NOTICE!

Nevada
Workers Compensation

This business operates under Nevada 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;

It is a pleasure to welcome you to Berkley Net Underwriters, LLC! We are committed to providing high quality products and services to our valued customers. Utilizing state-of-the-art risk management, safety and claim management techniques, we strive to help you manage your insurance expenditures and minimize your loss costs.

I'm often asked how employers can lower their workers' compensation costs, and while there's no single answer, here are a few items employers can manage that will prove beneficial in the long-run:

- **Report Claims as Quickly As Possible – ideally within 24 hours of occurrence**
  - www.berkleynet.com
  - BNUClaims@berkleynet.com
  - Fax: 1.866.275.6320 ; call 1.800.435.1127

- **Post All Necessary State Notices for Employees**
  - All forms and posting requirements are included in this packet.

- **Discuss and Promote Safety within your Company**
  - A Safe Attitude begins at the top. Make Safety a Priority.

- **Keep Accurate Records**
  - Your premium is based on employee payroll. Keeping accurate payroll and job records throughout the year will facilitate a smoother final audit.

- **Discuss Potential Changes in Operations with your Insurance Agent**
  - Changes in employee operations can have a direct impact on your premium and coverage. Discuss any potential changes with your agent and avoid costly surprises in the future.

On behalf of our entire team, I thank you for entrusting Berkley Net Underwriters, LLC to service your workers' compensation insurance needs. If you have any questions, please feel free to contact your insurance agent or call us at 1.877.497.2637. You may also visit us online at www.berkleynet.com.

Sincerely

John K. Goldwater
President & CEO

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

About Berkley Net Underwriters, LLC

Berkley Net Underwriters, LLC is a subsidiary of the W.R. Berkley Corporation, one of the nation's premier property and casualty insurance providers. We are authorized to provide workers' compensation coverage through affiliated W.R. Berkley subsidiaries, including **StarNet Insurance Company**, **Carolina Casualty Insurance Company** and **Midwest Employers Casualty Company**; all are an A rated insurance company. As your workers' compensation carrier, we pride ourselves on having a reputation of unsurpassed quality, service and integrity.

The BerkleyNet Claim Management Difference

BerkleyNet is a world class provider of claim and managed care services; utilizing the best practices in claim management, managed care initiatives and technology to achieve superior outcomes. Our commitment to our clients is: teamwork, responsiveness, mutual respect and technical innovation in delivering industry-leading claims management services.

Important Claims Information Included

In this packet, you will find important risk management information, including claims forms, posting notices and other documents to assist with the administration of your workers' compensation policy. **Please retain this information for future reference**.

- ✓ Claim Reporting Forms
- ✓ Statutory Posting Notices
- ✓ Supervisory Accident Reports
- ✓ Physical Demand Analysis
- ✓ Medical Authorization Form
- ✓ First Health Preferred Provider Network & Panel of Physicians
- ✓ Discount Pharmacy Information
- ✓ Position Physical Demand Analysis Assessment

To Report Claims:

www.berkleynet.com

Email: BNUClaims@berkleynet.com

866.275.6320 Fax

800.435.1127 Phone

Reporting Worker's Compensation Claims

Worker's Compensation claims can be reported in several different ways:

- www.berkleynet.com
- Via email at: **BNUClaims@berkleynet.com**
- Complete and fax the Employer's First Report of Injury to; **1.866.275.6320**
- Call 24 hours/7 days a week at **1.800.435.1127**
- Mail the Employers Report of Injury to:
  Berkley Net Underwriters, LLC
  12701 Marblestone Drive, Ste 250
  Woodbridge VA 22192

Claims Reporting

- **www.berkleynet.com**
- Fax at 1.866.275.6320
- Email Reporting at **BNUClaims@berkleynet.com**
- 24/7 claims reporting facility
- Adjusters begin direct care process immediately
- After Hours toll free number: 1.800.435.1127

Everything you need to know about reporting a claim is included in this packet.

- Employer's First Report of Injury and report your claim
- A step by step telephone reporting guide
- The Employer Rights and Responsibilities
- Information on provider panel and discount pharmacy. Reinforce treating with panel provider and use of the TMESYS pharmacy network with your employee

The After-Hours phone number provides access to the Claims Management staff as well as our most experienced adjusters. Loss details are gathered to determine if an emergency exists and if an immediate field investigation or field contact is indicated.

Employer Rights & Responsibilities in Workers Compensation

Early Reporting. Set an expectation that all injuries be reported promptly; also, have a "same-day" reporting standard for communicating any claims to Berkley Net Underwriters, LLC. Train your managers and supervisors in what to do if an injury occurs. Late reports may impact the rights of an employer. A copy of the Employer's First Report is attached. **To report: www.berkleynet.com; Email: BNUClaims@berkleynet.com; Call toll free to 800.435.1127; Fax 866.275.6320**

Physician List. Make all employees aware of a list of providers. The physician list should be in a prominent location. This list is being prepared specifically for your business. These practioners are members of the First Health network, experienced in the care of injured workers. If you need additional providers to be added, we will direct you on making changes within the panel.

Excellent Medical Care. Develop a relationship with the physicians on the physician list. Contact the provider from the outset and advise that your employee is on the way to seek care. Let them know of your interest to provide modified work.

