Table of Contents

Virginia Workers' Compensation Claim Kit

ARGENT®
A DIVISION OF WEST BEND

– Vision –

To be the company of choice for associates, agents, and policyholders.

– Mission –

Exceed in service. Lead in results.

– Core Values –

Excellence

Integrity

Innovation

WORKERS' COMPENSATION REPORTING TIPS

– ATTENTION–
YOU MAY BE FINED IF YOU DO NOT REPORT ON–THE–JOB INJURIES ON TIME

You must complete an Employer's First Report of Injury immediately after an on–the–job injury occurs and forward the report to Argent. **You may be fined if you do not submit the report on time.**

Report online, fax, or email the Employer's First Report of Injury even if you do not have all the information about the injury.

- Do not wait for medical bills.
- Do not withhold the Employer's First Report of Injury because you believe the claim is questionable. Reporting a loss is not an admission of liability.
- Be sure to include the claim number on all correspondence.

Claim Reporting Options for NEW LOSSES ONLY:

- Online Reporting (Insured Access) - Our online reporting system is referred to as Insured Access. Online claim reporting is our **preferred** method, and allows you to instantly obtain confirmation of your report, as well as the claim number. Insured Access also allows you to have limited access to claim notes, claim reserves, and loss control resources. In order to set up Insured Access, please contact your dedicated claim representative. Or,
- Fax: 888-926-9299 or,
- Email: ArgentWCCLossScanCtr@wbmi.com

Do not withhold the Employer's First Report of Injury for any reason. You may be fined if the claim representative cannot make the initial lost time payment because you failed to send the Employer's First Report of Injury on time.

If you need to notify your agent, please send your agent a copy of the Employer's First Report of Injury and indicate the report has been filed with Argent. Direct reporting saves time.

If you have any questions, please call your claim representative.

For any follow up correspondence, please refer to the below instructions:

Submit follow up correspondence with the claim number to:

- Fax: 888-926-9299
- Email: Argent_WCC_scan_ctr@wbmi.com

HOW TO WRITE INJURY DESCRIPTIONS

The following instructions will help you avoid some common errors and save time when describing an injury on the Employer's First Report of Injury form.

For most accidents, you can describe what happened in one or two sentences. "He strained his lower back lifting a box." "She bruised her left knee when she fell on a wet floor." However, your descriptions must be specific. "Hurt back working" does not provide enough information.

Answer the following questions when describing an injury:

1.What part of the body was injured?

- Lower back
- Upper right leg
- Right forearm
- Third toe on left foot

2. How did the accident happen?

- Did the person fall?
- Did they twist their body as they got out of a chair?
- Were they moving or stationary when the accident happened?

3. Was the injured person carrying anything?

Even if it probably didn't cause the injury, we need to know if the person was carrying anything. For example, "Carrying broom, stepped wrong and twisted left ankle."

4. What specifically appears to have caused the accident?

If someone hurt their back lifting a box, say that. Don't say:

- Lifting a unit of material
- Lifting equipment
- They hurt their back lifting product

Avoid jargon or trade names for equipment. Explain precisely what they were doing.

- Lifting an air conditioner
- Carrying magazines
- Pushing a cart
- Bending over to pick up a wrench

If a machine caused the injury, tell us what kind.

- A grinder
- A shear
- A hoist

Again, avoid jargon or trade names.

5. What injury appears to have resulted?

- Strain
- Bruise
- Fracture
- Cut

Please be sure to include the injured person's birthdate or age and Social Security number. Also, indicate the geographical location of the accident (city, county, and state).

First Report of Injury

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond Virginia 23220
1-877-664-2566

SEE INSTRUCTIONS ON REVERSE SIDE

www.vwc.state.va.us

Reason for filing: _____
VWC Jurisdiction Claim #: (If assigned) _____
Claim Administrator File#: _____

Employer

Employer's Legal Name	Federal Employer Identification Number (FEIN)
Employer's Mailing Address	
Name/FEIN of Entity on Policy	Nature of Business
Name and Address of Insurer or Self-Insurer for this Claim	Policy Number

Time and Place of Accident

Location where accident occurred	Date of injury	Hour of injury ☐ a.m. ☐ p.m.
Date injury or illness reported	If fatal, give date of death If fatal, give number of dependent children	If fatal, give marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Injured Worker

Name of Injured Worker	Phone Number	Injured Worker ID Number
Injured Worker's mailing address		Type of ID ☐ Social Security No. ☐ Employment Visa ☐ Green Card ☐ Passport No. ☐ Unknown
Occupation at time of injury or illness	Date of birth	Sex ☐ Male ☐ Female

Nature and Cause of Accident

Machine, tool, or object causing injury or illness
Describe fully how injury or illness occurred
Describe nature of injury, occupational disease, or illness, including body parts affected

Signatures

Submitter (name, signature, title)	Date	Phone number
Submitter's Address		

First Report of Injury

Filing Instructions

The Virginia Workers' Compensation Act requires that **ALL** injuries occurring in the course of employment be reported to the Commission pursuant to Va. Code §65.2-900.

