sedgwick®

Sedgwick Claims Kit

Arizona

SOMPO

ATLAS™
An RPS Company

P.O. Box 14779
Lexington, KY 40512
Toll Free: 866-738-9201
Fax: 859-280-3275

Dear Insured:

We would like to welcome you as a policyholder of Endurance Assurance Corporation. Sedgwick is your Claims Administrator, and we are pleased to be able to provide you with workers' compensation claims handling services. Please follow the below instructions for filing a new claim and note the claim kit attachments.

Where do I report a claim?

> **Phone:** **855-728-5277 (855-7ATLAS7)**
> **Email:** 6200AtlasGeneralInsurance@sedgwick.com
> **Fax:** 866-383-3296

Where do I send my injured employee for medical treatment?

> **Website:** www.sedgwickproviders.com/AG

Sedgwick Claim Kit Attachments:

- Employer's First Report of Injury Form
- Employer's FAQ
- Workers Report of Injury form
- Injured Worker Handbook
- Notice to Employees poster – ***TO BE POSTED IN WORKPLACE***
- Work Exposure to MSRA, TB, Spinal Meningitis – ***TO BE POSTED IN WORKPLACE***
- Work Exposure to Bodily Fluids poster – ***TO BE POSTED IN WORKPLACE***
- Employee Safety and Health Protection poster - ***TO BE POSTED IN WORKPLACE***
- Authorization for Release and Use of Medical Information
- Express Scripts First Fill Temporary Pharmacy Card
- Designated Provider List
- Treatment Referral Form

Need a Loss Run? Email us @ RPS.SanDiego-2.LossRuns@rpsins.com

Have more questions?

Contact the Atlas Customer Care Team at Sedgwick - One of our friendly Client Services Associates will be happy to assist you.

> **Phone:** 866-738-9201
> **Email:** AtlasTeam@Sedgwick.com

We appreciate your business and believe that communication is critical for successful claims administration. We encourage you to contact us if you have any questions.

www.Atlas.us.com/claims

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment. ARIZONA REVISED STATUTES 23-908 & 23-1061

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

MAIL TO: (CARRIER NAME & ADDRESS)

FOR CARRIER USE ONLY

FOR OSHA PURPOSES ONLY

OSHA Case #: _____

RECORDABLE INJURY _____

NON-RECORDABLE INJURY _____

EMPLOYEE

1. LAST NAME | FIRST | M.I.
2. SOCIAL SECURITY NUMBER *
3. BIRTH DATE
4. HOME ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE
5. TELEPHONE
6. SEX ☐ MALE ☐ FEMALE
7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYER

8. EMPLOYER'S NAME
9. POLICY NUMBER
10. NATURE OF BUSINESS (MANUFACTURING, ETC.)
11. OFFICE ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE
12. TELEPHONE

ACCIDENT

13. DATE OF INJURY OR ILLNESS
14. TIME OF EVENT ☐ A.M. ☐ P.M.
15. TIME EMPLOYEE BEGAN WORK ☐ A.M. ☐ P.M.
16. DATE EMPLOYER NOTIFIED OF INJURY
17. LAST DAY OF WORK AFTER INJURY
18. DATE OF RETURN TO WORK
19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED
20. CLASS CODE ON PAYROLL REPORT
21. EMPLOYEE'S ASSIGNED DEPARTMENT
22. DEPARTMENT NUMBER
23. DID INJURY OCCUR ON EMPLOYER PREMISES? ☐ YES ☐ NO
24. ADDRESS OR LOCATION OF ACCIDENT | CITY | COUNTY | STATE | ZIP CODE
25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
26. PART OF BODY INJURED
27. FATAL ☐ YES ☐ NO
28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH
29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO
NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL | ADDRESS (STREET, CITY, STATE & ZIP CODE)
30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ YES ☐ NO
IF HOSPITALIZED, HOSPITAL NAME | ADDRESS (STREET, CITY, STATE & ZIP CODE)
31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON

CAUSE OF ACCIDENT

32. **WHAT HAPPENED?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
33. **WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*
34. **WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ☐ YES ☐ NO
37. HOURS PER DAY EMPLOYEE WORKED FROM A.M. P.M. THRU A.M. P.M.
38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ☐ YES ☐ NO
39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY

IMPORTANT

IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

40. DATE OF LAST HIRE
41. WAS WORKER PAID FOR DAY OF INJURY? ☐ YES ☐ NO IF YES, $
42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ☐ YES ☐ NO
43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR
44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE HOUR DAY WEEK MONTH
$ PER ☐ ☐ ☐ ☐
45. IS EMPLOYEE FURNISHED VALUE
☐ LODGING ☐ BOARD ☐ BOTH $
46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)
47. DOES EMPLOYEE CLAIM DEPENDENTS? ☐ YES ☐ NO

IMPORTANT

IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55

48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR
49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK
50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEEDING INJURY FROM THRU $
51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $
52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY
53. WAGE BEFORE INCREASE $
54. WAGE AFTER INCREASE $
55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $

AUTHORIZED SIGNATURE

DATE | AUTHORIZED SIGNATURE | TITLE

NOTE TO EMPLOYER:

1. Mail one copy to the Industrial Commission within 10 days.
2. Mail one copy to your insurance carrier within 10 days.
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Workers' Compensation Insurance

EMPLOYERS' FREQUENTLY ASKED QUESTIONS

INTRODUCTION

This information is intended to provide employers with a basic overview of the workers' compensation system in Arizona. The information provided does not cover every aspect of workers' compensation law. There are often exceptions to general rules, unsettled areas of law, and recent changes in the system. Therefore, it is strongly recommended that you consult with an attorney for competent and comprehensive advice based on your individual business or the facts of your particular legal issue. Additionally, information regarding any aspect of other non-workers' compensation law related or applicable to an employer/employee relationship or otherwise enforced by the ICA is not addressed herein.

WHAT ARE THE LAWS AND RULES THAT GOVERN WORKERS' COMPENSATION?

Workers' compensation is governed by the laws found in Article 18, Section 8 of the Arizona State Constitution, Chapter 6 of Title 23 of the Arizona Revised Statutes (A.R.S. § 23-901 et seq., also sometimes referred to as "the Act") and Workers' Compensation Practice and Procedure rules contained in the Arizona Administrative Code (A.A.C. R20-5-101 et seq.). All parties to a workers' compensation claim should familiarize themselves with these provisions of law. You can obtain copies free of charge at either Industrial Commission office. Copies may also be available for the cost of copying at county law libraries and many local libraries including the Maricopa County Superior Court Law Library located at 101 West Jefferson Street, East Court Building, first floor, Phoenix, Arizona. The Arizona State Constitution and statutes are available on-line at www.azleg.state.az.us. The rules are available online at www.azsos.gov.

