TENNESSEE WORKERS' COMPENSATION INSURANCE

POSTING NOTICE

How to Report Work-Related Injuries

What should be done if injured at work?

Employee

1. Immediately **report the injury** to the employer representative named below.
2. **Select a treating physician** from a panel provided by your employer.
3. If you have questions or problems, contact the employer representative or the Bureau of Workers' Compensation.

Employer

1. Complete your company's internal "Workplace Injury form" and **notify your workers' compensation insurance company** immediately, even if you have concerns about the validity of the claim.
2. **Offer a panel of physicians** to the employee via Form C-42 available on the Bureau's website. *In cases of emergency, call an ambulance and provide this form as soon as the injured employee has stabilized.*

_____

*Printed **name and title** of the employer representative to be notified in the event of a work-related injury*

_____

*Printed name of an **alternative employer representative** to be notified in the event of a work-related injury*

_____

***Telephone number** of employer representative to notify in event of a work-related injury*

_____

***Address** of employer representative to notify in event of a work-related injury*

The Tennessee Bureau of Workers' Compensation is available to help both employees and employers.

BWC Bureau of WORKERS' COMPENSATION

220 French Landing Dr. 1-B
Nashville, TN 37243-2667

800-332-2667

615-532-4812 *TTD: 800-332-2257*

tn.gov/workerscomp

Workers' Compensation law requires this notice to be posted in a conspicuous place at the work site at all times.

LB-0922 (REV. 4/18) Authorization No. 337545 RDA 10183

SEGURO DE COMPENSACIÓN A TRABAJADORES DE TENNESSEE

PUBLICACIÓN DE AVISO

Cómo informar de lesiones laborales

¿Qué se debe hacer en caso de lesión laboral?

Empleado

1. **Informe** inmediatamente de **la lesión** al representante del empleador indicado aquí abajo.
2. **Seleccione un médico tratante** del panel provisto por su empleador.
3. Si tiene alguna pregunta o problema, comuníquese con el representante de empleadores de la Oficina de Compensación a Trabajadores.

Empleador

1. Complete el formulario interno de su empresa de "Lesión laboral" y **notifique a su aseguradora de compensación a trabajadores** inmediatamente, incluso aunque tenga dudas acerca de la validez de la reclamación.
2. **Ofrezca un panel de médicos** al empleado a través del Formulario C-42, disponible en el sitio web de la Agencia. *En casos de emergencia, llame a una ambulancia y proporcione este formulario en cuanto el empleado lesionado se haya estabilizado.*

_____

Nombre en letra de molde y título *del representante del empleador a ser notificado en caso de una lesión laboral*

_____

Nombre en letra de molde del ***representante del empleador alterno*** *a ser notificado en caso de una lesión laboral*

_____

Número de teléfono *del representante del empleador a ser notificado en caso de una lesión laboral*

_____

Dirección *del representante del empleador a ser notificado en caso de una lesión laboral*

La Oficina de Compensación a Trabajadores de Tennessee está disponible para ayudar a empleados y empleadores.

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La ley de Compensación a Trabajadores exige que se publique este aviso en un lugar visible en el centro de trabajo en todo momento.

LB-0922 (REV. 4/18) Autorización No. 337545 RDA 10183

TENNESSEE 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 Work Injury or Illness (LB-0021)

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 Work Injury or Illness may be submitted to us online at: www.berkindcomp.com. Online Reporting Instructions are enclosed. Maintain a copy of the Employer's First Report of Work Injury or Illness 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 Work Injury or Illness. If the Employer's First Report of Work 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 (Form C-41, LB-0384)

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

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

Do not delay reporting the Employer's First Report of Work 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).

Choice of Physician

Copies, in English and Spanish, of the Agreement between Employer/Employee Choice of Physician (Form C-42) are enclosed. This form must be completed and signed by you and the injured worker to designate the treating physician. If you do not have physicians in your area that you can use relative to your workers' compensation claims, please contact our adjuster or branch manager and we will help you establish your panel. After you have completed this form, please send us a copy.

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)

CLAIMS ADM CLAIM # (INSURER CLAIM #)

OSHA LOG CASE #

CLAIM TYPE CODE
- ☐ MED ONLY
- ☐ INDEMNITY
- ☐ BECAME LOST TIME
- ☐ BECAME MED ONLY
- ☐ NOTIFY ONLY
- ☐ TRANSFER

NAME OF INSURANCE CARRIER

CARRIER FEIN

CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)

FEIN OF CLMS ADM

CLAIMS ADJUSTER NAME

CLMS ADJ PHONE #

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE TENNESSEE WORKERS' COMPENSATION LAW AND MUST BE COMPLETED AND FILED WITH YOUR INSURANCE CARRIER IMMEDIATELY AFTER NOTICE OF INJURY.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS' COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

IF YOU HAVE QUESTIONS, THE STATE NOW HAS A BENEFIT REVIEW SYSTEM WHERE A WORKERS' COMPENSATION SPECIALIST CAN PROVIDE ASSISTANCE. CALL 1-800-332-2667 (TDD).