Employer

The employer is responsible for accurately completing all sections of this form when an employee is injured. It should be typed or legibly printed, signed, and dated by the preparer. Send the original form to the claim administrator for the insurance company who provided insurance coverage on the date of the occurrence. The claim administrator will report this information to the Commission. Contact your workers' compensation insurance provider for additional information.

Claim Administrator

Claim administrators who are EDI enabled will use the information contained on the paper form and submit electronic data to the Commission.

Claim administrators who are NOT EDI enabled must immediately file the completed form with the Commission. Please note: EDI is mandatory no later than June 30, 2009, after which time paper reports will no longer be accepted. Until you are in EDI production, mail the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. At the top of the form, use a numerical code (1-7) to indicate the reason for filing the form for accidents meeting one of the filing criterion.* If none of the criteria apply, you must still report the accident, but may use either Form 45A or this form to do so. (Leave "reason for filing" blank in such a case.)

For questions or assistance in completing the form, please contact the Commission toll-free at 877-664-2566.

*Criteria for filing are: (1) lost time exceeds seven days; (2) medical expenses exceed $1,000.00; (3) compensability is denied; (4) issues are disputed; (5) accident resulted in death; (6) permanent disability or disfigurement may be involved; and (7) a specific request is made by the Virginia Workers' Compensation Commission.

WORKERS COMPENSATION
COST CONTAINMENT INITIATIVES

Argent participates in several medical cost containment programs. The use of these programs helps reduce your workers' compensation expenses. A brief summary of each program is outlined below.

If you have any questions about any of the programs we offer, please call your dedicated claim representative at 888-236-5008.

PHARMACY PROGRAM

This program is designed to provide discounts on workers' compensation prescriptions submitted by your injured worker's. This service is provided by a national pharmaceutical management company using a network of retail pharmacies.

How the program works:

1. The injured worker files a workers' compensation claim with employer, seeks medical treatment, and receives a prescription from a provider.
2. The injured worker presents the prescription along with the temporary ID form to a participating pharmacy where the claim is electronically submitted by the pharmacy to our vendor.
3. Once Argent receives notification of the claim from the employer, an employee ID drug card is issued, along with a list of participating pharmacies and instructions on the use of the program.
4. The injured worker presents the ID drug card to a participating pharmacy for any workers' compensation prescriptions.
5. High cost/long term use medications are conveniently supplied through our vendor's mail service pharmacy.

DIAGNOSTIC TESTING PROGRAM

Using the services of a diagnostic management vendor, we can save money on diagnostic tests (i.e., CT scans, MRIs, EMGs, etc.) the treating provider orders for injuries an employee sustains in a work-related incident. Our vendor will schedule the test then notify the injured worker of the date, time, and location. Once the test is performed the films/x-rays will be forwarded to the referring provider.

To make this program successful, we ask that you encourage your employees to contact their Argent claim representative as soon as their provider orders a diagnostic test. We will handle it from there.

MEDICAL COST CONTAINMENT

Strong medical management brings about the early and safe return to work of your employees and reduces claim costs. In order to control the medical bill costs, we contract with a medical bill review service. All of our medical provider charges (hospital, physician, physical therapist, chiropractor, and pharmaceutical) are verified for the appropriateness of the charge, and to determine if they adhere to state mandated fee schedules or local usual and customary (U&C) reimbursement levels. This process often reduces our medical expenses by 10-30%.

Another way we are containing costs is through the use of PPO Networks. The Preferred Providers have agreed to discount their billings to the agreed upon PPO Network rates for our insured's injured workers. This in turn keeps your premium costs down.

Your support in encouraging your injured workers to use a PPO provider is important. It sends an important message to the medical care providers that we support them in their effort to offer quality, cost effective care to patients.

For a list of PPO's in your area, please visit our website, www.argentworkerscomp.com for a link to the PPO Directory.

Argent
Workers' Compensation Prescription Information

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

Employee Name:	
Group#:	10602464
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
Day supply is limited to 30 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:

Employee:

Argent has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 5 to 15 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist: Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

---

myMatrixx™
good medicine for business

P.O. Box 274070
Tampa FL • 33688
877.804.4900

ARGENT™
A DIVISION OF WEST BEND

Joe Sample
123 2nd Street
Anywhere, FL 33635

Thu May 24 12:50 EDT 2007

RE: Argent Workers' Compensation Prescription Drug Program

Dear Joe Sample,

Argent has contracted with myMatrixx to have prescriptions for your work related injury filled at no expense to you.