WORKERS' COMPENSATION INSURANCE

Under Arizona law, it is mandatory for employers to secure workers' compensation insurance for their employees. Workers' compensation is a "no fault" system in which an injured employee is entitled to receive benefits for an industrial injury, no matter who caused the job-related accident. If an illness or injury is job-related, then the injured worker (also known as a claimant or applicant) receives medical benefits and may receive temporary compensation, if eligibility requirements are met. In some cases, a claimant may also receive permanent compensation benefits, "job retraining," and supportive medical care.

WHAT IS A "NO FAULT" SYSTEM?

Workers' compensation is a "no fault" system in which an injured employee is entitled to receive medical and compensation benefits no matter who causes the job-related accident. This means that even if the employee was at fault or partially at fault in causing the industrial injury, he/she will, in most instances, be entitled to benefits under the workers' compensation system. There are some exceptions, however. For example, an employee is not entitled to workers' compensation benefits for injuries that are "purposely self-inflicted."

HOW CAN I OBTAIN WORKERS' COMPENSATION INSURANCE FOR MY EMPLOYEES?

Workers' compensation insurance can be obtained from an insurance company licensed to issue workers' compensation insurance in the State of Arizona. For a listing of these companies you may contact the Arizona Department of Insurance at (800) 325-2548 or www.id.state.az.us. Employers who meet certain requirements can also apply to the ICA for permission to be self-insured for workers' compensation. Once an employer obtains insurance or authority to self-insure, the employer is required to post a notice of workers' compensation insurance advising their employees of the coverage and of the employee's right

to reject this coverage. The employer is also required to supply "rejection" forms for employees who chose to reject their employer's workers' compensation coverage.

AM I REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE IF I HAVE ONLY ONE WORKER OR PART-TIME WORKERS?

If an employer regularly hires workers in its customary business then the employer is required to carry workers' compensation insurance regardless of the number of workers they have, whether those workers are part-time, full-time, minors, aliens, or family members. Workers' compensation insurance is not required for an independent contractor, or a worker whose employment is both casual and not in the usual business of the employer. Also, workers' compensation insurance is not required for a domestic servant who works in your home.

AM I REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE IF I AM A SOLE PROPRIETOR?

Although a sole proprietor having no employees is not required to maintain workers' compensation insurance on himself/herself, the sole proprietor may elect to secure coverage for himself/herself. However, if there are any employees working for the sole proprietor, the sole proprietor must maintain workers' compensation insurance on them.

AM I REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE IF MY BUSINESS IS A CORPORATION?

A corporation is an employer under the Act and, therefore, must obtain workers' compensation insurance for its employees which may include officers, directors or shareholders.

AM I REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE IF MY BUSINESS IS A LIMITED LIABILITY COMPANY (L.L.C.)?

If an L.L.C. employs one or more employees, an L.L.C. is required to obtain workers' compensation insurance for its employees. Employees may include members and managing members.

CAN AN EMPLOYEE ELECT NOT TO BE COVERED UNDER MY WORKERS' COMPENSATION INSURANCE?

An employer may not require the employee to waive rights to workers' compensation as a condition of employment, nor require an employee pay any portion of the employer's workers' compensation insurance premium. An employee may, however, voluntarily reject workers' compensation insurance by providing a written notice to the employer which the employer files with his workers' compensation insurance carrier. In most instances, this rejection must be filed before the employee suffers an industrial injury. An employee may also later rescind that rejection in writing but must do so before the occurrence of an industrial injury.

AM I REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE IF I HIRE AN INDEPENDENT CONTRACTOR AND HOW DO I KNOW IF A WORKER IS AN INDEPENDENT CONTRACTOR?

Generally, you do not have to provide workers' compensation insurance for an independent contractor. But, there are often disputes over whether a worker is an employee or an independent contractor. To resolve these disputes courts consider the "totality of facts" on a case-by-case basis. Some of the factors a court might consider include: the duration of the employment, the method of payment, the right to hire

and fire, the extent to which the employer may exercise control over the work, who supplies the tools, who sets the hours of work, and whether the work was performed in the usual and regular course of the employer's business. There may be other factors the court will consider and no one factor is, in itself, conclusive. Therefore, even if you believe you have an "independent contractor" relationship, a court could still decide that based on the totality of the facts, the worker was an employee entitled to workers' compensation benefits.

WHAT DO I DO IF AN EMPLOYEE IS INJURED ON THE JOB?

Immediately upon notice of an industrial injury, an employer is required to provide certain information to the injured worker who reports the injury. This information includes the name and address of the workers' compensation insurance carrier, the policy number, and the date of expiration of coverage. An employer is also required to notify their workers' compensation insurance carrier and the Industrial Commission of Arizona within ten days after receiving notification of a work related injury or disease using the Employer's Report of Industrial Injury form which is available from the ICA and online at www.ica.state.az.us. For fatalities, an employer is required to notify the ICA Claims Division immediately by telephone or telegraph. Other reporting obligations are required under the Arizona Occupational Safety and Health Act, but are not addressed here.

CAN I TELL MY EMPLOYEE WHICH DOCTOR TO SEE?

An employer can direct an injured employee to a physician of the employer's choice for a one-time evaluation. Following that visit, the injured worker may return to that physician or pursue treatment with a physician of his/her choice. There are exceptions to this rule for a self-insured employer that has complied with the requirements of A.R.S. § 23-1070.

WHAT WILL HAPPEN IF I DO NOT HAVE INSURANCE AND MY EMPLOYEE CLAIMS A WORK RELATED INJURY?

If an employee is injured but you do not carry workers' compensation insurance, your employee can choose to file a civil suit against you or file a workers' compensation claim with the ICA. If the employee files a civil lawsuit, proof of the injury is evidence of negligence on the employer's part. If an employee chooses to file a claim with the ICA, it will be referred to the Special Fund Division/No Insurance Section. The Special Fund will process the injured worker's claim and pay medical and compensation benefits if the claim is accepted. The Special Fund will seek reimbursement from the uninsured employer for any benefits paid to the injured worker plus a penalty of 10% of the benefits paid or $1,000, whichever is greater (and interest on the total).

IS THERE A FINANCIAL PENALTY IF I DON'T HAVE REQUIRED WORKERS' COMPENSATION INSURANCE?

Subject to limited exceptions, an uninsured employer may be assessed a civil penalty of $1,000 for failure to obtain workers' compensation insurance, whether or not an employee files a workers' compensation claim. The penalty is increased to $5,000 for a second instance of being uninsured within a five-year period and $10,000 for a third instance in a five-year period.

CAN MY BUSINESS BE SHUT DOWN IF I DON'T HAVE REQUIRED WORKERS' COMPENSATION INSURANCE?