Medical Authorization. Ask the employee to sign the medical authorization form when they've notified you of a claim. This will enable Berkley Net Underwriters, LLC to secure all relevant medical documentation and accelerate the claim handling process. A copy of the form is attached.

Pharmacy Network. Berkley Net Underwriters, LLC has a program through TMESYS which will save cost and allow an employee to fill a prescription without waiting for reimbursement. Any questions by either the employee or pharmacist can be addressed through TMESYS at 800-964-2531.

Posting Required Notices. A notice of insurance placard and workers compensation fraud notice should be posted. Those forms are attached to the correspondence.

Good communication. Take the mystery out of workers comp. Educate employees about their rights and responsibilities in advance. Stay in touch with employees throughout their care and rehabilitation.

Supervisory Investigation. Reinforce that supervisors get all details on injury and accident claims and document in a report format. A recommended copy is attached.

Return to Work. Develop a plan to return the employee to gainful employment from the outset. Look to modify parts of the employee's position to accommodate. Advise employee and attending physician that return to work is expected.

Employee Rights & Responsibilities in Workers Compensation

Notify Supervisor. Let your supervisor know of any injury or accident that happens in the workplace immediately. Failure to notify may impact the rights of the employee.

Medical Authorization. Sign, date and return the medical authorization form to your employer immediately. This will enable the insurer to properly process all related medical costs.

Physician List. Your employer will assist you to a list of physicians that are committed to rehabilitation and the best care. You may consult this list before scheduling any appointment. These are practioners who are familiar with work related injuries.

Pharmacy. A program is available to you through TMESYS with no out of pocket expenses. Make sure that the pharmacy is aware that your employer and insurer are part of the TMESYS program. A first fill sheet is available through your employer or you or the pharmacist may call TMESYS directly at 800-964-2531.

Communicate. Stay in touch with your employer and insurance company after each medical treatment. Keep everyone up to date on your treatment plan and return to work prognosis.

Return to Work. Work with your employer and attending physician to return to work. Share all information regarding your physical capabilities and the potential for making modifications to your job.

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Supervisor's Injury/Accident Investigation

Insured Name _____ Policy Number _____
Location where injury occurred: _____Employer's Premises? _____
Date of accident_____Job site location_____
Who was injured? _____Employee Name _____
Time: _____ Did you or anyone witness? _____ Witness Name _____
When were you notified? _____
Job title of injured employee _____
How long has employee worked at this job? _____
Where did injury or illness occur? _____
Was property or equipment or tools involved with injury? _____
Property/equipment owned by: _____
What was employee doing when injury/illness occurred? _____
What machine or tool was being used? _____
How did injury/illness occur? _____
List all objects and substance involved._____
Part of body affected/injured? _____
Any prior physical conditions? _____If so, what? _____

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS:

____ Improper instruction ____ Failure to lockout ____ Unsafe arrangement or process
____ Lack of training or skill ____ Unsafe position ____ Poor ventilation
____ Operating without authority ____ Improper dress ____ Improper guarding
____ Horseplay ____ Improper protective equipment
____ Improper maintenance ____ Physical or mental impairment
____ Unsafe equipment ____ Inoperative safety device
____ Failure to secure ____ Poor housekeeping
____ Other _____

What can be done to avoid this in the future?

Was employee trained in the use of Personal Protective Equipment/Proper safety procedures? __Yes ___ No.

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? __ Yes ___ No

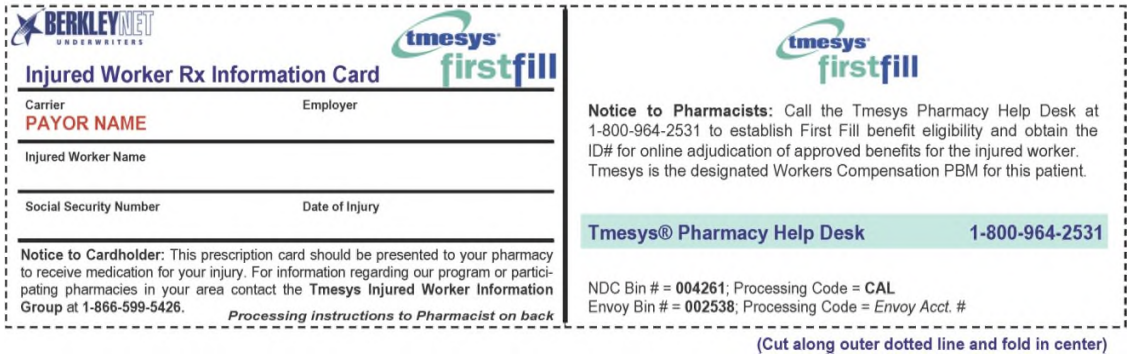
Was the notice of injury prompt? _____

Is there modified duty available? _____ Can the existing job be modified? _____

Supervisor Name_____ Signature _____

Date _____

EMPLOYER – Please give to injured employee before they fill first prescription



Injured Worker Rx Information Card

Carrier: PAYOR NAME
Employer:
Injured Worker Name:
Social Security Number:
Date of Injury:

Notice to Cardholder: This prescription card should be presented to your pharmacy to receive medication for your injury. For information regarding our program or participating pharmacies in your area contact the **Tmesys Injured Worker Information Group** at **1-866-599-5426.**

Processing instructions to Pharmacist on back

Notice to Pharmacists: Call the Tmesys Pharmacy Help Desk at 1-800-964-2531 to establish First Fill benefit eligibility and obtain the ID# for online adjudication of approved benefits for the injured worker. Tmesys is the designated Workers Compensation PBM for this patient.

