Claim Handling **Protocols**

Program Sponsors

NYCOM AOT

COMP ALLIANCE Since 1994

Exceptional Service. Long Term Stability.

WRIGHT™ Risk Management

Claim Handling Protocols

Taking Care of Employee

1. When an accident occurs, the first step is to assess the injury and seek the appropriate medical attention or first aid if necessary. Employee well being is the priority and information gathering is secondary.

2. We have provided you with Workers Compensation ID Cards to give your employees to present to their treating physician. This helps make your employees medical provider aware that this is a workers' compensation claim and that fees must be billed at the applicable fee schedule and bills should be forwarded directly to the Comp Alliance for processing. Each employee should have one of these cards and they should present to the medical facility if they require treatment.

3. A supply of Instant Fill Prescription Cards was sent to you when you joined the Alliance, which you may hand to employees who have been injured and who may need a prescription as part of their treatment. The card may be used by the employee even if the claim has not been reported yet, and will advise the pharmacy about billing (it is not a substitute for a prescription). We recommend that only site supervisors or Department Heads be given a supply of these cards, to be handed out as necessary as an injury arises. This will provide the employee the ability to get an initial prescription filled the day of the accident before they have any claim information, as it may not have been filed yet.

Filing the Claim

4. Once the employee is situated, start gathering the information necessary to complete the initial incident report. Gather as much information as possible, in accordance with your local rules or policies on investigations. We recommend completing an internal incident report. We are able to provide a generic template if you do not have one. We also recommend completing "near miss" incident reports to help identify situations which might cause an injury in the future. This can help prevent claims!

5. Your internal incident report should have most of the information you will need to complete a C-2F (Employer's Report of Accident). A copy of this form is attached. This information should include all the personal information about the injured party (name, home address, employment status etc). Additionally, you will want to gather all the information about the incident and extent of the injury. It is important to be as specific as possible in your investigation, including injury descriptors such as the injured body part, type of injury etc. Witnesses should be interviewed, and their contact information maintained to be shared with us.

6. We ask that all incidents resulting in an employee injury be reported to us. If you are in doubt about whether to report (only first aid was required and employee quickly back to work), please call Maria Luciano at 516-357-4135 to discuss.

7. You should prepare the C-2F (Employer's report of accident) and forward the original to the New York State Municipal Workers' Compensation Alliance (Comp Alliance) via one of the three methods discussed previously on the flip side of this sheet. (Claim Portal, Email or Fax). An electronic copy of the C-2F is available from us, and paper copies have been provided in your startup kit. The Comp Alliance will review the C-2F and determine whether it is necessary to file the claim with the Workers' Compensation Board (WCB), based on the Workers' Compensation Law. Using our template, helps you as much of the information will be pre-filled. See Appendix A for a list of information needed to complete a C-2F along with a Blank C-2F with highlighted fields.

8. Once the claim is filed with us, our adjuster will reach out to you and the injured worker and will walk everyone through the claim process. Any additional forms will be provided. Let us know if you have any questions.

Comp Alliance members can receive login credentials, more information and access instructions by contacting us today!

Maria Luciano
Workers' Compensation Claims Manager

516-357-4135 www.compalliance.org mluciano@wrightinsurance.com

C-2F Completion **Guide**

Program Sponsors

COMP ALLIANCE Since 1994

Exceptional Service. Long Term Stability.

WRIGHT™ Risk Management

Instructions for Completing the C-2F by Page

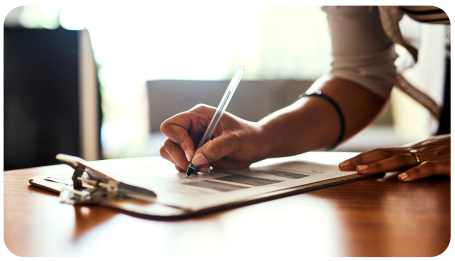
Page One:

At the top of the form, you do not need to complete the blanks for the WCB Case Number (JCN) or the Claim Administrator Claim Number. Those are assigned after the claim is submitted.

Insurer/Claim Administrator Section should be prefilled, but in case it is not, the information is:
Insurer Name: Wright Risk Management Insurer ID: W848139
Insurer: Workers Compensation Alliance
Info/Attn: Workers Compensation Claim Dept.
Address: 900 Stewart Avenue Suite 600
City: Garden City State: NY
Postal Code:11530 Country: USA
T Number: T100094

Phone Number, Date of Birth and Social Security Number (SSN) are all required. The full SSN is required, not just the last four digits. **The WCB will not accept the claim without this information and a penalty may be the result.**

The claimant's phone number is required because it is important for our adjuster to contact the injured employee.



Page Two

Date Employer had Knowledge of the Injury: This is the date an employee in a management or supervisory position had knowledge of the injury and had knowledge that it was work related.

Employment Status: This would be designated as full time, part-time, seasonal FT or seasonal PT.

Date Employer Had Knowledge of Date of Disability: This is the date an employee in a management or supervisory capacity was advised the injured employee was missing work and was advised that the disability was due to the work-related injury.

