

NOTICE!

Nebraska Workers Compensation

This business operates under Nebraska Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, OR AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR OR FOREMAN OF THE EMPLOYER.

Workers Compensation insurance benefits are provided through:



www.berkley.net.com

12701 Marblestone Dr, Ste 250

Woodbridge, Virginia 22192

877-497-2637

**Promptly Report all Claims: www.berkley.net.com; Email: Claims@berkley.net.com;
Fax 866.275.6320; Call 800.435.1127;**

www.berkley.net.com

Nebraska Workers' Compensation Court

NWCC Form 1
Revised 11/2006

First Report of Alleged Occupational Injury or Illness

Employer

Employer FEIN _____ SIC Code _____ Report Purpose _____ OSHA Log Case # _____	
Employer Name(s) _____ Address _____ City _____ State _____ Zip Code _____ Phone _____	Insured Name <i>(If different from employer name)</i> _____ Insured Address <i>(If different)</i> _____ Location _____

Insurance Carrier

Carrier FEIN _____ Administrator FEIN _____	
Name _____ Address _____ City _____ State _____ Zip Code _____ Phone _____ Policy Number _____ Policy Period: From _____ To _____ Insurance Carrier/Self-Insured Code # _____	Claim Administrator <i>(Name, address & phone number)</i> _____ Self Insured <input type="checkbox"/> <i>Check if Appropriate</i> Claim Administrator Claim # _____ Jurisdiction Claim # _____ Insured Report # _____ Jurisdiction _____

Employee

Name <i>(Last, First, Middle)</i> _____		Full Pay for DOI Yes <input type="checkbox"/> No <input type="checkbox"/>		Number of Days _____		Sex Male <input type="checkbox"/>	
Address _____		Salary Continued Yes <input type="checkbox"/> No <input type="checkbox"/>		Worked Per Week _____		Female <input type="checkbox"/>	
City _____		Number of Dependents _____		Occupational Job Title _____			
State _____ Zip Code _____ Phone _____		Marital Status		Wage \$ _____		Occupational Code _____	
Date of Birth _____		Married <input type="checkbox"/>		Hourly <input type="checkbox"/>		NCCI Class Code _____	
Social Security Number _____		Separated <input type="checkbox"/>		Daily <input type="checkbox"/>		Date Employee Began _____	
Date Hired _____		Unmarried <input type="checkbox"/>		Weekly <input type="checkbox"/>		Work-Related Duties _____	
		Unknown <input type="checkbox"/>		Bi-Weekly <input type="checkbox"/>		Employment Status FT <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/>	
				Monthly <input type="checkbox"/>			

Occurrence/Treatment

Date of Injury/Illness _____		Time Employee Began Work0 _____		Time of Occurrence _____		Last Work Date _____	
		AM <input type="checkbox"/>		AM <input type="checkbox"/>			
		PM <input type="checkbox"/>		(Cannot be determined <input type="checkbox"/> PM <input type="checkbox"/>			
Where Did Injury/Illness Occur? County _____ State _____ Zip _____				Did Injury/Illness Occur On Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Date Employer Notified _____		Date Disability Began _____		Date Returned to Work _____		If Fatal, Give Date of Death _____	
Type of Injury/Illness <i>(Briefly describe the nature of the injury or illness; e.g. lacerations to forearm)</i> _____							Nature of Injury Code _____
Part of Body Affected <i>(Indicate the part of the body affected by the injury/illness; e.g. right forearm, lowerback; and how it was affected)</i> _____							Part of Body Code _____
How Injury/Illness Occurred <i>(Describe activity and tools, materials, equipment the employee was using; how injury occurred)</i> _____							Cause of Injury Code _____
Initial Treatment: No medical treatment <input type="checkbox"/> First aid by employer <input type="checkbox"/> Minor clinic/hospital <input type="checkbox"/>		Emergency Room <input type="checkbox"/> Hospitalized overnight <input type="checkbox"/> Hospitalized > 24 hours <input type="checkbox"/>		Future major medical/lost time <input type="checkbox"/>		Name of physician or other health care provider: _____	
Date Administrator Notified _____		Form Preparer's Name, Title and Phone _____				Date Prepared _____	

General Instructions (Item—Definitions)

Items in bold are mandatory fields. First Report of Injury or Illness (FROI) without this information will be returned.

Employer:

- **Employer FEIN—the employer/insured's Federal Employer's Identification Number.**
- SIC Code—Standard Identification Classification code which represents the nature of the employer's business.
- Report Purpose—defines the specific purpose of the transaction. (examples: original=00; cancel=01; change=02; denial=04; correction=co).
- OSHA Log Case #—the Log Case number required for reporting to OSHA.
- **Employer Name—include all business names/doing business as (dba)**
- Address (including city, state, zip)—the address of the employer's actual location where the employee was employed at the time of the injury.
- Phone—phone number at the employer's facility.
- **Insured Name (if different from employer)—the named insured on the policy or the financially responsible self-insured employer.**
- Insured Address (if different from employer)—mailing address of the insured.
- Location—a code defined by the insured/employer which is used to identify the employer's location.

