NOTICE!

Kentucky
Workers Compensation

This business operates under Kentucky 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.berkleynet.com
12701 Marblestone Dr, Ste 250
Woodbridge, Virginia 22192
877-497-2637

Promptly Report all Claims: www.berkleynet.com; Email: Claims@berkleynet.com;
Fax 866.275.6320; Call 800.435.1127;

IA-1 WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)	Carrier/Administrator Claim Number	Report Purpose Code
	Jurisdiction	Jurisdiction Claim Number
	Insured Report Number	
	Employer's Location Address (if different)	Location No.
Sic Code / Employer FEIN		Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)	Policy Period / To / ☐ Check if self insured	Claims Admin (Name, Address & Phone Number)
Carrier FEIN	Policy Number or Self-Insured Number	Administrator FEIN
Agent Name & Code Number		

Employee/Wage

Legal Name (Last, First, Middle)	Date of Birth	Social Security Number	Date Hired	State of Hire
Address (Incl. Zip)	Sex: ☐ Male ☐ Female ☐ Unknown	Marital Status: ☐ Unmarried/ Single/Div. ☐ Married ☐ Separated ☐ Unknown	Occupation/Job Title	
			Employment Status	
Phone	No. of Dependents		NCCI Class Code	
Wage Rate $ ☐ Day ☐ Week	☐ Month ☐ Other	# Days Worked/WK / # Hrs Worked per Day	Full Pay for Date of Injury? ☐ Yes ☐ No	Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM	Date of Injury or Illness	Time Occurred ☐ AM ☐ PM	Last Work Date	Date Employer Notified	Date Disability Began

Employer Contact Name/Phone Number	Type of Illness/Injury	Part of Body Affected
Did Injury/Illness Exposure Occur on Employer's Premises? Yes ☐ No ☐	Type of Illness/Injury Code	Part of Body Affected Code

Department or location where accident or illness exposure occurred	All Equipment, Materials, or Chemicals Employee was using when accident or illness exposure occurred.
Specific Activity the Employee was engaged in when the accident or illness exposure occurred.	Work Process the Employee Was Engaged in when accident or illness exposure occurred.
How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill.	Cause of Injury Code

Date Returned to Work	If Fatal, Date of Death	Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No
		Were they used? ☐ Yes ☐ No

Treatment

Physician/Health Care Provider (Name & Address)	Hospital (Name & Address)	Initial Treatment
		0 ☐ No Medical Treatment 1 ☐ Minor: By Employer 2 ☐ Minor Clinic/Hosp 3 ☐ Emergency Care 4 ☐ Hospitalized > 24 hr. 5 ☐ Future Major Medical/Lost Time Anticipated

Other

Witness to Accident (Name & Phone Number)			
Date Administrator Notified	Date Prepared	Preparer's Name & Title	Preparer's Phone Number

IA-1 (2/95) **SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE**

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Applicable in Alaska

A person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception.

Applicable in Arkansas

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding worker's compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

Applicable in California

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Applicable in Connecticut

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Applicable in Delaware and Oklahoma

Any person who, knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. *Delaware Statutes Regulation: Del #C Section 913(B)

Applicable in Florida

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Applicable in Idaho

Any person who Knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company, Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kentucky and New York

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Michigan

Any person who knowingly and with intent to injure or defraud any insurer submits a claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to $5,000.00.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Pennsylvania

Any person who knowingly and with intent to injure or defraud any insurer files a claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years or payment of a fine of up to $50,000.

Applicable in Utah

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

EMPLOYEE SIGNATURE: ____________________

IA-1 (2-95)

COMMONWEALTH OF KENTUCKY

WORKERS' COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers' Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name: ____
Address: ____
Workers Compensation Carrier
(or third party administrator): ____
Policy #:______________________, effective ____________ to _____________________________
Address: ____
Telephone: _________________, Contact Person ____

EMPLOYEES: IF INJURED – NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.

This employer IS ☐ IS NOT ☐ participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is _______________________, its representative is ______________________________, phone number __________________________________.

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) day of disability. A CLAIM MUST BE filed with the Department of Workers' Claim WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers' compensation rights are not promptly answered call THE KENTUCKY DEPARTMENT OF WORKERS CLAIMS at 1-800-554-8601 to speak to an Ombudsman or Workers' Compensation Specialist.