An employer that fails to obtain the required workers' compensation insurance is subject to an action by the ICA for an injunction (Superior Court Order) that will require the employer to cease the operation of

business until the employer complies with the requirement to maintain workers' compensation insurance for its employees.

AM I COMMITTING A CRIME IF I DON'T HAVE REQUIRED WORKERS' COMPENSATION INSURANCE?

An employer that does not carry workers' compensation insurance is guilty of a Class 6 felony. A.R.S. § 23-932.

CAN AN EMPLOYEE SUE ME IN CIVIL COURT IF HE/SHE IS INJURED ON THE JOB?

In most instances, workers compensation is the exclusive remedy against an employer that is insured for workers' compensation. However, if an employee has rejected workers' compensation coverage prior to their injury or if the employer fails to post the notice advising an employee of the right to reject workers' compensation, then the employee retains the right to pursue a civil lawsuit against the insured employer. Additionally, if an employee is injured through the "willful misconduct" of the employer or a co-worker, then the injured worker has the right to file a civil lawsuit against the employer and the co-worker who injured them. If the employer was uninsured for workers' compensation at the time of the work injury, then the injured employee has the option to file a civil lawsuit against the uninsured employer.

WHAT IS THE DIFFERENCE BETWEEN A CIVIL LAWSUIT AND A WORKERS' COMPENSATION CLAIM?

There are many differences between a civil lawsuit and a workers' compensation claim. For example, in a workers' compensation claim, an injured employee is entitled to lifetime medical and compensation benefits but the compensation for lost wages is capped by law. If you are sued in civil court, there is no cap on the amount of damages an injured worker can claim. Under the workers' compensation system, an injured worker cannot seek compensation for "pain and suffering" or "punitive" damages such as can be sought in a civil lawsuit. A workers' compensation dispute is decided by an administrative law judge whereas civil lawsuits are usually decided by a jury. A workers' compensation claim also has rules of procedure and evidence that differ from those that apply in a civil lawsuit. Certain legal principles such as "contributory negligence" that may apply in a civil lawsuit do not apply in a workers' compensation claim. An attorney can advise you regarding the many other differences between a civil lawsuit and a workers' compensation claim.

WHAT CAN I DO IF I DO NOT BELIEVE MY EMPLOYEE'S WORKERS' COMPENSATION CLAIM IS VALID?

If you doubt the validity of a workers' compensation claim, then you may state your reasons on the Employer's Report of Industrial Injury form. You may also provide your insurance carrier with any information or documentation you have to support your position. As a general rule, any action or determination taken or made by the insurance carrier is binding upon the employer, except if the employer provides written notice to the carrier and the Commission within the applicable protest period that it disagrees with the carrier's determination. If you were uninsured for workers' compensation at the time of the workers' injury, then you may provide information or documentation regarding the validity of the claim to the Special Fund Division/No Insurance Section. If you disagree with an acceptance of a claim by the Special Fund, then you only have 30 days from the notice accepting the claim to file your protest with the ICA. Other notices issued by the Special Fund may carry a shorter protest period.

SHOULD I HIRE AN ATTORNEY TO REPRESENT ME?

You should consult an attorney to answer any question you have concerning your liabilities and obligations under the Workers' Compensation Act. If you have workers' compensation insurance, then you should contact your insurance carrier to determine if they have assigned an attorney to handle a particular workers' compensation claim. If a claim is processed as a "no insurance" claim, then the employer will be required to hire an attorney if the employer is a corporation or limited liability company. Corporations and limited liability companies may not practice law in Arizona, nor be represented by an officer or agent who is not otherwise an attorney licensed to practice in Arizona. The appearance and practice before the ICA constitutes the practice of law.

WHAT IS THE INDUSTRIAL COMMISSION OF ARIZONA?

The Industrial Commission of Arizona (ICA) was created in 1925 as a result of legislation implementing the constitutional provisions establishing Arizona's workers' compensation system. The ICA divisions administer and enforce all applicable laws and regulations not specifically delegated to others, relative to the protection of life, health, safety, and welfare of employees within the State. The ICA does not issue workers' compensation insurance policies. The ICA's general number is (602) 542-4411. Additional information and forms are available on the online at www.ica.state.az.us.

WHAT ARE SOME OF THE DIFFERENT DIVISIONS AT THE ICA?

Ombudsman

The Ombudsman is available to offer assistance to injured workers in processing workers' compensation claims and to make referrals to other agencies when appropriate. The Ombudsman does not provide legal advice.

Claims

The Claims Division regulates workers' compensation insurance carriers and self-insured employers to ensure that workers receive those benefits to which they are entitled under the Arizona Workers' Compensation Act. The Claims Division also maintains the "file of record" for Arizona workers' compensation claims, and in certain circumstances, is involved in claims processing (e.g. issuance of Average Monthly Wage and Loss of Earning Capacity Awards).

Legal Division

The Legal Division represents the ICA in all legal matters affecting the agency in order to ensure that the agency's regulatory, enforcement and quasi-judicial mandates and functions are carried out in accordance with all applicable laws.

The Special Fund

The Special Fund is a "trust fund" legislatively created for the express purpose of providing workers' compensation benefits in limited areas. For example, the Special Fund Division/No Insurance Section processes and pays workers' compensation claims involving an uninsured employer. In certain cases, the Special Fund may also provide vocational rehabilitation benefits, supportive care, and apportionment benefits.

Administrative Law Judge Division (ALJ)

The ALJ Division resolves disputes in cases referred to it, including workers' compensation and occupational safety and health matters.

Occupational Safety and Health (ADOSH)

The Arizona Division of Occupational Safety and Health (ADOSH) enforces state occupational safety and health regulations for both public and private employers within the state. ADOSH also provides free consultation services for both public and private employers upon request.

CAN THE ICA GIVE ME LEGAL ADVICE?

No one at the ICA can give you legal advice. This includes ALJs, their secretaries, and other ALJ Division staff. If an employee or a worker needs assistance regarding the processing of their claim, they can contact the Ombudsman's Office at (602) 542-4538. If you wish to obtain legal advice, then you should consult a private attorney.

WHO CAN GIVE ME LEGAL ADVICE?

You may wish to consult a lawyer licensed to practice law in Arizona for legal advice about a workers' compensation case. To find a lawyer, you can call the Maricopa County Lawyer Referral Service at 602-257-4434 or the Pima County Lawyer Referral Service at 520-623-4625. The State Bar of Arizona does not have a lawyer referral service but it can send you a list of lawyers who are certified as specialists in workers' compensation law. Specialists have been certified after an investigation of their qualifications and experience. You can search for a certified specialist on the State Bar of Arizona's web site at www.azbar.org or by calling the Hotline for Certified Specialists at (602) 340-7300. You can also look in the Yellow Pages of your telephone book under Attorneys or ask friends, family members, co-workers, or colleagues who may have used a lawyer in the past.