What is Covered?
Only medication(s) prescribed by your authorized treating physician for your work-related injury will be approved. This program does not cover prescriptions for any other medical condition.

What do I do?
After receiving your prescription from your workers' compensation physician, visit any network pharmacy and present your prescription and prescription card. Your pharmacy will submit the required information to myMatrixx. You do nothing else.

In the event there is a problem processing your prescription(s) please call or have the pharmacist call myMatrixx 24 hours a day, 7 days a week at 877-804-4900.

Which pharmacies can I use?
Your prescription Card is honored at over 60,000 pharmacies nationwide. Here are just a few in your area. For more network pharmacy locations, please call 877-804-4900.

Walgreens Pharmacy
1211 Hillsborough Ave.

CVS #5196
11670 Country Way Blvd.

CVS Pharmacy
8801 W. Linebaugh Ave.

Publix Pharmacy
8975 Race Track Rd.

Publix Pharmacy
12139 W. Linebaugh Ave.

Publix Pharmacy
7835 Gunn Highway

Walgreens Pharmacy
7925 Gunn Highway

Kash N Kerry Pharmacy
10617 Sheldon Road

CVS Pharmacy
7920 Gunn Highway

Answers to your questions.

1. What is this card?
This card is for your workers' compensation prescription needs. Please take this card to the pharmacy when you are filling medications for your work-related injury.

2. Why did I receive this card?
You received this card due to an injury that occurred on the job.

3. What if I am not currently taking any medications due to the injury?
Please put the card in a safe place in case you start taking medications for your current injury.

4. When should I use this card?
Anytime you need to fill a medication for your work-related injury.

5. Are all medications pre-approved?
Your insurance company may have pre-selected medications that will go through without authorization. If you drop off a prescription at the pharmacy and it rejects for any reason the pharmacy should call us and we will call your insurance co. for approval. If you would like to know the types of medications that are pre-approved before going to the pharmacy, please call 877-804-4900 and a customer service rep will be happy to assist you.

6. Can my family members use this card?
No, this is only for your work-related injury.

7. What should I do if there is a problem with my card when I take it to the pharmacy?
Your pharmacy should call us with any problems they are having with the card. If for ANY reason they do not call us, or if you have any questions regarding your work-related medications, please call our customer service team at 877-804-4900.

8. Are you my workers' compensation insurance company?
No, we were contracted by your workers' compensation insurance company to handle all of your work-related prescription needs.

9. What happens if my medication doesn't provide any relief from my symptoms or pain?
You should contact your doctor or our pharmacist to verify that the medication prescribed for your pain is the most appropriate for your condition.

10. Should I tell my doctor about other medications I am taking not related to my injury?
Yes, it is very important that your physician and pharmacist know ALL the medications you are currently taking. Some medications may counter the effect of other medications you are taking and some may even be harmful or life threatening when taken together. If you are unsure of your current medications, call our myMatrixx pharmacist.

11. Can I talk to one of your pharmacists if I have a question?
Yes, our pharmacists are available to answer all of your medication related questions.

For any additional questions please contact myMatrixx at 877-804-4900

Patient - You must present this identification card each time you go to the pharmacy for your authorized prescriptions only. If you are denied medication, please call.

Pharmacist - For questions, please call 24 hours a day, 365 days a year. Dispensed quantity of medications is limited to a 30 day supply. Do not send patient home without first contacting myMatrixx for all rejections.

Note: Insurance company has pre-approved certain medications for this patient; these medications will process without an authorization. Any medications that are rejecting, must be called into myMatrixx for authorization.

Any questions or problems, please call:
877.804.4900

ARGENT
A DIVISION OF WEST BEND

THE BEST REMEDY FOR WORKERS' COMPENSATION™

AUTHORIZATION TO DISCLOSE NON-PUBLIC PERSONAL HEALTH INFORMATION AND WAIVER OF PRIVILEGE

TO:

Patient Name:
Claim Number:
Birth Date:
Social Security Number:

I hereby authorize the above named health care provider to give to, release, and permit copies to be made of all health care records that are in your possession.

The health care records should be disclosed to any authorized representative of Argent, a division of West Bend Mutual Insurance Company. Argent, a division of West Bend Mutual Insurance Company, is the insurer for the employer and acts as its agent for insurance purposes.

The purpose of the disclosure of these records is to aid Argent's, a division of West Bend Mutual Insurance Company, evaluation of my claim.

