BerkleyNet | a Berkley Company

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:

BerkleyNet

To report a claim, contact us at:

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

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 ***(If different from employer name)***

Insured Address ***(If different)***

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 ***(Name, address & phone number)***

Self Insured ☐
Check if Appropriate

Claim Administrator Claim # _____

Jurisdiction Claim # _____

Insured Report # _____

Jurisdiction _____

Employee

Name ***(Last, First, Middle)*** _____

Address _____

_____

City _____

State _____ Zip Code _____ Phone _____

Full Pay for DOI Yes ☐ No ☐
Salary Continued Yes ☐ No ☐

Number of Days Worked Per Week _____

Sex Male ☐ Female ☐

Number or Dependents _____

Occupational Job Title

Marital Status
Married ☐
Separated ☐
Unmarried ☐
Unknown ☐

Wage $ _____
Hourly ☐
Daily ☐
Weekly ☐
Bi-Weekly ☐
Monthly ☐

Occupational Code _____

NCCI Class Code _____

Date Employee Began Work-Related Duties _____

Employment Status FT ☐ PT ☐ Other ☐

Date of Birth	Social Security Number	Date Hired

Occurrence/Treatment

Date of Injury/Illness	Time Employee Began Work0	Time of Occurrence	Last Work Date
	AM ☐ PM ☐	(Cannot be determined ☐) AM ☐ PM ☐	

Where Did Injury/Illness Occur?
County _____ State _____Zip _____

Did Injury/Illness Occur On Employer's Premises?
Yes ☐ No ☐

Date Employer Notified	Date Disability Began	Date Returned to Work	If Fatal, Give Date of Death

Type of Injury/Illness ***(Briefly describe the nature of the injury or illness; e.g. lacerations to forearm)***

Nature of Injury Code

Part of Body Affected ***(Indicate the part of the body affected by the injury/illness; e.g. right forearm, lowerback; and how it was affected)***

Part of Body Code

How Injury/Illness Occurred ***(Describe activity and tools, materials, equipment the employee was using; how injury occurred)***

Cause of Injury Code

Initial Treatment:					Name of physician or other health care provider:
	No medical treatment ☐	*Emergency Room* ☐	*Future major medical/lost time* ☐		
	First aid by employer ☐	*Hospitalized overnight* ☐			
	Minor clinic/hospital ☐	*Hospitalized > 24 hours* ☐			

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—**S**tandard **I**dentification **C**lassification 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** F**ederal 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] _____