNDERLYING INSURANCE PROVIDER INFORMATION

Carrier Code (If applicable) _____ FEIN (Insurance Provider) _____

Represented Entity Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

Policy Number _____

Effective Dates _____

Adjuster/Contact Person _____

For information regarding the Workers' Compensation System please visit www.sdjobs.org

## STATEMENT OF WEEKLY EARNINGS

If the actual payroll records reflect the format below, a printout of the records can be attached. If not, please complete this form.

INSTRUCTIONS:

1. Give employee's regular weekly earnings and **overtime hours** in separate columns for the 52 weeks prior to the date of injury. Do not include any sums paid the employee for expenses due to the special nature of his/her employment. Whatever allowances specified as a part of the wage contract in lieu of wages shall be deemed a part of the employee's earnings.
2. If the above information cannot be given, show:
   - ☐ Weekly earnings of employee for the length of time he/she has been in your employ.
   - ☐ Weekly earnings of a similar worker in the same class of work either in your employ or in the same locality for same period as checked in item (1) above.
3. If above information cannot be given show weekly earnings for any employee who has worked during the same period checked above.
4. How many days constitute your normal work week?_____ How many hours?_____
5. Give hourly rate _____ Weekly rate _____
6. If the employee was not paid on a weekly basis, explain fully give his/her earnings for the period checked above.

   _____

   _____

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| Week No. | Week From Date | Week To Date | Number of days worked | Amount paid exclusive of overtime | Overtime hours worked or OT earnings |
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