Tmesys® Pharmacy Help Desk **1-800-964-2531**

NDC Bin # = **004261**; Processing Code = **CAL**
Envoy Bin # = **002538**; Processing Code = *Envoy Acct. #*

(Cut along outer dotted line and fold in center)

Injured Worker Rx Information Card

Carrier: PAYOR NAME
Employer:
Injured Worker Name:
Social Security Number:
Date of Injury:

Notice to Cardholder: This prescription card should be presented to your pharmacy to receive medication for your injury. For information regarding our program or participating pharmacies in your area contact the **Tmesys Injured Worker Information Group** at **1-866-599-5426.**

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(Cut along outer dotted line and fold in center)

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

MEDICAL RECORDS RELEASE AUTHORIZATION

In order for your claim to be fully evaluated for purposes of determining your eligibility for the receipt of benefits with respect to this claim, you must sign the following authorization. Please note that the amount and type of medical information sought pursuant to this authorization will depend upon the nature of the claim, but that it will be used solely to facilitate determinations regarding the validity of the claim and the payment of benefits or the administration of the insurance program under which the claim has been made. The authorization is subject to your revocation at any time except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to Berkley Net Underwriters, LLC. , 12701 Marblestone Dr, Ste 250, Woodbridge, VA 22192, otherwise this authorization will continue to be valid. Your acceptance of benefits shall be considered an acceptance of the terms in this medical authorization, unless you indicate to the contrary in writing.

Authorization to Release Medical Information: I hereby authorize any employer, insurance company, government agency, medical prepayment plan, or service organization, and any physician, surgeon, therapist, pharmacist, or other duly licensed practitioner of the healing arts, and any hospital, including the Veteran's Administration, or medical transportation company, to release to Berkley Net Underwriters and their subsidiaries, affiliates, representatives and agents (collectively, Berkley Net Underwriters), any and all applicable medical records, medical information and benefit payment information with respect to any illness, injury, medical history, consultations, prescriptions, treatment or benefits, and copies of all applicable records thereof, which may be appropriate or necessary to establish the validity of this claim.

This authorization shall specifically include but shall not be limited to medical records, medical information and benefit payment information pertaining or relating to the treatment of AIDS, HIV, mental illness, and drug or alcohol related medical problems. I also authorize the Social Security Administration to release to Berkley Net Underwriters, information concerning entitlement dates and benefit amounts for myself and my dependents.

I further authorize Berkley Net Underwriters to release any such medical information to its reinsurers, attorneys or to medical peer review panels, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, or my employer and its excess insurer, to the extent that Berkley Net Underwriters considers doing so to be reasonably appropriate or necessary for purposes of its administration of the claim or the insurance program under which the claim has been made. I understand that authorizing the disclosure of this health information is voluntary. I understand the information released to Berkley Net Underwriters as a result of this authorization may no longer be subject to certain protections provided under the Health Insurance Portability and Accountability Act of 1996.

Unless revoked earlier by me in writing this authorization shall be valid for three years after the claim has been closed by Berkley Net Underwriters. A copy of this authorization is to be considered as valid as the original.

Employee Signature _____ ***Date***_____

Employee Name _____ *Claim No.* _____

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

PHYSICAL DEMAND ANALYSIS ASSESSMENT

This Position Physical Demand Analysis Assessment describes the physical requirements of the injured workers job or position. The focus is on strength, flexibility, sensory and environmental requirements or conditions of specific tasks. This form should be completed for the injured employee's present position as well as modified duty positions available, so it may be used by the health care provider to determine if the employee is capable of returning to work at regular or modified duties. Employer _____

Job or Position _____ Date form completed _____

Regular Hours of work per day _____ Completed by _____

Employee _____

During a regular work day, the employee must (circle number of hours and indicate if intermittent **(I)** or constant **(C)** for each activity.

Sit	**0 1 2 3 4 5 6 7 8 hours**	**I / C**
Stand	**0 1 2 3 4 5 6 7 8 hours**	**I / C**
Walk	**0 1 2 3 4 5 6 7 8 hours**	**I / C**
Drive	**0 1 2 3 4 5 6 7 8 hours**	**I / C**
Bend	**0 1 2 3 4 5 6 7 8 hours**	**I / C**

Job Requirements include (**Y/N**): __ Squatting; __ Kneeling; __ Bending; __Twisting; __Reaching; __Crawling; __Ladder Work; __Stair Climbing; __Work above Shoulder; __Work below Shoulder; __Walking on Rough Ground; __Working at Heights; __Exposure to Heat or Cold (circle which or both); __Exposure to Dust, Fumes or Gases; __Exposure to High Humidity; __Exposure to Noise; __Repetitive Movements

Lifting Requirements

	Never	Occasionally	Frequently	Continuous
Up to 10 lbs	☐	☐	☐	☐
11 to 24 lbs	☐	☐	☐	☐
25 to 34 lbs	☐	☐	☐	☐
35 to 50 lbs	☐	☐	☐	☐
51 to 74 lbs	☐	☐	☐	☐
75 to 100 lbs	☐	☐	☐	☐
Above 100 lbs	☐	☐	☐	☐