HELPFUL CONTACT INFORMATION

Industrial Commission of Arizona

Website Address: www.ica.state.az.us

Phoenix Office: 800 West Washington St.
P.O. Box 19070
Phoenix, Arizona 85005-9070

- Claims: Main Number (602) 542-4661
  Fax Number (602) 542-3373
- Hearings (ALJ): Main Number (602) 542-5241
  Fax Number (602) 542-4135
- Ombudsman: Main Number (602) 542-4538
  Toll Free (800) 544-6488
- Safety & Health: Main Number (602) 542-5795
- Labor: Main Number (602) 542-4515

Tucson Office: 2675 East Broadway Blvd.
Tucson, Arizona 85716-5342

- Hearings (ALJ): Main Number (520) 628-5188
- Safety & Health: Main Number (520) 628-5478

Arizona Department of Insurance
www.id.state.az.us
Phoenix Area: (602) 364-2499
Tucson Area: (520) 628-6370
Statewide: (800) 325-2548

State Bar of Arizona
www.azbar.org
4201 N. 24th Street, Suite 200
Phoenix, Arizona 85016-6288
602-252-4804
1-866-48-AZBAR (outside Maricopa County)

Maricopa County Lawyer Referral Service
www.maricopabar.org
602-257-4434

Pima County Lawyer Referral Service
520-623-4625

Arizona State Legislature
www.azleg.state.az.us

Arizona Secretary of State
www.azsos.gov

Rev. October 2011

WORKER'S REPORT OF INJURY

MAIL TO: Industrial Commission of Arizona, P.O. Box 19070, Phoenix, AZ. 85005-9070
Do not attach form to email; mail in envelope to address above or FAX to 602-542-3373.

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the Industrial Commission of Arizona claims and hearing process are available at the Industrial Commission offices and through the ICA web-site located at: www.ica.state.az.us

ANSWER ALL QUESTIONS FULLY (Use the back of this form to indicate any further information.)

1. NAME OF INJURED WORKER: _____ (LAST) _____ (FIRST) _____ (M.I.)
   SOCIAL SECURITY # *: _____ BIRTH DATE: _____ PHONE #: ( ) _____
2. ADDRESS: _____ (CITY) _____ (STATE) _____ (ZIP CODE)
3. MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ DEPENDENTS AT TIME OF INJURY: YES ☐ NO ☐
4. EMPLOYER'S FULL NAME: _____ PHONE #: _____
5. ADDRESS: _____ (CITY) _____ (STATE) _____ (ZIP CODE)
6. DATE HIRED: _____ WHERE HIRED: _____ OCCUPATION: _____
7. HOURS WORKED PER DAY: _____ PER WEEK: _____ HOURLY WAGE: _____
8. DID YOU RECEIVE FOOD OR LODGING IN ADDITION TO WAGE? YES ☐ NO ☐
9. DATE OF INJURY (MO/DAY/YEAR): _____ TIME OF INJURY: _____ AM ☐ PM ☐
10. ADDRESS OR LOCATION OF ACCIDENT: _____
11. DID YOU STOP WORK IMMEDIATELY? _____ WHEN DID YOU STOP? _____
12. WHEN DID YOU REPORT THE INJURY? _____ TO WHOM? _____ TITLE: _____
13. WHEN DID YOU RETURN TO WORK? _____ REGULAR WORK _____ OTHER WORK _____
14. NAMES OF PERSONS WHO SAW THE ACCIDENT.
    1. NAME: _____ ADDRESS: _____ PHONE #: _____
    2. NAME: _____ ADDRESS: _____ PHONE #: _____
15. WAS ACCIDENT CAUSED BY ANOTHER PERSON? _____ IF SO, BY WHOM? _____
16. NAME OF MACHINE OR TOOL WHICH MAY HAVE CAUSED THE ACCIDENT: _____
17. STATE HOW ACCIDENT HAPPENED: _____
    _____
    _____
18. BODY PART INJURED: _____ DESCRIBE THE INJURY (CUT, BRUISE, ETC.): _____
19. WHERE WERE YOU FIRST TREATED: NAME: _____ ADDRESS: _____
20. WHO TREATED YOU FOR THIS INJURY: NAME: _____ ADDRESS: _____
21. OTHER THAN THIS INJURY, HAVE YOU LOST TIME FROM WORK DUE TO AN ACCIDENT IN THE PAST 12 MONTHS? YES ☐ NO ☐
    NAME OF STATE WHERE ACCIDENT HAPPENED: _____ WORK INJURY: YES ☐ NO ☐
22. OTHER THAN THIS INJURY, HAVE YOU EVER RECEIVED ANY PERMANENT DISABLING INJURY? YES ☐ NO ☐
    DATE OF INJURY: _____ WORK INJURY: YES ☐ NO ☐
    NAME OF STATE WHERE ACCIDENT HAPPENED: _____
23. OTHER THAN THIS INJURY, ARE YOU RECEIVING COMPENSATION FOR ANY DISABLING CONDITIONS? YES ☐ NO ☐
    IF SO, FROM WHOM? _____ AMOUNT? _____ WHY? _____

I make application for all benefits to which I may be entitled under the law. I certify, with full knowledge that it is a crime to make willful, false statements to obtain compensation and that all of my statements on this form are true, accurate and complete.

_____ _____
Signature of injured worker or injured worker's authorized representative is REQUIRED. **Date**

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

ICA 04-0407 REV 5/02

INDUSTRIAL COMMISSION OF ARIZONA

WORKERS' COMPENSATION INFORMATION FOR THE INJURED WORKER

Phoenix Office:

Industrial Commission of Arizona
800 W. Washington Street
Phoenix, Arizona 85007-2922
Claims Phone: 602-542-4661
Claims Fax: 602-542-3373

Tucson Office:

Industrial Commission of Arizona
2675 E. Broadway
Tucson, Arizona 85716-5342
Claims Phone: 520-628-5188
Fax: 520-628-5182

www.ica.state.az.us

INTRODUCTION

The Arizona Workers Compensation Law is administered by The Industrial Commission of Arizona, which is referred to in this booklet as the ICA. This booklet is intended to be an overview for injured workers outlining their rights and responsibilities in the workers' compensation system. Representatives of the ICA are available to answer questions regarding the workers' compensation act, telephone numbers are listed in the back of this booklet. **The information provided is not legal advice and should not be considered as such**.

Workers' Compensation is a "no-fault" system in which the injured worker receives medical care and compensation benefits no matter who caused the job-related accident. If the injury or illness is job related, the injured worker receives medical benefits and if eligible, temporary compensation. In some cases the injured worker may also receive permanent compensation and "job training". Lawsuits against the employer, except under very limited circumstances, are not permitted.