Argent, a division of West Bend Mutual Insurance Company, may re-disclose my records to others retained by Argent, a division of West Bend Mutual Insurance Company, to assist in the evaluation of my claim. Re disclosure of this protected health information will no longer be protected under any federal or state privacy law.

The type of information to be disclosed may include, but not limited to, x-rays, x-ray reports, summaries, reports, narratives, test results, notes and any other health care record from all in-patient visits at your institution or facility.

This authorization also permits release of all information relating to treatment for:

(a) drug and/or alcohol abuse;
(b) any mental disease, defect, or psychological/psychiatric condition;
(c) any communicable disease, AIDS, or AIDS-related disease.

I understand that executing this authorization is a waiver of my privileges of physician-patient confidentiality, and I freely and voluntarily waive that privilege.

The above-named health care provider may not condition treatment, payment, enrollment or eligibility of benefits on obtaining your authorization.

A photocopy or facsimile of this authorization shall be valid and effective just as the original.

I understand that I may revoke this authorization in writing to the records department of the above named health care provider at any time, except where information has already been released as a result of this authorization.

Unless revoked, this authorization shall remain in affect for the period of one year beyond the date of patient's signature, or until my claim is closed, whichever is later. Records may be disclosed whether dated before or after the date of this authorization.

I understand that I or my authorized representative is entitled to receive a copy of the completed authorization form.

_____ _____

Signature of Patient/Claimant Date

_____ _____

Signature of Patient/Claimant Date

WR-0210(7-18)

Regardless of normal job duties, light duty work will be accommodated.
Please prepare restrictions below:

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Claim No.

Patient's Name (First) (Middle Initial) (Last)

Date of Injury/Illness

TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK

Diagnosis/Condition (Brief Explanation)

I saw and treated this patient on _____ (date) and based on the above description of the patient's current medical problem:

1. ☐ Recommend his/her return to work with no limitations on _____ (date)

2. ☐ He/She may return to work on _____ (date) **capable of performing the degree of work checked below with the following limitations:**

- ☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.
- ☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.
- ☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.
- ☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.
- ☐ **Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.
- ☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8 hour work day patient may:
   a. Stand/Walk
      ☐None ☐1-4 hours ☐4-6 hours ☐6-8 hours
   b. Sit
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
   c. Drive
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
2. Patient may use hand(s) for repetitive:
   ☐Single Grasping
   ☐Pushing & Pulling
   ☐Fine Manipulation
3. Patient may use foot/feet for repetitive movement as in operating foot controls:
   ☐Yes ☐No
4. Patient is able to:

	Frequently	Occasionally	Not At All
a. Bend	☐	☐	☐
b. Squat	☐	☐	☐
c. Climb	☐	☐	☐
d. Twist	☐	☐	☐
e. Reach	☐	☐	☐

Other Instructions and/or Limitations Including Prescribed Medications:

These restrictions are in effect until _____ (date) or until patient is re-evaluated on _____ (date)

3. ☐ He/She is totally incapacitated at this time. Patient will be re-evaluated on _____ (date)

Physician's Signature

Date

Print name:

Phone number

Facility Name:

Loss Control Services

Argent offers a comprehensive, proactive approach to managing your workers compensation exposures. Our goal is to enhance the current safety culture within your organization. This is a sample of the variety of services Argent's Loss Control Department may provide.

- Comprehensive assessment of exposures specific to the operations that may impact workers safety:
  - Assessment of established controls for the physical environment;
  - Assessment of management approach to safety;
  - Employee responsibilities for safety;
  - In depth analysis of losses; and
  - Identification of loss drivers.
- Development of a comprehensive, collaborative safety plan to address those factors affecting the workers compensation program.
- Onsite and job site specific assessments of physical exposures:
  - Machine guarding;
  - Ergonomics;
  - PPE use; and
  - Identification of hazards in the workplace.
- Training of management, supervisors, and key personnel:
  - Accident investigation;
  - Costs and effects of workers compensation insurance;
  - Transitional return to work programs;
  - Safety roles;
  - Accountability; and
  - Loss drivers, observations, and opportunities to improve operational safety.

- Development of specific safety recommendations based on observations and interactions with management and employees.
- Hands-on approach for assisting in the development and implementation of safety recommendations.
- Personalized consultation for management based on the customer's individual needs.
- Hands-on assistance with developing:
    - Transitional return to work program;
    - Slip/fall prevention programs;
    - Safe patient/resident handling programs for medical facilities;
    - Effective safety committee;
    - Ergonomic committee;
    - Injury review committee; and
    - Fleet safety programs.
- Periodic service review meetings are provided to assure your needs are being addressed.
- Resources available for OSHA programs, training videos, and training documents.