Carrying Requirements

	Never	Occasionally	Frequently	Continuous
Up to 10 lbs	☐	☐	☐	☐
11 to 24 lbs	☐	☐	☐	☐
25 to 34 lbs	☐	☐	☐	☐
35 to 50 lbs	☐	☐	☐	☐
51 to 74 lbs	☐	☐	☐	☐
75 to 100 lbs	☐	☐	☐	☐
Above 100 lbs	☐	☐	☐	☐

Pushing Requirements

	Never	Occasionally	Frequently	Continuous
Up to 10 lbs	☐	☐	☐	☐
11 to 24 lbs	☐	☐	☐	☐
25 to 34 lbs	☐	☐	☐	☐
35 to 50 lbs	☐	☐	☐	☐
51 to 74 lbs	☐	☐	☐	☐
75 to 100 lbs	☐	☐	☐	☐
Above 100 lbs	☐	☐	☐	☐

To Report Workers' Compensation Claims

www.berkleynet.com

Fax: 866.275.6320

Call Toll-Free 800.435.1127

Email:BNUClaims@berkleynet.com

In case of Injury or Illness on the job, the following participating providers are available in your area.

CLINICS

HOSPITALS

PHYSICIANS

TMESYS Pharmacy Program - To contact your local TMESYS Pharmacy, please call (800) 964-2531

Notify your immediate supervisor of your injury. If you feel that you need medical attention, **you may choose one of the providers listed here or a provider of your own choice**. Please call the provider to confirm First Health participation and to schedule an appointment for faster service. Many clinics are open extended hours for your convenience. For urgent care needs after clinics hours, you may proceed directly to the hospital listed here. Patients will be seen on a medical priority basis. In emergency situations you may immediately seek treatment from the nearest qualified facility or provider. IF YOU NEED AN ALTERNATE TO THE PROVIDERS LISTED HERE, CALL 888-476-2669.

Your Employer and its Insurance Carrier utilizes **First Health contracted providers**. The above list is not a complete list of healthcare providers with First Health. For a complete listing of providers, or to verify whether a particular doctor does participate, please call800-828-2389. **If your situation is a medical emergency requiring immediate attention, dial 911 or proceed to the nearest hospital which provides emergency services.** Use of network does not confirm or verify compensability under the Workers' Compensation Act, which is determined solely by the claims administrator.

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

En caso de lesión o enfermedad laboral, los siguientes proveedores participantes están disponibles en su área.

CLINICS

HOSPITALS

PHYSICIANS

TMESYS Pharmacy Program - To contact your local TMESYS Pharmacy, please call (800) 964-2531

Notifique a su supervisor inmediato acerca de su lesión. Si usted siente que necesita atención médica, puede elegir a uno de los proveedores acá listados. Por favor llame el proveedor para confirmar que participa en el programa de First Health y fije una cita para un servicio más rápido. Muchas clínicas están abiertas durante un horario ampliado para su conveniencia. Para situaciones de cuidado médico urgentes después de horas de atención al público, puede proceder directamente al hospital listado acá. Los pacientes serán vistos de acuerdo con la urgencia médica. En situaciones de emergencia usted puede solicitar tratamiento inmediato en la instalación o proveedor calificado más cercano. SI USTED NECESITA UNA ALTERNATIVA A LOS PROVEEDORES INDICADOS ACÁ LLAME 888-476-2669.

Su empleador y la empresa aseguradora utilizan la red **The First Health**® Network. Para un listado completo de proveedores, o verificar si un doctor en particular está en la red, por favor llame al 800-828-2389. **Si su situación es una emergencia médica que requiere atención inmediata, marque el 911 o proceda al hospital más cercano que proporcione un servicio de emergencias.** El uso de la red no confirma o verifica la facultad de ser compensado conforme a la Ley de Compensación de Trabajadores lo cual es determinado exclusivamente por el administrador de reclamaciones.

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TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Office Mail Address	Location . . . If different from mailing address		Telephone
City State Zip	**INSURER**		**THIRD-PARTY ADMINISTRATOR**

EMPLOYEE

First Name M.I. Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Home Address (Number and Street)	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
City State Zip	Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No		How long has this person been employed by you in Nevada?	
In which state was employee hired?	Employee's occupation (job title) when hired or disabled		Department in which regularly employed:	
Telephone	Is the injured employee a corporate officer? ☐ Yes ☐ No . . . sole proprietor? ☐ Yes ☐ No . . . partner? ☐ Yes ☐ No		Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No	

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
Address or location of accident (Also provide city, county, state) (if applicable)			Accident on employer's premises? (if applicable) ☐ Yes ☐ No
What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)			
How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.			

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)		Witness	Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No
Part of body injured or affected	If fatal, give date of death	Witness	
Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)		Witness	
		Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No	Will you have light duty work available if necessary? ☐ Yes ☐ No
If validity of claim is doubted, state reason		Location of Initial Treatment	
Treating physician/chiropractor name		Emergency Room ☐ Yes ☐ No	Hospitalized ☐ Yes ☐ No

IMPORTANT How many days per week does employee work?	From ☐ am ☐ pm To ☐ am ☐ pm	Last day wages were earned
Scheduled days off: S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐	Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No	

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
Was the employee hired to work 40 hours per week? ☐ Yes ☐ No	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know	

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	Emloyee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY	On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title | Date

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

It is a pleasure to welcome you to Berkley Net Underwriters, LLC! We are committed to providing high quality products and services to our valued customers. Utilizing state-of-the-art risk management, safety and claim management techniques, we strive to help you manage your insurance expenditures and minimize your loss costs.