As an injured worker reads this booklet, special attention should be paid to their rights and responsibilities. Failure to meet those responsibilities can mean the loss of benefits under Arizona Workers' Compensation Law.

THE INDUSTRIAL COMMISSION OF ARIZONA (ICA)

The ICA and the insurance company have different functions. The ICA has certain regulatory duties which include notifying carriers of an industrial injury, holding hearings to resolve disputes between injured workers and carriers and monitoring the carriers processing of the industrial injury claim. There is a Special Fund Division of the ICA which provides benefits to employees injured while working for a non-insured employer.

EMPLOYER RESPONSIBILITIES

Arizona law requires that all public and private employers provide worker's compensation coverage for their employees if they employee one or more persons full or part-time.

Every employer must have a posted notice of industrial insurance coverage in the work place. At the same place this notice is posted, the law requires that forms be provided to workers to complete if they choose NOT to have coverage under the Arizona Workers Compensation Act. **THIS FORM MUST BE COMPLETED AND GIVEN TO YOUR EMPLOYER IN DUPLICATE BEFORE THERE IS AN INJURY**.

The entire cost of the workers' compensation insurance coverage is paid by the employer. Arizona law forbids the employer to deduct any portion of the premium for workers' compensation insurance from an employee's wages.

When an employer is advised by a worker that an on the job injury/illness has occurred, the employer is required to report the incident to the insurance carrier and the ICA within ten days.

If the injured worker's employer is self-insured, the employer may have the right to direct the injured worker's medical care for the entire injury. If the employer is not self-insured, the employer has the right to direct the injured worker to the employer's doctor for one visit only after which the injured worker may report to the doctor of their choice.

INJURY

An injury is covered under workers' compensation if it is job related. It is the injured worker's responsibility to make sure the injury is reported to the supervisor/employer as soon as an injury occurs or when the injured worker becomes aware of the condition. The prompt reporting of the accident to the supervisor/employer will accelerate the processing of the claim and avoid unnecessary delays or possible denial of benefits.

FILING A CLAIM

A claim must be filed within one year from the date of injury or when the injured worker became aware of the condition. The injured worker is responsible for making sure that the claim is filed. It is the injured worker's responsibility to understand all notices and documents which allow for hearing requests in the event of disagreements and to make sure all hearing requests are filed within the protest periods. It is the injured worker's responsibility to advise ICA and the insurance carrier of the most current address through out the duration of the claim.

When the injured worker first receives treatment they should advise the doctor's office or emergency room this was an on the job injury. The injured worker should be provided with a "pink form" to complete and sign. This "pink form" is titled "Worker's and Physicians Report of Injury." If the "pink form" is not completed at the doctor's office or emergency room, another form can be completed which is available at the ICA, titled "Workers' Report of Injury". By signing one of these two forms the injured worker is applying for worker's compensation benefits.

The doctor's office or hospital will send the original of the "pink form" to the ICA, a copy to the employer and a copy to the worker's compensation insurance carrier. Once ICA receives the "pink form" your claim will be notified to the correct insurance carrier, and ICA will send a letter to the injured worker with the name of the insurance carrier. If the injured worker does not receive a letter from ICA within fourteen (14) days following the injury, ICA should be contacted to determine the status of the claim. Once the claim has been notified to the insurance carrier their obligation would be to do one of two things: accept or deny the claim for benefits within twenty-one (21) days from the date of notification.

DENIAL OF CLAIM

If the injured worker's claim is denied for benefits, you will receive a "Notice of Claim Status" from the insurance carrier which will have a ninety (90) day protest period. The injured worker can request a hearing by sending a letter or by filing a Request for Hearing form which is available at the ICA. The letter or "Request for Hearing" form must be signed by the injured worker or the legally authorized representative. When a request for hearing is filed the injured worker will receive a Notice Of Hearing which will tell the injured worker the date, place and time of the hearing. This Notice will also tell the injured worker the name of the Administrative Law Judge who will conduct the hearing.

It is the injured worker's responsibility to understand all notices and documents which allow for hearing requests in the event of disagreements and to make sure all hearing requests are filed within the protest periods. If the injured worker does not understand a notice or document they receive, they may want to contact their authorized legal representative or ICA for an explanation.

TYPES OF ACCEPTABLE CLAIMS

There are two types of acceptable Workers' Compensation claims: (1) medical only or no time lost claims, which means that only medical expenses are paid and; (2) time loss claims, which means medical expenses and temporary compensation benefits for lost wages are paid. A detailed explanation of both types of claims are as follows:

MEDICAL ONLY CLAIMS

Medical only claims are those claims for which the insurance carrier will pay all of the medical expenses associated with the injury but will not pay compensation benefits for lost wages because the injured worker did not lose more than 7 calendar days from work. Examples of medical expenses that are paid are: emergency room charges, doctor's fees, doctor visits, prescriptions, crutches, braces and splints.

On medical only claims, the insurance carrier does not have to let the injured worker know that they are accepting the claim and it can be assumed that all medical bills will be paid. Even though the injured worker does not lose time from work, the medical bills will continue to be paid until the doctor states no further medical treatment is needed. If the injured worker voluntarily stops medical treatment, the insurance carrier may close the claim without the doctor's discharge.

Once the claim is accepted, the injured worker is not responsible for the payment of any medical expenses for treatment related to the injury. If the injured worker receives a bill and is being asked to pay it, call the insurance carrier to find out why the bill has not been paid. If the injured worker has personally paid for medical expenses related to the injury, send the receipt(s) to the insurance carrier.

TIME LOST CLAIMS

If a doctor states you are unable to work because of your injury and you are off work more than 7 days, you are entitled to compensation for your lost wages. The days off do not have to be consecutive (in a row) but are cumulative (total). Entitlement to compensation is based on calendar days (not work days) and includes Saturdays, Sundays and holidays.

The first 7 days off are not paid for lost wages unless you are off for 14 days or more. For example: If you are off 10 days, the first seven days are subtracted and you are paid for days 8, 9, and 10 only. If you are off 14 full days, compensation is retroactive (goes back) to the date of injury and you are paid for 14 days. Compensation is not generally paid for the date of injury because you were working that day.

Compensation is paid at $66^{2}/_{3}\%$ of your established average monthly wage. The average monthly wage is usually calculated on your earnings during the 30 days before your injury, although there are other methods for calculating the average monthly wage. The law establishes a maximum wage figure which can be used to calculate the average monthly wage. As of January 1, 2014 the maximum monthly wage is $4,256.94. Even though you may have earned more than $4,256.94 per month, the most a person can receive is $66^{2}/_{3}\%$ of $4,256.94. The wage is set as of the date of injury. The law does not allow for cost of living increases.