Estimated Weekly Wage: This is very important to provide so the Claim Administrator may issue compensation payments if the employee is not receiving sick leave or salary continuation from the employer.

(Continued on Next Page)

Comp Alliance members can receive login credentials, more information and access instructions by contacting us today!

Maria Luciano
Workers' Compensation Claims Manager

516-357-4135 www.compalliance.org mluciano@wrightinsurance.com

C-2F Completion **Guide**

Program Sponsors

COMP ALLIANCE Since 1994

Exceptional Service. Long Term Stability.

WRIGHT™ Risk Management

Instructions for Completing the C-2F by Page

Page Two (Continued)

Work Week Type: If the employee works a standard 5 day work week, the first box would be checked and the boxes below marked Mon through Fri would be checked. If the employee works a fixed nonstandard work week, e.g. Monday through Thursday, the second box would be checked, and the boxes below marked Mon through Thurs would be checked. Should the employee work a non-fixed, irregular work schedule, the third box would be checked and all the boxes below would be left blank.

Employee Injury

Full Wages Paid for Date of Injury: This is typically answered "Yes" since most employers pay the employee for the remainder of the day of injury. It is important to note that the date of injury is never the subject of an award of compensation. All awards begin the date after the injury, including awards of reimbursement to the employer.

Employee Paid Salary in Lieu of Compensation: This box should be checked "yes" if the injured employee is missing work and the employer will be starting up sick leave payments or salary continuation to the employee at the onset of the claim.

Nature, Part of Body, Cause & Description of Injury: We ask that you please be as descriptive and detailed as possible.

Work Status: Please ensure this section is completed. If the employee has returned to work, the date should be noted in the appropriate space.

Accident Location & Witnesses

This would not be the employer's official mailing address but the actual street location where the accident took place. If the accident occurred on the road or at a residence, the Organization Name would be left blank.

Page Three

Employer Information

Employer FEIN: This is required and is another name for the employer's Tax ID number.

UI Number: This designates the employer's Unemployment Insurance ID number. It is not required.

Manual Classification Code: This is not required.

Industry Code: This is required and the code # is 92

Info/Attn: This should be the name of the person at the employer designated with administrative responsibilities for claim reporting. This name is usually the same as the Contact Name requested further below.

Insured Information

The name of the employer should again be provided here as well as the employer FEIN (Tax ID No.).

Insured Type: The middle circle (Self Insured) should be checked. (The Comp Alliance is a group self-insurance program).

Policy Number ID, Policy Effective Date and Policy Expiration Date should all be marked N/A, as the employer is a member of a self-insured pool identified by a Carrier ID number and not by a policy number.

Comp Alliance members can receive login credentials, more information and access instructions by contacting us today!

Maria Luciano
Workers' Compensation Claims Manager

516-357-4135 www.compalliance.org mluciano@wrightinsurance.com

NEW YORK STATE Workers' Compensation Board

State of New York - Workers' Compensation Board

Employer's First Report of Work-Related Injury/Illness

C-2F

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

Employee Name _____

WCB Case Number (JCN) _____ **Date of Injury** _____

Claim Administrator Claim Number _____

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name Wright Risk Management **Insurer ID** W848139

Name NYS Workers' Compensation Alliance

Info/Attn Workers' Compensation Claims Dept.

Address 900 Stewart Avenue, Ste. 600

City Garden City **State** NY

Postal Code 11530 **Country** USA

Claim Admin ID T100094

EMPLOYEE INFORMATION

First Name _____ **Middle Name/Initial** _____

Last Name _____ **Suffix** _____

Mailing Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Phone Number _____ **Date of Hire** _____

Date of Birth _____ **Gender** ☐ Male ☐ Female ☐ Unknown

Employee SSN _____

Occupation Description _____

CLAIM INFORMATION

Time of Injury _____ **Date Employer Had Knowledge of the Injury** _____

Employment Status _____ **Date Employer Had Knowledge of Date of Disability** _____

Estimated Weekly Wage _____ **Number of Days Worked Per Week** _____

Work Week Type ☐ Standard Work Week ☐ Fixed Work Week ☐ Varied Work Week

Work Days Scheduled ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

EMPLOYEE INJURY

Full Wages Paid for Date of Injury ☐ Yes ☐ No **Employer Paid Salary in Lieu of Compensation** ☐ Yes ☐ No

Initial Treatment ☐ No Medical Treatment ☐ Minor On-Site Treatment By Employer ☐ Minor Clinic/Hospital Treatment
☐ Emergency Evaluation ☐ Hospitalization Greater Than 24 Hours ☐ Future Major Medical/Lost Time Anticipated

Death Result of Injury ☐ Yes ☐ No ☐ Unknown **Date of Death** _____ **Number of Dependents** _____

Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc) _____

Part of Body (i.e. left arm, right foot, head, multiple, etc) _____

Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc) _____

Accident/Injury Description (see instructions)