EMPLOYER SUPERVISORS – NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

04/09/09

Form 113
Designation of Physician
Revised 03-12-03

Two-Sided Form

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS

Claim No. _______________

NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: ____
Name

____
Street Address

____
City, State, Zip

( ) __________
Telephone Number

________________________ ________________________
Date of Birth Social Security Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

____
Name

____
Street Address

____
City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: ____

____

DATE OF INJURY OR LAST EXPOSURE: ____

FIRST DESIGNATED PHYSICIAN:

____
Name

____
Street Address

____
City, State, Zip

( ) __________
Telephone Number

Accepted by: ____

MEDICAL INFORMATION RELEASE: I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

________________________ ________________________
Date Employee Signature

MEDICAL PAYMENT OBLIGOR:

____
Name Of Obligor

____
Representative

____
Street Address

____
City, State, Zip

( ) __________
Telephone Number

This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.

Notice: The Workers' Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as "designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for medical services.

FORM 106
ADOPTED JULY 2003

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
CLAIM NO:__________________

MEDICAL WAIVER AND CONSENT

I, ____ having filed a claim for workers' compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize any health care provider to furnish to myself, my attorney, my employer, its workers' compensation carrier or its agent, the Division of Workers' Compensation Funds, the Uninsured Employers' Fund, or Administrative Law Judge any information or written material reasonably related to my work-related injury occurring on or about _______________ any medical information relevant to the claim including past history of complaints of, or treatment of, a condition similar to that presented in this claim or other conditions related to the same body part.

Such information is being disclosed to the purpose of facilitating my claim for Kentucky workers' compensation benefits.

I understand I have the right to revoke this authorization in writing at any time, by sending written notification to each individual health care provider, but such revocation will not have any affect on actions taken prior to revocation. Moreover, inasmuch as KRS 342.020(8) requires a medical waiver to be executed, revocation may result in suspension or delay of the workers' compensation claim.

I understand that no medical provider may condition treatment or payment on whether I sign this medical waiver; however, I further understand that failure to sign this medical waiver may result in suspension or delay of the workers' compensation claim.

I understand that the information used or disclosed pursuant to this medical waiver may be subject to re-disclosure by the recipient.

This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

The authorization includes, but is not restricted to, a right to review and obtain all copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

Signed at ___________________________________, Kentucky, this ________ day of __________________, 20______.

____
Signature of Patient Or Personal Representative

Social Security Number: ____________________

____
Witness Signature

____
Description Of Personal Representative's Authority

KENTUCKY WORKERS' COMPENSATION AND HIPAA

On April 14, 2003, the federal Health Insurance Portability and Accountability Act [HIPAA] privacy regulation will take effect. This regulation limits the situations in which medical providers may release patient infomation, unless the information is necessary for the purpose of treatment, payment, or health care operations. Moreover, it is important to note that disclosures for workers' compensation are in most instances exempt from HIPAA privacy requirements. The exact wording is as follows: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation…"

Since HIPAA defers to state law regarding disclosures relating to workers' compensation, it is important for claimants and medical providers to know what Kentucky law requires for disclosure of patient information. An employee who reports a work injury or who files for workers compensation benefits must "execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation." KRS 342.020 (8). Kentucky law further states that once this Form 106 is signed, any health care provider "shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer [or its agent or assignee], special fund, uninsured employers' fund, or the administrative law judge, provide the **requesting party** with any information or written material reasonably related to any injury or disease for which the employee claims compensation."

Once the Form 106 is signed, health care providers may disclose information as set out in Kentucky law. Another section of the regulation allows release of information pursuant to an administrative or judicial order or subpoena, provided that there has been a reasonable effort to notify the injured worker [or his attorney] that such a request has been made. Should there be questions regarding disclosures pursuant to this form, appropriate legal counsel should be consulted or you can contact the Department of Workers' Claims at 1-800 554-8601.

FORM 105
ADOPTED: January 1, 1997

KENTUCKY
DEPARTMENT OF WORKERS CLAIMS
PLAINTIFF'S CHRONOLOGICAL MEDICAL HISTORY

Include all injuries and major illnesses to the date of filing of the claim
(Begin with most recent treatment)

Name & Address of Physician or Hospital	Date Treatment Received	Nature of Injury or Disease and Part of body affected?	Still under a doctor's care?
1.			
2.			
3.			
4.			
5.			
6.			

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

Plaintiff's Signature

Date