If you are losing time from work, the law requires that the carrier inform you that your claim is being accepted by sending to you a Notice of Claim Status form with your first temporary compensation check. The Notice will tell you the wage as calculated by the carrier. A second form, Wage Calculation Sheet, should be attached to the Notice. This form will explain how the carrier arrived at the figures. The same information is also sent to the ICA for review. If there is a question regarding the accuracy of the data used in calculating the average monthly wage, you are asked to contact the Wage Section of the ICA's Claims Division.

The ICA reviews the carrier's calculations and issues the Notice of Average Monthly Wage which officially sets the wage. If the wage recommended by the carrier is not calculated correctly, the ICA can disapprove that wage and establish the correct wage. Because the ICA's review covers only the reasonableness of the data and the accuracy of the calculations, it will send you, the injured worker, a letter seeking your assistance in verifying the accuracy of the figures used in the calculation. If there is a question regarding the accuracy of the data used in calculating the average monthly wage, you are asked to contact the Wage Section of the ICA's Claims Division.

You only have 90 days from the issuance of the Notice of Average Monthly Wage to protest the accuracy of the determination. Again, to avoid any delay or loss of benefits, make sure that the carrier and the ICA have your current address.

TEMPORARY COMPENSATION

Temporary compensation benefits must be paid every two weeks while the doctor has you on a no work status. It is during this time that your doctor is actively treating you in the hopes of improving your medical condition so that you can eventually go back to work. There is no time limit on how long you can receive compensation; it is based on when a doctor believes you can be released to work.

While under active medical care, a doctor may release you to return to work, light duty or your regular job, if that happens, the status of your claim changes. Your carrier will officially tell you of the change in your work status by issuing another Notice of Claim Status form informing you of the date you are released to return to work. You must make a sincere and conscientious effort to find work. You must report your efforts to find work and any income you earn, including unemployment benefits, to the carrier on the form they provide. Once released to work, continuing temporary compensation benefits are not automatic or guaranteed.

The carrier will review each case to determine if temporary benefits well continue. If it is determined that you have a loss of wages because of your injury, the carrier will pay $66^{2}/_{3}\%$ of the difference between the wages you are now able to earn and your established average monthly wage. This compensation is paid once a month instead of every two weeks. If you have returned to your regular wage, compensation will stop.

While you are under active medical care, it is important for you to remember that the carrier has the right to have you periodically examined, at a reasonably convenient time and place, by a doctor of its choosing. Failure to attend the examination could result in suspension of your benefits, and you could be required to pay for the cost of the missed examination. The carrier may accept the opinion of its consulting doctor and base a change in your claim status, or the closure of your claim, on that doctor's opinion.

Again, if there is a change in the status of your claim, you will receive a Notice of Claim Status from the carrier identifying that change.

When you have recovered from your injury, the doctor will report this to the carrier, and your claim will be closed to temporary compensation benefits as of the date your doctor discharges you from treatment. The carrier will issue a new Notice of Claim Status telling you your claim is closed and the date of closure.

Again, if there is a change in the status of your claim, you will receive a Notice of Claim Status from the carrier identifying that change.

Remember, it is your responsibility to understand all notices. If you disagree, you must file your request for hearing with the ICA within 90 days from the date of the Notice of Claim Status or the Notice becomes final.

PERMANENT COMPENSATION

If, after active medical treatment, the doctor determines that your medical condition is stationary, which means that nothing further can be medically done to improve your condition and your medical condition will not deteriorate, and that you have a permanent injury (impairment), the doctor will notify your carrier at the time you are discharged from treatment.

The percentage of impairment is usually rated by the doctor in accordance with standards as published by the American Medical Association in Guides to the Evaluation of Permanent Impairment. Compensation for permanent injuries is generally paid once per month.

TYPES OF PERMANENT INJURIES

There are two types of permanent injuries: (1) Scheduled and (2) Unscheduled. The following is an explanation of both types.

SCHEDULED INJURIES

If the permanent injury is to a certain part of the body, such as eye, hand, arm, foot or leg, the part of the body and the period allowed for compensation is set out in a schedule in the Workers' Compensation Law. The carrier will issue a form entitled Notice of Permanent Disability, which states the amount the carrier will pay each month and the number of months it will be paying that amount. The method of calculating the monthly compensation is based upon law and court decisions interpreting that law.

Compensation is calculated in three different ways for scheduled injuries: (1) For partial loss, you will receive 50% of the average monthly wage, (2) for a loss that is the result of an amputation or a total loss of use, you will receive 55% of the average monthly wage, and (3) if the doctor indicates that the permanent injury prevents you from returning to your regular work, you will receive 75% of the average monthly wage.

FACIAL SCARRING AND LOSS OF PERMANENT TEETH

If the permanent injury results in visible facial scarring or loss of permanent teeth you may be entitled to compensation. The carrier will issue a form entitled Notice of Permanent Disability and Request for Determination of Benefits which requests the ICA determine how much compensation, if any, you will receive. The compensation for facial scarring is based on the actual appearance of the scar, the compensation for loss of teeth is based on a schedule located in the ICA procedures manual. The compensation for awards for facial scarring or loss of teeth is calculated at 55% of the average monthly wage per month and the maximum allowable is 18 months.

UNSCHEDULED INJURIES

If your permanent injury does not fall into the categories listed in the schedule (scheduled injuries), it is classified as an unscheduled general disability. Examples of these types of injuries include occupational diseases and injuries to the hip, shoulder, or back or a combination of impairments or a history of prior impairment(s). With this type of injury, the ICA determines how much compensation, if any you will receive. This decision is based on the effect the injury has on your ability to return to work and the wages you are able to earn compared to your average monthly wage on the date of your injury. Many factors are taken into consideration, such as age, education, previous occupations, physical limitations, and wages earned after the injury. You will receive a questionnaire from the ICA requesting this information.

The ICA will calculate your unscheduled permanent partial compensation at 55% of the difference between your average monthly wage and the amount they estimate you will be able to earn (reduced earning capacity) given your injury or at $66^{2}/_{3}$% if you are determined to be totally disabled. The Claims Division of the ICA will send you a form entitled "Findings and Award for Unscheduled Permanent Partial/Total Disability," explaining the amount of money you will be receiving each month. The money is paid by the carrier and is retroactive (goes back) to the date of discharge by the doctor(s). The ICA may find that because you have returned back to work earning the same as or in excess of your established average monthly wage that you have sustained no loss of earning capacity. This means that the ICA recognizes that you have a permanent impairment, however, it is not effecting your earning capacity at this time. Some awards may also take a credit if you have received an award for compensation on a prior disability.