The Silver Lining® ADVANTAGE

With the **Silver Lining Advantage,** you benefit from the expertise and guidance of qualified nurse case managers. Using their experience in the medical field, these professionals carefully examine the medical aspects of your company's workers' compensation claims to reduce the claim costs and the duration of the disability. This not only helps control the cost of these claims, it results in a more positive outcome for your employees and your company.

The **Silver Lining Advantage** program offers a variety of services customized to help your company reduce your workers' compensation claim costs. These services include:

- Reducing medical and disability costs through a collaborative approach;
- Expert medical resources available to all accounts;
- An average of 24 years of experience for each member of your nurse case manager team;
- A focus on building relationships with the medical community; and
- The ability to capture and report cost savings.

WEST BEND®

THE SILVER LINING®

WB-2593 (4-13)

ARGENT- Claim Practices

Initial Contacts – Within 24 hours of receipt of claim, contacts made to employee, employer and medical provider.

Investigation – Investigation of claims is to include, but not limited to: recorded statements of employees and witnesses, requesting prior and present medical records, obtaining job descriptions or videos, subrogation potential, Independent Medical Evaluations, and other investigative services when necessary.

Transitional Return to Work - Will be addressed immediately. Consult with employer as to availability and the importance of prompt return to work.

Reserves - Set for known and probable exposures based on the facts of the case. If the reserves exceed $25K the Claims Representative will complete a reserve letter explaining the basis for the numbers and send to Employer, Agent, Underwriter, Loss Control and Claims Assistant Vice President.

Denials – After claim is denied, it will remain open based on the merits of the case. Upon denial, letters will be sent from Claims Representative to employee, employer, and medical provider.

Dedicated Claim Team- Lost time and medical only claim professionals will be assigned to your account.

Managed Care Program- We have a team of highly knowledgeable nurses who are proficient in treatment protocols and in getting the right care at the right time to injured workers.

Narcotic Program – Comprehensive internal program to mitigate the use of narcotic medications through education, early intervention and evaluation to facilitate favorable outcomes.

Sample Panel of Physicians Form

Section 65.2-603 of the *Virginia Workers' Compensation Act* requires employers to provide a panel of at least three physicians. You must select a physician from this panel to treat your work-related injury.

If you do not use one of these physicians for your work-related injury, you may be responsible for the cost of medical care and you may jeopardize your entitlement to workers' compensation benefits as outlined in the Act.

Please select a physician from this panel, complete and sign the form and return it to your supervisor.

Physician #1: _____

Physician #2: _____

Physician #3: _____

I have been presented with a panel of at least three physicians and have selected:

_____

to provide me with medical care for my work-related injury.

Employee's Signature: _____

Employee Printed Name: _____

Date: _____

Date of Injury: _____

Employer Name: _____

Form VWC1

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.

2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.

3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.

4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.

2. Report the injury to the Commission through your carrier or directly to the Commission.

3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. Franklin St
Richmond, Virginia 23219

1-877-664-2566
www.workcomp.virginia.gov

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

Subrogation

What is subrogation? Subrogation is process by which an insured/insurer can recover the amount paid on a claim from a legally-liable party. The workers' compensation policy grants the insurer subrogation recovery rights.

Why is subrogation important to your business? Subrogation allows the first- party payer (typically the insurer) to recover money paid from the liable party, thereby reducing the total costs incurred, as well as your experience modifier. This means your premium will not increase if an employee is injured in an accident for which someone else is liable.

How can you help our subrogation efforts to maximize recoveries?

- Discuss/explain the subrogation process in your safety committee meetings.
- Advise employees who work at or travel to other worksites to notify you and the off-premises property owner of any unsafe exposures, such as accumulated snow/ice, cluttered walkways, unsafe stairways, generally slippery floors, poor lighting, etc.
- Educate employees who work at or travel to other worksites to take photographs of off-premises accidents, such as motor vehicle accidents, falls from ladders, construction scene accidents, etc.
- For construction site accidents, provide the name of the general contractor and a list of all subcontracts involved.
- Advise your employees to immediately notify the property owner when/where the accident occurred.
- Report the workers' compensation claim to Argent immediately; subrogation investigations are extremely time sensitive.
- When applicable, provide Argent or our representative with copies of rental agreements, contracts, owner's manuals, maintenance records, photographs, diagrams, invoices, certificates of insurance, etc.
- Do not discard or repair any equipment that may have led to your employee's injury (i.e., broken ladder). The item may need to be inspected/tested by an independent engineer.

Subrogation considerations:

- Would the at-fault party pursue a liability claim against your company if the tables were turned?
- If the injury to your employee and its effect on your employee's family were life changing, would that influence your decision to subrogate?
- Should your insurance premiums increase because of exposures you can't control?