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Sincerely

John K. Goldwater
President & CEO

About Berkley Net Underwriters, LLC

Berkley Net Underwriters, LLC is a subsidiary of the W.R. Berkley Corporation, one of the nation's premier property and casualty insurance providers. We are authorized to provide workers' compensation coverage through affiliated W.R. Berkley subsidiaries, including **StarNet Insurance Company**, **Carolina Casualty Insurance Company** and **Midwest Employers Casualty Company**; all are an A rated insurance company. As your workers' compensation carrier, we pride ourselves on having a reputation of unsurpassed quality, service and integrity.

The BerkleyNet Claim Management Difference

BerkleyNet is a world class provider of claim and managed care services; utilizing the best practices in claim management, managed care initiatives and technology to achieve superior outcomes. Our commitment to our clients is: teamwork, responsiveness, mutual respect and technical innovation in delivering industry-leading claims management services.

Important Claims Information Included

In this packet, you will find important risk management information, including claims forms, posting notices and other documents to assist with the administration of your workers' compensation policy. **Please retain this information for future reference**.

- ✓ Claim Reporting Forms
- ✓ Statutory Posting Notices
- ✓ Supervisory Accident Reports
- ✓ Physical Demand Analysis
- ✓ Medical Authorization Form
- ✓ First Health Preferred Provider Network & Panel of Physicians
- ✓ Discount Pharmacy Information
- ✓ Position Physical Demand Analysis Assessment

To Report Claims:

www.berkleynet.com

Email: BNUClaims@berkleynet.com

866.275.6320 Fax

800.435.1127 Phone

Reporting Worker's Compensation Claims

Worker's Compensation claims can be reported in several different ways:

- www.berkleynet.com
- Via email at: **BNUClaims@berkleynet.com**
- Complete and fax the Employer's First Report of Injury to; **1.866.275.6320**
- Call 24 hours/7 days a week at **1.800.435.1127**
- Mail the Employers Report of Injury to:
  Berkley Net Underwriters, LLC
  12701 Marblestone Drive, Ste 250
  Woodbridge VA 22192

Claims Reporting

- **www.berkleynet.com**
- Fax at 1.866.275.6320
- Email Reporting at **BNUClaims@berkleynet.com**
- 24/7 claims reporting facility
- Adjusters begin direct care process immediately
- After Hours toll free number: 1.800.435.1127

Everything you need to know about reporting a claim is included in this packet.

- Employer's First Report of Injury and report your claim
- A step by step telephone reporting guide
- The Employer Rights and Responsibilities
- Information on provider panel and discount pharmacy. Reinforce treating with panel provider and use of the TMESYS pharmacy network with your employee

The After-Hours phone number provides access to the Claims Management staff as well as our most experienced adjusters. Loss details are gathered to determine if an emergency exists and if an immediate field investigation or field contact is indicated.

Employer Rights & Responsibilities in Workers Compensation

Early Reporting. Set an expectation that all injuries be reported promptly; also, have a "same-day" reporting standard for communicating any claims to Berkley Net Underwriters, LLC. Train your managers and supervisors in what to do if an injury occurs. Late reports may impact the rights of an employer. A copy of the Employer's First Report is attached. **To report: www.berkleynet.com; Email: BNUClaims@berkleynet.com; Call toll free to 800.435.1127; Fax 866.275.6320**

Physician List. Make all employees aware of a list of providers. The physician list should be in a prominent location. This list is being prepared specifically for your business. These practioners are members of the First Health network, experienced in the care of injured workers. If you need additional providers to be added, we will direct you on making changes within the panel.

Excellent Medical Care. Develop a relationship with the physicians on the physician list. Contact the provider from the outset and advise that your employee is on the way to seek care. Let them know of your interest to provide modified work.

Medical Authorization. Ask the employee to sign the medical authorization form when they've notified you of a claim. This will enable Berkley Net Underwriters, LLC to secure all relevant medical documentation and accelerate the claim handling process. A copy of the form is attached.

Pharmacy Network. Berkley Net Underwriters, LLC has a program through TMESYS which will save cost and allow an employee to fill a prescription without waiting for reimbursement. Any questions by either the employee or pharmacist can be addressed through TMESYS at 800-964-2531.

Posting Required Notices. A notice of insurance placard and workers compensation fraud notice should be posted. Those forms are attached to the correspondence.

Good communication. Take the mystery out of workers comp. Educate employees about their rights and responsibilities in advance. Stay in touch with employees throughout their care and rehabilitation.

Supervisory Investigation. Reinforce that supervisors get all details on injury and accident claims and document in a report format. A recommended copy is attached.

Return to Work. Develop a plan to return the employee to gainful employment from the outset. Look to modify parts of the employee's position to accommodate. Advise employee and attending physician that return to work is expected.

Employee Rights & Responsibilities in Workers Compensation

Notify Supervisor. Let your supervisor know of any injury or accident that happens in the workplace immediately. Failure to notify may impact the rights of the employee.