If you, the employer, or the carrier disagree with this award, a request for hearing must be filed within 90 days from the issuance date of this award.

Keep in mind that from the time you are discharged from treatment to the time the ICA issues its ”Findings and Award for Unscheduled Permanent Partial Disability,” the carrier is not required to continue compensation. They may voluntarily continue to pay. If the amount is larger than what is found in the award issued by the ICA, the carrier will take a credit against future payments, if it is smaller, the carrier will make up the difference. Once the award is issued by the ICA, the carrier is required to pay the amount on the award, even if it disagrees, until the amount of permanent compensation is finalized through the hearing process. Once the amount of permanent compensation has been finalized, that amount will be paid monthly by the carrier.

Each year, on the anniversary date of the award, the carrier will send you a form entitled “Annual Report of Income.” You must report on that form how much you earned as wages during the past 12 months. The form must be sent to the carrier, not the ICA. If you fail to return the form, your permanent compensation payments may be suspended until you file the form. Your unscheduled permanent compensation benefits can only be stopped by: (1) Your death, (2) Failure to file an “Annual Report of Income”, or (3) Rearrangement of your benefits by the ICA following a petition by the employer or the carrier, of which you will be notified.

PETITIONS FOR REARRANGEMENT OR READJUSTMENT OF COMPENSATION

If you have sustained a permanent injury where a Findings and Award for Unscheduled Permanent Partial Disability has been issued and later on your earning capacity increases or decreases a petition for rearrangement or readjustment of compensation could be filed by you or by the carrier. The petition requests the ICA review your award and determine whether your monthly benefits should increase, decrease or cease. The burden of proving the change in earning capacity is the responsibility of the person filing the petition.

If your earning capacity decreases due to a change in your physical condition arising out of the injury or where you can show a reduction in your earning capacity when there is no change in your physical condition you may file a petition for rearrangement or readjustment of compensation.

You should not file a petition for rearrangement or readjustment of compensation if your earning capacity decreases due to a deterioration of a non-industrial condition, the aging process, a rising cost of living, moving to an area where work is not available or a change in the economic condition which affects work availability.

The carrier may file a Petition for Rearrangement or Readjustment of Compensation if they can show that your earning capacity has increased since the “Findings and Award for Unscheduled Permanent Partial Disability” was issued.

When the ICA receives a Petition for Rearrangement or Readjustment of Compensation an acknowledgment letter is sent to the filing party with copies of the petition and the injured worker is sent a questionnaire to obtain current employment information.

The ICA will review the file and the petition and issue an award either approving or disapproving the rearrangement of the monthly benefits. If approved, your monthly benefits could decrease or cease entirely.

If you, the employer, or the carrier disagree with this award, a request for hearing must be filed within 90 days from the issuance date of this award.

LUMP SUM COMMUTATIONS

Arizona Workers’ Compensation Law requires that permanent benefits be paid on a monthly basis. The law allows awards to be commuted to a lump sum at the discretion of the Commissioners. A lump sum commutation on a scheduled award cannot exceed $25,000.00 and does not require the carrier’s approval. A lump sum commutation on an unscheduled award cannot exceed $150,000.00 and does require the approval of the carrier, or the ICA is without jurisdiction to consider the request. The value of the commutation is determined on the day you file the request, considering payments you were due to receive, advances and payments made after your request are subtracted from the commutation. The value of the award is also discounted .07% per annum.

The ICA will only grant a lump sum commutation request when it can be shown that the facts demonstrate a reasonable basis for financial betterment or rehabilitation of the injured worker.

Action will not be taken on a lump sum commutation until the award has become final or waivers of appeal have been signed by all parties.

Upon request the ICA will provide the packet of forms required to file for a lump sum commutation, these forms must be completed in full and all requested documentation must be provided. The carrier's opinion is solicited and appropriate lump sum requests are then presented to the Commissioners for their decision. An award will be issued by the ICA either approving or disapproving the request. If the lump sum commutation request is denied and you disagree with the denial, the award will have a 10 day protest period within which you must file your request for hearing with the ICA by means of a letter or on a Request for Hearing form available from the ICA upon request. This request for a hearing must be signed by you or your legal representative.

If you file a request for hearing, you will receive a Notice from the ICA which will tell you when a hearing before the Commissioners will be set. If you do not file a request for hearing during the 10 day protest period, the decision of the ICA becomes final.

It is your responsibility to understand all notices and documents which allow for hearing requests in the event of disagreements, and it is also your responsibility to make your current address known to the ICA and the carrier.

If you do not understand a notice or document, you may want to contact your legal representative or the ICA for an explanation.

PETITIONS TO REOPEN

You may file with the ICA to reopen your closed claim to secure additional benefits on the basis of new, additional or previously undiscovered temporary or permanent condition by means of a letter or by completing petition to reopen form. This form is available from the ICA upon request. The petition or letter must be accompanied by a current medical report from a doctor setting forth the relationship of your present condition to the industrial injury.

The payment of such reasonable and necessary medical expenses will be paid for if the claim is reopened as provided by law and if such expenses are incurred within 15 days of the filing of the petition to reopen. No surgical benefits or monetary compensation shall be payable for any period prior to the date of the filing of the petition.

When the ICA is in receipt of both the petition to reopen and the current medical report we will send the carrier a Notice of Petition to Reopen which advises them that they must take action on the reopening within 21 days. The carrier will issue a Notice of Claim Status either accepting or denying your petition to reopen. If your reopening is denied and you disagree with the carrier's denial, the notice will have a 90 day protest period within which you must file your request for hearing with the ICA by means of a letter or on a Request for Hearing form available from the ICA upon request. This request for a hearing must be signed by you or your legal representative.

If you file a request for hearing, you will receive a Notice from the ICA which will tell you when a hearing before an Administrative Law Judge will be set. If you do not file a request for hearing during the 90 day protest period, the decision of the carrier becomes final.

It is your responsibility to understand all notices and documents which allow for hearing requests in the event of disagreements, and it is also your responsibility to make your current address known to the ICA and the carrier.

If you do not understand a notice or document, you may want to contact your legal representative or the ICA for an explanation.

CHANGING DOCTORS

You have the right to select the doctor of your choice, unless your employer is self-insured. If your employer is self-insured and has contracted medical care which is registered with the ICA, you are required to see your employers doctor, in these circumstances, a change of doctors would only be approved on a very limited basis.

The law allows your employer to request that you be seen by a doctor of their choice for one visit. Keep in mind, however, that if you voluntarily visit this doctor more than once, it is interpreted that you have officially chosen your doctor.