WORK STATUS

Initial Date Last Day Worked _____ **Return To Work Type** ☐ Actual ☐ Released

Initial Date Disability Began _____ **Physical Restrictions** ☐ Yes ☐ No

Initial Return to Work Date _____ **Return To Work Same Employer** ☐ Yes ☐ No

ACCIDENT LOCATION AND WITNESSES

Premises (see instructions) ☐ Employer ☐ Lessee ☐ Other

Organization Name _____

Street _____ **State** _____

City _____ **Postal Code** _____

County _____ **Country** _____

Location Narrative _____

Witnesses **Business Phone Number**

_____ _____

_____ _____

_____ _____

EMPLOYER INFORMATION

Name _____ **Employer FEIN** _____

UI Number _____ **Manual Classification Code** _____

Industry Code _____

Info/Attn _____

Mailing Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Physical Addr _____

City _____ **State** _____

Postal Code _____ **Country** _____

Contact Name _____

Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ **Insured FEIN** _____

Insured Type ☐ Insured ☐ Self-Insured ☐ Uninsured **Insured Location ID** _____

Policy Number ID _____

Policy Effective Date _____ **Policy Expiration Date** _____

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form _____ **Date** _____

Print Name _____

Title _____ **Phone Number** _____

NEW YORK STATE Workers' Compensation Board

State of New York - Workers' Compensation Board

Employer's First Report of Work-Related Injury/Illness

C-2F

A work-related injury or illness must be reported within 10 days (Per Section 110) of the injury/illness or be subject to a penalty. Employers are not required to submit form C-2F to the Workers' Compensation Board if the employer's insurer will be submitting the accident information electronically to the Board on the employer's behalf. If you need assistance completing this form, please contact your insurer for guidance on the best method of reporting work-related accident information. If you submit this form to the Board, please send it to P.O. Box 5205, Binghamton, NY 13902 and provide a copy to your insurer.

Employee Name _____

WCB Case Number (JCN) _____ **Date of Injury** _____

Claim Administrator Claim Number _____

INSURER / CLAIM ADMINISTRATOR INFORMATION

Insurer Name Wright Risk Management **Insurer ID** W848139

Name NYS Workers' Compensation Alliance

Info/Attn Workers' Compensation Claims Dept.

Address 900 Stewart Avenue, Ste. 600

City Garden City **State** NY

Postal Code 11530 **Country** USA

Claim Admin ID T100094

EMPLOYEE INFORMATION

First Name _____ **Middle Name/Initial** _____

Last Name _____ **Suffix** _____

Mailing Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Phone Number _____ **Date of Hire** _____

Date of Birth _____ **Gender** ☐ Male ☐ Female ☐ Unknown

Employee SSN _____

Occupation Description _____

CLAIM INFORMATION

Time of Injury _____ **Date Employer Had Knowledge of the Injury** _____

Employment Status _____ **Date Employer Had Knowledge of Date of Disability** _____

Estimated Weekly Wage _____ **Number of Days Worked Per Week** _____

Work Week Type ☐ Standard Work Week ☐ Fixed Work Week ☐ Varied Work Week

Work Days Scheduled ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

EMPLOYEE INJURY

Full Wages Paid for Date of Injury ☐ Yes ☐ No **Employer Paid Salary in Lieu of Compensation** ☐ Yes ☐ No

Initial Treatment ☐ No Medical Treatment ☐ Minor On-Site Treatment By Employer ☐ Minor Clinic/Hospital Treatment
☐ Emergency Evaluation ☐ Hospitalization Greater Than 24 Hours ☐ Future Major Medical/Lost Time Anticipated

Death Result of Injury ☐ Yes ☐ No ☐ Unknown **Date of Death** _____ **Number of Dependents** _____

Nature of Injury (i.e. Laceration, Burns, Fracture, Strain, etc) _____

Part of Body (i.e. left arm, right foot, head, multiple, etc) _____

Cause of Injury (i.e. Motor Vehicle, Machine, Strain or Injury by lifting, etc) _____

Accident/Injury Description (see instructions)

WORK STATUS

Initial Date Last Day Worked _____ **Return To Work Type** ☐ Actual ☐ Released

Initial Date Disability Began _____ **Physical Restrictions** ☐ Yes ☐ No

Initial Return to Work Date _____ **Return To Work Same Employer** ☐ Yes ☐ No

ACCIDENT LOCATION AND WITNESSES

Premises (see instructions) ☐ Employer ☐ Lessee ☐ Other

Organization Name _____

Street _____ **State** _____

City _____ **Postal Code** _____

County _____ **Country** _____

Location Narrative _____

Witnesses **Business Phone Number**

_____ _____

_____ _____

_____ _____

EMPLOYER INFORMATION

Name _____ **Employer FEIN** _____

UI Number _____ **Manual Classification Code** _____

Industry Code _____

Info/Attn _____

Mailing Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Physical Addr _____

City _____ **State** _____

Postal Code _____ **Country** _____

Contact Name _____

Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ **Insured FEIN** _____

Insured Type ☐ Insured ☐ Self-Insured ☐ Uninsured **Insured Location ID** _____

Policy Number ID _____

Policy Effective Date _____ **Policy Expiration Date** _____

An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

The above information is true to the best of my knowledge and belief.

If prepared by the employer:

Signature of Person Preparing Form _____ **Date** _____

Print Name _____

Title _____ **Phone Number** _____