Medical Authorization. Sign, date and return the medical authorization form to your employer immediately. This will enable the insurer to properly process all related medical costs.

Physician List. Your employer will assist you to a list of physicians that are committed to rehabilitation and the best care. You may consult this list before scheduling any appointment. These are practioners who are familiar with work related injuries.

Pharmacy. A program is available to you through TMESYS with no out of pocket expenses. Make sure that the pharmacy is aware that your employer and insurer are part of the TMESYS program. A first fill sheet is available through your employer or you or the pharmacist may call TMESYS directly at 800-964-2531.

Communicate. Stay in touch with your employer and insurance company after each medical treatment. Keep everyone up to date on your treatment plan and return to work prognosis.

Return to Work. Work with your employer and attending physician to return to work. Share all information regarding your physical capabilities and the potential for making modifications to your job.

NOTICE!

Nevada
Workers Compensation

This business operates under Nevada 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:BNUClaims@berkleynet.com; Fax 866.275.6320; Call 800.435.1127;

Supervisor's Injury/Accident Investigation

Insured Name _____ Policy Number _____
Location where injury occurred: _____Employer's Premises? _____
Date of accident_____Job site location_____
Who was injured? _____Employee Name _____
Time: _____ Did you or anyone witness? _____ Witness Name _____
When were you notified? _____
Job title of injured employee _____
How long has employee worked at this job? _____
Where did injury or illness occur? _____
Was property or equipment or tools involved with injury? _____
Property/equipment owned by: _____
What was employee doing when injury/illness occurred? _____
What machine or tool was being used? _____
How did injury/illness occur? _____
List all objects and substance involved._____
Part of body affected/injured? _____
Any prior physical conditions? _____If so, what? _____

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS:

____ Improper instruction ____ Failure to lockout ____ Unsafe arrangement or process
____ Lack of training or skill ____ Unsafe position ____ Poor ventilation
____ Operating without authority ____ Improper dress ____ Improper guarding
____ Horseplay ____ Improper protective equipment
____ Improper maintenance ____ Physical or mental impairment
____ Unsafe equipment ____ Inoperative safety device
____ Failure to secure ____ Poor housekeeping
____ Other _____

What can be done to avoid this in the future?

Was employee trained in the use of Personal Protective Equipment/Proper safety procedures? __Yes ___ No.

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? __ Yes ___ No

Was the notice of injury prompt? _____

Is there modified duty available? _____ Can the existing job be modified? _____

Supervisor Name_____ Signature _____

Date _____

EMPLOYER – Please give to injured employee before they fill first prescription

Injured Worker Rx Information Card

Carrier: PAYOR NAME

Employer

Injured Worker Name

Social Security Number

Date of Injury

Notice to Cardholder: This prescription card should be presented to your pharmacy to receive medication for your injury. For information regarding our program or participating pharmacies in your area contact the **Tmesys Injured Worker Information Group** at **1-866-599-5426.**

Processing instructions to Pharmacist on back

Notice to Pharmacists: Call the Tmesys Pharmacy Help Desk at 1-800-964-2531 to establish First Fill benefit eligibility and obtain the ID# for online adjudication of approved benefits for the injured worker. Tmesys is the designated Workers Compensation PBM for this patient.

Tmesys® Pharmacy Help Desk **1-800-964-2531**

NDC Bin # = **004261**; Processing Code = **CAL**
Envoy Bin # = **002538**; Processing Code = *Envoy Acct. #*

(Cut along outer dotted line and fold in center)

Injured Worker Rx Information Card

Carrier: PAYOR NAME

Employer

Injured Worker Name

Social Security Number

Date of Injury

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(Cut along outer dotted line and fold in center)

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

BERKLEYNET
berkleynet.com

MEDICAL RECORDS RELEASE AUTHORIZATION

In order for your claim to be fully evaluated for purposes of determining your eligibility for the receipt of benefits with respect to this claim, you must sign the following authorization. Please note that the amount and type of medical information sought pursuant to this authorization will depend upon the nature of the claim, but that it will be used solely to facilitate determinations regarding the validity of the claim and the payment of benefits or the administration of the insurance program under which the claim has been made. The authorization is subject to your revocation at any time except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to Berkley Net Underwriters, LLC. , 12701 Marblestone Dr, Ste 250, Woodbridge, VA 22192, otherwise this authorization will continue to be valid. Your acceptance of benefits shall be considered an acceptance of the terms in this medical authorization, unless you indicate to the contrary in writing.

Authorization to Release Medical Information: I hereby authorize any employer, insurance company, government agency, medical prepayment plan, or service organization, and any physician, surgeon, therapist, pharmacist, or other duly licensed practitioner of the healing arts, and any hospital, including the Veteran's Administration, or medical transportation company, to release to Berkley Net Underwriters and their subsidiaries, affiliates, representatives and agents (collectively, Berkley Net Underwriters), any and all applicable medical records, medical information and benefit payment information with respect to any illness, injury, medical history, consultations, prescriptions, treatment or benefits, and copies of all applicable records thereof, which may be appropriate or necessary to establish the validity of this claim.

This authorization shall specifically include but shall not be limited to medical records, medical information and benefit payment information pertaining or relating to the treatment of AIDS, HIV, mental illness, and drug or alcohol related medical problems. I also authorize the Social Security Administration to release to Berkley Net Underwriters, information concerning entitlement dates and benefit amounts for myself and my dependents.

