BerkleyNet | a Berkley Company

NOTICE:
LOUISIANA WORKERS COMPENSATION

This business operates under Louisiana 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:

BerkleyNet

To report a claim, contact us at:

Website: berkleynet.com
Email: claims@berkleynet.com
Address: 9301 Innovation Drive, Suite 200, Manassas, VA 20110
Phone: 877.497.2637
Fax: 866.275.6320

MAIL TO:
WORKERS' COMPENSATION INSURER

_____ - _____ - _____
Employee Social Security Number

Employer UI Account Number

Employer Federal ID Number

EMPLOYER REPORT
OF
INJURY/ILLNESS

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately.

PURPOSE OF REPORT: (Check all that apply)

- ☐ More than 7 days of disability
- ☐ Injury resulted in death
- ☐ Amputation or disfigurement
- ☐ Possible dispute
- ☐ Lump Sum Compromise/Settlement
- ☐ Other
- ☐ Medical only

(DO NOT mail copy to OWCA)

1.Date ofReport MM/DD/YY	2. Date / time of Injury MM/DD/YY Time ☐AM ☐PM	3. Normal Starting Time Day of Accident ☐AM ☐PM	4. If Back toWork - Give date MM/DD/YY	5. At same wage? ☐Yes ☐No	DO NOT WRITE IN THIS COLUMN
6. If Fatal Injury, Give Date of Death MM/DD/YY	7. Date Employer Knew of Injury MM/DD/YY	8. Date Disability began MM/DD/YY	9. Last Full Day Paid MM/DD/YY		Date Received
10. Employee Name First Middle Last		11. ☐ Male ☐ Female	12. Employee Phone # ( )		Naics:.
13. Address and Zip Code			14. Parish of Injury		State-Parish
15. Date of Hire	16. Date of Birth	17. Occupation	18. Dept/Division Employed		Occupation
19. Place of Injury-Employer's Premises ? ☐Yes ☐No	20. If No, Indicate Location-Street, City, Parish and State				Nature
21. What work activity was the employee doing when the injury occurred? (Give weight, size and shape of materials or equipment involved). Explain what employee was doing with them. Indicate if correct procedures were followed.					Part of Body Source Event NCCI
22. What caused injury to happen? (Describe fully the events which resulted in injury or disease. Explain what happened and how it happened. Name any objects or substances involved and explain how they were involved. Give full details on all factors which led to or contributed to this injury or illness.)					
23. Part of Body Injured and Nature of Injury or Illness (ex. left leg; multiple fractures)					24. If Occ. Disease-Give Date Diagnosed
25. Physician and Address			26. If Hospitalized, give name & address of facility		
27. Employer's Name			28. Person Completing This Report - Please print		
29. Employer's Address and Zip Code			30. Employer's Telephone Number ( )		
31. Employer's Mailing Address-If Different From Above			32. Nature of Business-Type of Mfg., Trade, Construction, Service, etc.		
33. Wage Information (optional) Employee was paid ☐ Daily ☐ Weekly ☐ Monthly ☐ Other. T he average weekly wage was $_____ per week.					

LWC-WC-1007 Insurer Name:
Rev: 07/08 Phone:
Address:

Insurer's Administrator or Representative:
Phone:
Address:

Download Employer's Certificate of Compliance

Workers' Compensation

Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

1 the disease manifests itself.

2 the employee is disabled as a result of the disease.

3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

1 the date of death.

2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

_____

_____

_____

_____

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

_____

_____

_____

_____

Employer

_____

_____

_____

_____

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

Revised May 2003

LOUISIANA WORKFORCE COMMISSION

www.laworks.net