Management Accident Investigation Report

To Be Completed By One Of The Following: Supervisor / Plt Manager / HR. Director

Employee	Dept.	Job Title
Shift:	Date of Injury Time AM or PM	
Location of Incident		
Date Reported / / Time Reported	Reported to Whom?	

NAME OF WITNESS	DEPARTMENT/ADDRESS	PHONE
(1)		
(2)		

Have witnesses fill out separate forms and give attach.

1. What was employee doing when injured? BE SPECIFIC

2. How did the injury/illness occur?

3. Was employee performing function alone? ☐ yes ☐ no

Employee was assisting with the operations?

4. Did injury occur because of: Failure to follow safety rules ☐

Failure to use safety device ☐ Other ☐

5. How long has employee been doing this job? (days, months, years)

6. What safety equipment is required on the job the employee was performing?

7. Was the employee using all required safety equipment? Yes ☐ No ☐

8. If No, which specific personal protective equipment was not used & why?

9. Does an unsafe condition exist that contributed to the cause, if so, what is that condition?

10. How could the accident have been prevented? BE SPECIFIC

RECOMMENDED ACTION			**Person Responsible**	**Assigned Date/Completed Date**
Re-instruction	Yes ☐	No ☐	_____	_____/_____
Equipment repair/replacement	Yes ☐	No ☐	_____	_____/_____
Reduce Clutter	Yes ☐	No ☐	_____	_____/_____
Improve design/construction	Yes ☐	No ☐	_____	_____/_____
Workstation Modification	Yes ☐	No ☐	_____	_____/_____
Discipline of person(s) involved	Yes ☐	No ☐	_____	_____/_____
Other				

Signature of Person Completing Investigation: _____

Date: _____

Employee Accident Report

Name: _____ Accident Location: _____

Date of Injury: _____Time: _____a.m.☐ p.m.☐ Date Reported: _____

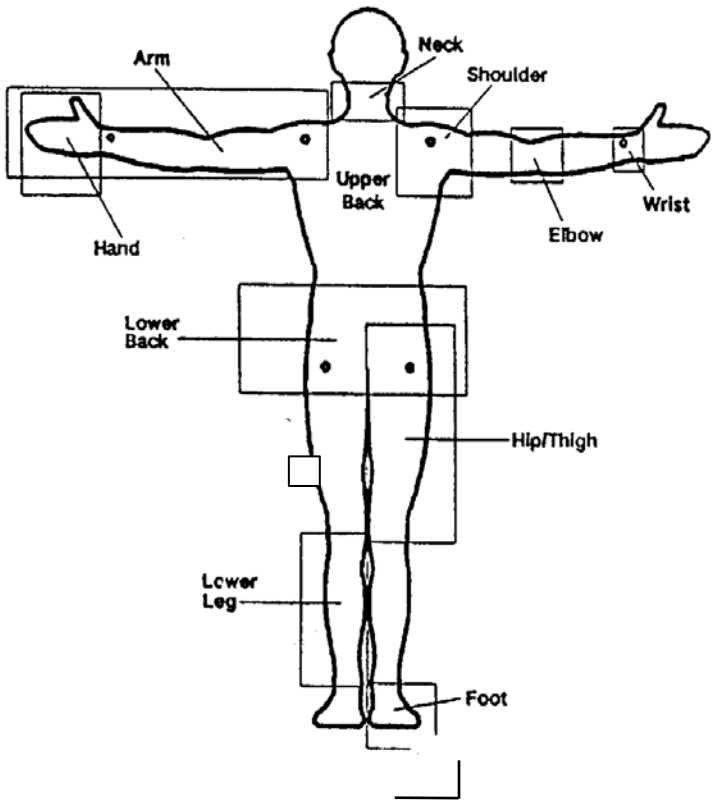
Witnesses:_____

Accident Description: _____

_____

_____

_____

Injured Area	Indicate Area of Injury	Type of Injury
1 ☐ Head 2 ☐ Eye: L / R 3 ☐ Shoulder L / R 4 ☐ Arm L / R 5 ☐ Elbow L / R 6 ☐ Wrist L / R 7 ☐ Hand L / R 8 ☐ Finger: Specify _____ 9 ☐ Back 10 ☐ Chest 11 ☐ Abdomen 12 ☐ Pelvis 13 ☐ Hip L / R 14 ☐ Leg L / R 15 ☐ Knee L / R 16 ☐ Ankle L / R 17 ☐ Foot L / R 18 ☐ Toe: Specify _____ 19 ☐ Other: _____ _____		1 ☐ Abrasion 2 ☐ Amputation 3 ☐ Bite: _____ 4 ☐ Bruise 5 ☐ Burn 6 ☐ Concussion 7 ☐ Cut / Laceration 8 ☐ Foreign Body 9 ☐ Fracture 10 ☐ Hearing Impaired 11 ☐ Infection 12 ☐ Pain: _____ _____ 13 ☐ Puncture 14 ☐ Rash/Derm. 15 ☐ Respiratory 16 ☐ Strain/Sprain 17 ☐ Other: _____ _____ _____