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2

CITY | STATE | ZIP

EMPLOYER

EMPLOYER NAME

EMPLOYER FEIN

SIC CODE

PHONE NUMBER

EMPLOYER ADDRESS LINE 1 AND LINE 2

NATURE OF BUSINESS

CITY | STATE | ZIP

INSURED REPORT #

EMPLOYER LOCATION

POLICY

INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)

POLICY NUMBER

SELF INSURED? ☐ YES ☐ NO

EFF DATE

EXP DATE

EMPLOYMENT STATUS CODE
- ☐ FULL TIME/REGULAR
- ☐ PART TIME
- ☐ PIECE WORKER
- ☐ SEASONAL
- ☐ VOLUNTEER
- ☐ APPRENTICE FULL TIME
- ☐ APPRENTICE PART TIME

EMPLOYEE

EMPLOYEE LAST NAME

PHONE INCL AREA CODE

FIRST | MI

DEPARTMENT REGULARLY WORKED

ADRRESS LINE 1 & 2

GENDER
- ☐ MALE
- ☐ FEMALE
- ☐ UNKNOWN

OCCUPATION DESCRIPTION

CITY | STATE | ZIP

MARITAL STATUS
- ☐ UNMARRIED, SINGLE, DIVORCED
- ☐ MARRIED
- ☐ SEPARATED
- ☐ UNKNOWN

NCCI CLASS CODE

SSN | DATE OF BIRTH | DATE OF HIRE

WAGE

WAGE $

PERIOD
- ☐ HOURLY
- ☐ DAILY
- ☐ WEEKLY
- ☐ BI-WEEKLY
- ☐ MONTHLY

NUMBER OF DAYS WORKED PER WEEK

SALARY CONTINUED IN LIEU OF COMPENSATION ☐ YES ☐ NO

FULL WAGES PAID FOR DATE OF INJURY ☐ YES ☐ NO

ACCIDENT/INJURY

DATE OF INJURY

TIME OF INJURY ☐ AM ☐ PM ☐ COULD NOT BE DETERMINED

TIME EMPLOYEE BEGAN WORK ON INJURY DATE ☐ AM ☐ PM

DATE EMPLOYER NOTIFIED OF INJURY

BODY PART AFFECTED CODE

NATURE OF INJURY CODE

CAUSE OF INJURY CODE

DATE CLAIM ADM NOTIFIED OF INJURY

DATE LAST DAY WORKED

DATE DISABILITY BEGAN

RETURN TO WORK DATE (IF APPLICABLE)

HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.

DATE OF DEATH (IF APPLICABLE)

IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP
- ☐ WIDOW
- ☐ WIDOWER
- ☐ MOTHER
- ☐ FATHER
- ____ DAUGHTER
- ____ SON
- ____ SISTER
- ____ BROTHER
- ____ HANDICAPPED CHILD

TOTAL # DEPENDENTS

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

ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)

CITY | STATE | ZIP

COUNTY OF INJURY

TREATMENT

PHYSICIAN NAME

HOSPITAL OR OFF SITE TREATMENT NAME

ADDRESS LINE 1 AND 2

ADDRESS LINE 1 AND 2

CITY | STATE | ZIP

CITY | STATE | ZIP

INITIAL TREATMENT
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYER
- ☐ MINOR BY CLINIC/HOSPITAL
- ☐ HOSPITALIZED > 24 HRS
- ☐ EMERGENCY CARE
- ☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

DATE PREPARED | PREPARER'S NAME & TITLE | PREPARER'S COMPANY NAME | PHONE NUMBER

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002

FORM C-42

EMPLOYEE'S CHOICE OF PHYSICIAN

An employer must provide a partially-completed form listing at least three physicians to an employee upon the report of a workplace injury. The employee must complete and then sign and date the section below that indicates the physician chosen. A copy of the fully-completed form should be provided to the employee with the original kept on file by the employer. If the employee refuses to accept medical services from the chosen physician, the employee's rights to benefits may be delayed. **NOTE**: Employees traveling more than 15 miles one way to or from medical treatment may seek reimbursement of their travel expenses from the insurance carrier.

TO BE COMPLETED BY THE EMPLOYER:

Employer _____ Date of Injury _____

Employer Contact _____ Phone _____ Email _____

Physician Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Physician Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Physician Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

TO BE COMPLETED BY THE EMPLOYEE:

I have selected the following physician from the list provided to me by my employer:

Physician Name _____ Date Selected _____

Employee Name _____ Appt Date/Time _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Employee Signature _____ Date _____

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002

FORM C-41

WAGE STATEMENT

EMPLOYEE: _____ SSN: _____ STATE FILE #:_____

Employer _____ Ins Claim # _____ Date of Injury: _____

Please list the wages earned by the employee named above during each of the 52 weeks prior to date of injury, if applicable.

WEEK	WEEK ENDING	GROSS WAGES	WEEK	WEEK ENDING	GROSS WAGES
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	$0.00

Date: _____ Name of Preparer and Title _____