Insurance Carrier:

- **Carrier FEIN—carrier's Federal Employer's Identification Number.**
- Administrator FEIN—administrator's Federal Employer's Identification Number.
- **Name—the worker's compensation insurer, approved self insured, or intergovernmental risk management pool.**
- **Address—address, city, state, zip code of insurer.**
- Phone—phone number of insurer.
- Claim Administrator (name, address, & phone)—enter the name, address and phone number of the carrier, third party administrator, risk management pool, or self-insurer responsible for administering the claims, if different from carrier information.
- Policy #—the number assigned to the contract/policy for that employer.
- Policy Period—the effective and expiration dates of the contract/policy.
- Insurance Carrier/Self Insured Code #—for insurance carriers, the number assigned by the Nat'l Assn. of Insurance Commissioners. For self-insured employers, the code number assigned by the court.
- **Self Insured—check if appropriate.**
- **Claim Administrator Claim #—identifies a specific claim within a claim administrator's claims processing system.**
- Jurisdiction Claim #—number assigned by the court when the initial First Report is accepted.
- Insured Report #—a number used by the insured to identify a specific claim.
- Jurisdiction—the governing body or territory whose statutes apply (NE).

Employee:

- **Name—give full name as shown on payroll (avoid initials if possible).**
- **Address—address, city, state and zip code of employee.**
- Date of Birth—the date the injured worker was born.
- **Social Security Number.**
- Date Hired—the date the injured worker began his/her employment with the employer.
- Full pay for DOI (date of injury)—check one.
- Salary Continued—check one.
- Number of Days Worked Per Week—the number of the employee's regularly scheduled work days per week.
- Sex—check one.
- Number of Dependents—the number of dependents as defined by the Nebraska Workers' Compensation Act.
- Marital Status—check one.
- Wage—check one and state wage.
- Occupational Job Title—the primary occupation of the claimant at the time of the accident.
- Occupational Code—Standard Occupational Classification code used to identify the primary occupation of the employee at the time of the accident.
- NCCI Code—The identifying number for an occupational classification.
- Date Employee Began Work-Related Duties—date pertaining to employee's present occupation.
- Employment Status—check one.

Occurrence/Treatment:

- **Date of Injury/Illness—date on which the accident occurred (only one date of injury per form).**
- Time Employee Began Work—time employee began work for that date.
- Time of Occurrence—time of day the injury occurred.
- Last Work Date—the last paid work day prior to the initial date of disability.
- **Where did Injury/Illness Occur—complete county, state, and zip code.**
- Did Injury/Illness Occur On Employer's Premises—check one.
- Date Employer Notified—the date that the injury was reported to a representative of the employer.
- Date Disability Began—if not disabled answer none and skip questions.
- Date Returned to Work—if injured has returned to work, complete this question.
- If Fatal, Give Date of Death, (date employee died as a result of a work-related injury.)
- **Type of Injury/Illness—describe the nature of injury.**
- Nature of Injury Code—the code which corresponds to the nature of the injury sustained by the employee.
- Part of Body Affected—the part of the body to which the employee sustained injury.
- Part of Body Code—the code which corresponds to the Part of the body to which the employee sustained injury.
- **How Injury/Illness Occurred—a free-form description of how the accident occurred and the resulting injuries.**
- **Cause of Injury Code—the code that corresponds to the cause of injury**
- Initial Treatment—check one.
- Name of physician or other health care provider—provide name of physician or other health care provider that treated employee for injury.
- Date Administrator Notified—the date the claim administrator who is processing the claim received notice of the loss or occurrence.
- Form Preparer's Name, Title and Phone.
- Date Prepared—date form was actually completed.

Type or print neatly your response in ink.

EMPLOYEE'S CHOICE OR CHANGE OF DOCTOR FORM

NOTICE TO EMPLOYER:

GIVE THIS FORM TO THE INJURED WORKER AS SOON AS POSSIBLE AFTER EACH INJURY

PART A: NOTICE REGARDING CHOICE OR CHANGE OF DOCTOR

Under the Nebraska workers' compensation laws, you may have the right to choose a doctor to treat you for your work-related injury. You may choose a doctor who has treated you or an immediate family member before this injury happened. Immediate family members are your spouse, children, parents, stepchildren and stepparents. The doctor you choose must have records to show that past treatment was provided. Your employer may ask the person who was treated to give permission so the doctor can verify past treatment.

If you want to choose your doctor, you must tell your employer the name of the doctor you choose. Do this as soon as possible after your employer gives you this notice and before getting any treatment unless it is emergency medical treatment. Once you tell your employer the name of the doctor, you may not change your choice unless your employer agrees or the Nebraska Workers' Compensation Court orders a change.

If you do not choose your doctor, your employer has the right to choose the doctor to treat you. The employer may also choose the doctor to treat you if you or your family member does not give permission so your employer can verify past treatment by the doctor you chose.

You may choose a doctor if your claim is denied. You may also choose the doctor to do major surgery or for an amputation.

You may use Part B (below) to tell your employer the name of the doctor you choose.

My employer has informed me of the above information regarding choice or change of doctor.

[SIGNATURE OF EMPLOYEE]

[DATE]

PART B: CHOICE OF DOCTOR

I choose the following doctor to treat me for this work-related injury. I certify that this doctor has treated me or an immediate family member before the work-related injury.

I do not have or I do not wish to choose a doctor who has treated me or an immediate family member.

[DOCTOR'S NAME]

[SIGNATURE OF EMPLOYEE]

[DOCTOR'S ADDRESS]

[DATE]

PART C: USE TO CHANGE THE CHOICE MADE IN PART B, ABOVE

I wish to change my choice of doctor or I wish to choose a doctor to treat me for my work-related injury. I certify the doctor named below has treated me or an immediate family member before this work-related injury. I understand that I cannot make this change unless my employer agrees or unless the Nebraska Workers' Compensation Court orders a change.

[DOCTOR'S NAME]

[SIGNATURE OF EMPLOYEE & DATE OF SIGNATURE]

[DOCTOR'S ADDRESS]

[SIGNATURE OF EMPLOYER & DATE OF SIGNATURE]