Have you ever injured this body part before? _____ if so, when? _____

Are you currently receiving medical treatment for the prior injury? _____

What do you believe caused this accident? _____

What can be done to prevent this from happening in the future? _____

_____

Signature: _____

Date: _____

WITNESS REPORT OF INCIDENT

Name: _____ Injured Employee Name: _____

Date of Injury: _____ Time of Accident: _____ (AM/PM)

Location where injury occurred:

_____

_____

_____

Describe activity prior to the accident:

_____

_____

_____

Describe the accident:

_____

_____

_____

What do you believe caused the accident:

_____

_____

_____

What part of the body was injured? _____

What do you think could prevent this type of accident from occurring again?

_____

_____

_____

Signed: _____ Date: _____

Temporary Work Schedule

DEFINITION: A form used by an employee returning to work in the Temporary Work Program.

POLICY
Every employee returning to temporary restricted work duty must use a Temporary Work Schedule. It is the employee's immediate supervisor's responsibility to thoroughly explain the use of the Temporary Work Schedule. The Temporary Work Schedule must be completed daily.
The temporary tasks assigned to you may or may not be normal and customary job duties.

The **employee's responsibility** to complete:

- Restrictions
- Symptom Control Techniques
- Date
- Hours Worked - Log Breaks, Rest and Lunch
- Duties Performed
- Employee Comments
- Employee Signature

The **supervisor's responsibility** to complete:

- Supervisor's Comments (document discussion of problems and actions taken)
- Supervisor's Signature

*The supervisor and employee must sign schedule daily.

Supervisors turn Work Schedule into Human Resources Department at end of week.

Employee should retain a copy for their file.

The Human Resources Department will forward copy to Argent Claims Representative and, if necessary, to treating physician

Temporary Work Schedule

Name:			Restrictions:	
Supervisor:			Symptom Control Techniques:	
Date	**Work Log (include breaks/lunch)**	**Tasks Assigned/Completed**	**Employee Signature and Comments**	**Supervisor Signature and Comments**
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

I clearly understand, take responsibility for, and acknowledge the limitations my physician, Dr. _____
has placed on me while participating in this Temporary work program.