I further authorize Berkley Net Underwriters to release any such medical information to its reinsurers, attorneys or to medical peer review panels, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, or my employer and its excess insurer, to the extent that Berkley Net Underwriters considers doing so to be reasonably appropriate or necessary for purposes of its administration of the claim or the insurance program under which the claim has been made. I understand that authorizing the disclosure of this health information is voluntary. I understand the information released to Berkley Net Underwriters as a result of this authorization may no longer be subject to certain protections provided under the Health Insurance Portability and Accountability Act of 1996.

Unless revoked earlier by me in writing this authorization shall be valid for three years after the claim has been closed by Berkley Net Underwriters. A copy of this authorization is to be considered as valid as the original.

Employee Signature _____ ***Date***_____

Employee Name _____ *Claim No.* _____

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

PHYSICAL DEMAND ANALYSIS ASSESSMENT

This Position Physical Demand Analysis Assessment describes the physical requirements of the injured workers job or position. The focus is on strength, flexibility, sensory and environmental requirements or conditions of specific tasks. This form should be completed for the injured employee's present position as well as modified duty positions available, so it may be used by the health care provider to determine if the employee is capable of returning to work at regular or modified duties. Employer _____

Job or Position _____ Date form completed _____

Regular Hours of work per day _____ Completed by _____

Employee _____

During a regular work day, the employee must (circle number of hours and indicate if intermittent **(I)** or constant **(C)** for each activity.

Sit	**0 1 2 3 4 5 6 7 8 hours**	**I / C**
Stand	**0 1 2 3 4 5 6 7 8 hours**	**I / C**
Walk	**0 1 2 3 4 5 6 7 8 hours**	**I / C**
Drive	**0 1 2 3 4 5 6 7 8 hours**	**I / C**
Bend	**0 1 2 3 4 5 6 7 8 hours**	**I / C**

Job Requirements include (**Y/N**): __ Squatting; __ Kneeling; __ Bending; __Twisting; __Reaching; __Crawling; __Ladder Work; __Stair Climbing; __Work above Shoulder; __Work below Shoulder; __Walking on Rough Ground; __Working at Heights; __Exposure to Heat or Cold (circle which or both); __Exposure to Dust, Fumes or Gases; __Exposure to High Humidity; __Exposure to Noise; __Repetitive Movements

Lifting Requirements

	Never	Occasionally	Frequently	Continuous
Up to 10 lbs	☐	☐	☐	☐
11 to 24 lbs	☐	☐	☐	☐
25 to 34 lbs	☐	☐	☐	☐
35 to 50 lbs	☐	☐	☐	☐
51 to 74 lbs	☐	☐	☐	☐
75 to 100 lbs	☐	☐	☐	☐
Above 100 lbs	☐	☐	☐	☐

Carrying Requirements

	Never	Occasionally	Frequently	Continuous
Up to 10 lbs	☐	☐	☐	☐
11 to 24 lbs	☐	☐	☐	☐
25 to 34 lbs	☐	☐	☐	☐
35 to 50 lbs	☐	☐	☐	☐
51 to 74 lbs	☐	☐	☐	☐
75 to 100 lbs	☐	☐	☐	☐
Above 100 lbs	☐	☐	☐	☐

Pushing Requirements

	Never	Occasionally	Frequently	Continuous
Up to 10 lbs	☐	☐	☐	☐
11 to 24 lbs	☐	☐	☐	☐
25 to 34 lbs	☐	☐	☐	☐
35 to 50 lbs	☐	☐	☐	☐
51 to 74 lbs	☐	☐	☐	☐
75 to 100 lbs	☐	☐	☐	☐
Above 100 lbs	☐	☐	☐	☐

To Report Workers' Compensation Claims

www.berkleynet.com

Fax: 866.275.6320

Call Toll-Free 800.435.1127

Email:BNUClaims@berkleynet.com

First Health

BERKLEYNET
berkleynet.com

In case of Injury or Illness on the job, the following participating providers are available in your area.

CLINICS

HOSPITALS

PHYSICIANS

TMESYS Pharmacy Program - To contact your local TMESYS Pharmacy, please call (800) 964-2531

Notify your immediate supervisor of your injury. If you feel that you need medical attention, **you may choose one of the providers listed here or a provider of your own choice**. Please call the provider to confirm First Health participation and to schedule an appointment for faster service. Many clinics are open extended hours for your convenience. For urgent care needs after clinics hours, you may proceed directly to the hospital listed here. Patients will be seen on a medical priority basis. In emergency situations you may immediately seek treatment from the nearest qualified facility or provider. IF YOU NEED AN ALTERNATE TO THE PROVIDERS LISTED HERE, CALL 888-476-2669.

Your Employer and its Insurance Carrier utilizes **First Health contracted providers**. The above list is not a complete list of healthcare providers with First Health. For a complete listing of providers, or to verify whether a particular doctor does participate, please call800-828-2389. **If your situation is a medical emergency requiring immediate attention, dial 911 or proceed to the nearest hospital which provides emergency services.** Use of network does not confirm or verify compensability under the Workers' Compensation Act, which is determined solely by the claims administrator.

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

En caso de lesión o enfermedad laboral, los siguientes proveedores participantes están disponibles en su área.