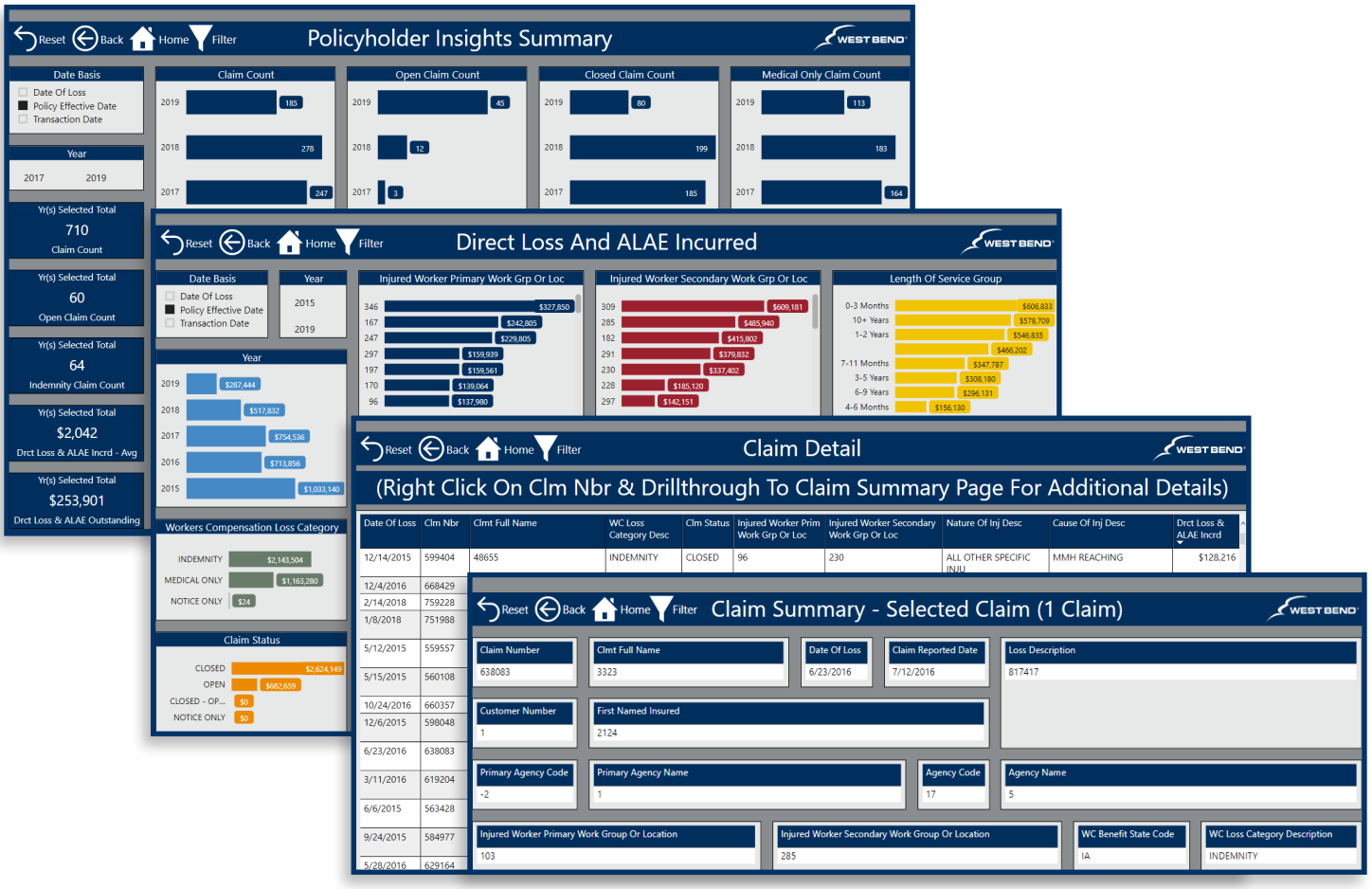
_____

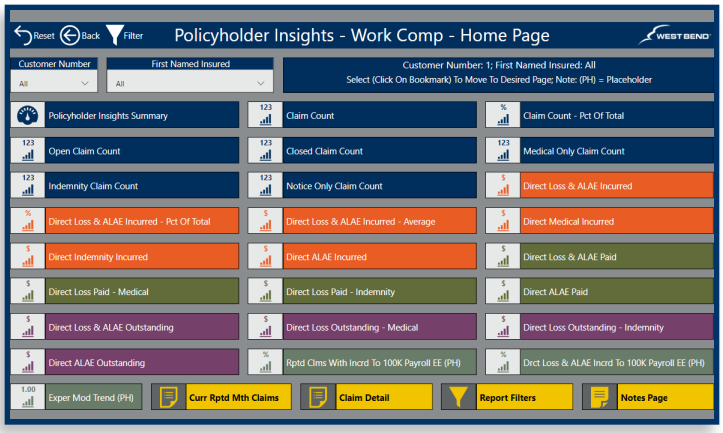
(Signature and Date)

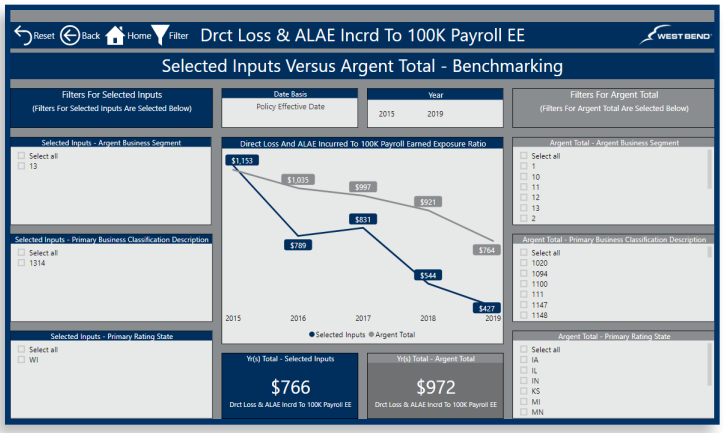
WEST BEND
A MUTUAL INSURANCE COMPANY®

Policyholder Insights Dashboard
WORKERS' COMPENSATION

Explore Your Workers' Compensation Data







Welcome to West Bend's Policyholder Insights Dashboard!

This new work comp dashboard offers sophisticated reporting with highly interactive data visualizations and benchmarking to allow for faster, easier, and better insights into claims-related data. In addition to intuitive results pages, you have the power to drill down and explore what's driving the data to better aid your decision making. The dashboard encourages collaboration among West Bend, our policyholders, and our agency partners to help produce exceptional results.

The Policyholder Insights Dashboard is accessible via West Bend's WBConnect website (www.wbconnect.com). Benchmarking is currently available to Argent/monoline work comp policyholders. Planned future enhancements include benchmarking that will include all work comp data and dashboards across all divisions and insurance lines.