CLINICS

HOSPITALS

PHYSICIANS

TMESYS Pharmacy Program - To contact your local TMESYS Pharmacy, please call (800) 964-2531

Notifique a su supervisor inmediato acerca de su lesión. Si usted siente que necesita atención médica, puede elegir a uno de los proveedores acá listados. Por favor llame el proveedor para confirmar que participa en el programa de First Health y fije una cita para un servicio más rápido. Muchas clínicas están abiertas durante un horario ampliado para su conveniencia. Para situaciones de cuidado médico urgentes después de horas de atención al público, puede proceder directamente al hospital listado acá. Los pacientes serán vistos de acuerdo con la urgencia médica. En situaciones de emergencia usted puede solicitar tratamiento inmediato en la instalación o proveedor calificado más cercano. SI USTED NECESITA UNA ALTERNATIVA A LOS PROVEEDORES INDICADOS ACÁ LLAME 888-476-2669.

Su empleador y la empresa aseguradora utilizan la red **The First Health®** Network. Para un listado completo de proveedores, o verificar si un doctor en particular está en la red, por favor llame al 800-828-2389. **Si su situación es una emergencia médica que requiere atención inmediata, marque el 911 o proceda al hospital más cercano que proporcione un servicio de emergencias.** El uso de la red no confirma o verifica la facultad de ser compensado conforme a la Ley de Compensación de Trabajadores lo cual es determinado exclusivamente por el administrador de reclamaciones.

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

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Office Mail Address	Location . . . If different from mailing address		Telephone
City State Zip	**INSURER**		**THIRD-PARTY ADMINISTRATOR**

EMPLOYEE

First Name M.I. Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Home Address (Number and Street)	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
City State Zip	Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No		How long has this person been employed by you in Nevada?	
In which state was employee hired?	Employee's occupation (job title) when hired or disabled		Department in which regularly employed:	
Telephone	Is the injured employee a corporate officer? ☐ Yes ☐ No ... sole proprietor? ☐ Yes ☐ No ... partner? ☐ Yes ☐ No		Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No	

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
Address or location of accident (Also provide city, county, state) (if applicable)			Accident on employer's premises? (if applicable) ☐ Yes ☐ No
What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)			
How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.			

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)		Witness	Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No
Part of body injured or affected	If fatal, give date of death	Witness	
Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)		Witness	
		Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No	Will you have light duty work available if necessary? ☐ Yes ☐ No
If validity of claim is doubted, state reason		Location of Initial Treatment	
Treating physician/chiropractor name		Emergency Room ☐ Yes ☐ No	Hospitalized ☐ Yes ☐ No
IMPORTANT How many days per week does employee work?	From ☐ am ☐ pm To ☐ am ☐ pm		Last day wages were earned
Scheduled days off: S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐	Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No		

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
Was the employee hired to work 40 hours per week? ☐ Yes ☐ No	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know	

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	Emloyee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY	On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title | Date

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"
(Incident Report)
Pursuant to NRS 616C.015

Name of Employer _____

Name of Employee		Social Security Number	Telephone Number
Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)	
What is the nature of the injury or occupational disease?		List any body parts involved:	
Briefly describe accident or circumstances of occupational disease: (Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)			
Names of witnesses:			
Did the employee leave work because of the injury or occupational disease? ____ YES ____ NO	If yes, when (date and time)?	Has the employee returned to work? ___ YES ___ NO	If yes, when (date and time)?
Was first aid provided? ____ YES ____ NO	If yes, by whom?	Name and address of treating physician, if applicable or known	
Did the accident happen in the normal course of work? (if applicable) ___ YES ___ NO			
Was anyone else involved? ____ YES ____ NO	Names of others involved		

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

_____ _____

Supervisor's Signature Date Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee

C-1 (Rev. 10/05)

State of Nevada
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

A T T E N T I O N

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

Notice of Injury or Occupational Disease (Incident Report Form C-1) If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

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Address: _____ Telephone Number: _____
City State Zip

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BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

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Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

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Pursuant to: **NRS 616B.227 Election by employee to report his tips; effect; regulation.**

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:
   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;
   (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and
   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

Medical Bill – Payment Process

Please be advised that in order to ensure prompt payment, medical bills must be sent directly to us.

Bills can be sent via fax, email or postal mail to:

Fax: 800.921.7683

Email: osceast@yorkrsg.com

Mail: P.O. Box 183188
Columbus, OH 43218-3188

If you have additional questions or need more information, please contact us at 877.497.2637

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"
(Incident Report)
Pursuant to NRS 616C.015

Name of Employer _____

Name of Employee		Social Security Number	Telephone Number
Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)	
What is the nature of the injury or occupational disease?		List any body parts involved:	
Briefly describe accident or circumstances of occupational disease: (Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)			
Names of witnesses:			
Did the employee leave work because of the injury or occupational disease? ____ **YES** ____ **NO**	If yes, when (date and time)?	Has the employee returned to work? ____ **YES** ____ **NO**	If yes, when (date and time)?
Was first aid provided? ____ **YES** ____ **NO**	If yes, by whom?	Name and address of treating physician, if applicable or known	
Did the accident happen in the normal course of work? (if applicable) ____ **YES** ____ **NO**			
Was anyone else involved? ____ **YES** ____ **NO**	Names of others involved		

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature Date

Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

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Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee

State of Nevada
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

A T T E N T I O N

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

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