Once you have chosen your doctor, you may not change to another doctor without the approval of your current doctor, the carrier or the ICA. If you want to change doctors and your current doctor will not authorize the change, call your carrier for their approval. If the carrier will not agree to the change, you may apply in writing to the ICA for approval. Your request should include your claim information, your signature, the names and complete addresses of both doctors and the reason for the request. Also be sure that the doctor you wish to change to will accept you as a new patient. The ICA will review your case, contact the carrier and/or the doctor for their opinion on the change, and issue an award either approving or disapproving the change. You should not begin treating with a new doctor prior to an approval being granted, as the bills may not be paid. If either you or the carrier disagree with the award, a request for hearing must be filed.

Please be advised that a very small number of employers have filed with the ICA a plan listing the doctors their employees are to use. The legality of this plan has not yet been decided by the courts. The ICA will consider a request to change doctors and issue an award either approving or denying the request. You are advised that if the ICA approves your change of doctors to a doctor who is not under your employer's plan and the courts find the plan legal, you may risk the loss of your benefits and could be held responsible for any medical bills for treatment received. You might discuss this matter with your carrier to see if you can agree on a new doctor or you may wish to discuss it with an attorney certified in workers' compensation.

REQUESTS TO LEAVE THE STATE

While you are under the workers' compensation system there are restrictions regarding leaving the state. You may not leave the state for more than 14 days while under active medical treatment without approval. If you are planning to be outside the state for more than 14 days, you must have written approval from the ICA before you leave the state. Requests to leave the state should be sent to the Claims Division of the ICA and should include your claim information, your signature, where you are going, when you are going, for how long and the reason for the request.

The ICA will review your case, contact the carrier and/or the doctor for their opinion on the leave the state request, and issue an award either approving or disapproving the request. If either you or the carrier disagree with the award, a request for hearing must be filed.

If you fail to get approval prior to leaving the state for periods in excess of 14 days, the carrier has the right to suspend your benefits.

If you are leaving the state for a period of less than 14 days you should advise your carrier so that they will be able to contact you if necessary.

If you are receiving supportive medical maintenance benefits you do not need to request permission to leave the state, however, you will need to file a request to change doctors if you are leaving the state permanently and intend to pursue your supportive medical care in another state.

ATTORNEY REPRESENTATION

Under the Workers' Compensation system you are not required to have an attorney, you can represent yourself. Keep in mind, however, that the Workers' Compensation Law is very complex and the carrier/employer will be represented by an attorney specializing in Workers' Compensation Law. If you choose to represent yourself, you will have to follow the rules of procedure for hearings before the ICA. A copy of the rules can be obtained from the ICA's Main Reception Desk.

Attorneys representing injured workers are paid on a contingency basis. This means that they will receive an agreed upon percentage, usually 25%, of your monthly benefits if they are successful. If they are not successful, then they do not receive a fee.

Be advised that you do have the right to dismiss your attorney, however, you have entered into a legal contract with your attorney and this dismissal may not satisfy your obligation for attorney fees due.

If you wish to hire an attorney it is recommended that you consult with an attorney who is a specialist in Workers' Compensation. You can contact the Arizona State Bar Association for a list of qualified attorneys.

HEARING PROCESS

When you formally disagree with a document that contains a protest period (notices, awards, etc.), you do so by requesting a hearing in writing. Your request for hearing is referred to the ICA's Administrative Law Judge Division.

The Judges are employees of the ICA who are attorneys licensed in this state to practice law.

When the claim is assigned to an Administrative Law Judge, you will receive a notice informing you of the time and place of the hearing. You must appear at the hearing unless you are excused by the Judge.

After the hearing(s) the Judge will issue an award informing all parties of the decision reached. The award becomes final and not appealable unless a request for review is filed in writing at the ICA by one of the parties within 30 days of the award date.

If a request for review is filed, the Judge will issue a decision based upon the review and again, the parties have 30 days from the date of that decision to appeal to the Arizona Court of Appeals.

REHABILITATION OR JOB RETRAINING

Injured workers who are unable to return to their regular work due to the medically verified physical limitations caused by their injuries may be eligible for vocational rehabilitation assistance through the ICA Special Fund Division. For additional information on rehabilitation, please contact ICA Special Fund at 602-542-3294.

Injured workers do not have to participate in retraining programs and may decline without affecting their workers' compensation benefits. The carrier may elect not to offer financial support for a vocational rehabilitation or retraining program. If the carrier rejects your request for retraining, you can contact the ICA's Special Fund Division for possible assistance.

OMBUDSMAN'S OFFICE

An ombudsman, as used by the ICA, is a person who provides assistance in explaining the workers' compensation system, attempts to resolve problems between the carrier and the injured worker, answers questions and provides assistance in directing the injured worker to social services available in the community.

The personnel within the Ombudsman's Office cannot provide legal advice.

The Ombudsman's office is located in the ICA building at 800 W. Washington Street, Phoenix, Arizona. You may contact the office by calling 602-542-4538, or for those outside metropolitan Phoenix, the toll-free in-state number is 1-800-544-6488.

FRAUD

In 1994 the Arizona Legislature created a special fraud unit within the Department of Insurance to investigate acts of fraud committed against insurance companies.

Claim fraud occurs when individuals tell their insurance companies they suffered a loss when no such loss occurred or when they inflate the amount of damage they report for a loss that did occur. Claims that are false, incomplete, or misleading are prohibited by the fraud statute. Any person who submits a false claim or helps another person submit a false claim "with the intent to injure, defraud, or deceive an insurance company," is guilty of a felony.

Examples of Fraud:

- An employee files a workers' compensation claim alleging wrist, rib and facial injuries occurred while working for a construction company and while collecting benefits for being off work the employee returns to work without advising the insurance carrier.

- Presenting or assisting in the preparation of written or oral statements in support of a claim for payment or other benefits knowing that the statement contains false, incomplete or misleading information concerning any fact or thing material to the claim.

If you believe a fraudulent claim has been made, you may file a report with the Department of Insurance Fraud Unit 602-912-8418. You may also report the matter to the workers' compensation insurance carrier involved or to the ICA Legal Division 602-542-5781.

SELF-INSURED EMPLOYERS

The ICA grants the authority to certain large employers, who meet very specific criteria, to act as their own insurance company for workers' compensation purposes. There are approximately 90 employers in the state who have been given this authority.

Most self-insured employers make a definite effort to inform their employees of their self-insured status. If, after talking with your employer, you are still not sure whether it is self-insured, contact the Claims Division of the ICA.

ISSUES SURROUNDING NON-INSURED EMPLOYERS

If your employer tells you the cost of compensation insurance is too great and he will pay for any medical bills you may incur if you're hurt, HE IS BREAKING THE LAW. Think of it this way: if your employer cannot afford insurance, how can he afford to pay your medical bills?

If your employer had no workers' compensation insurance on the date of your injury, you may either file a civil action (lawsuit) against your employer in Superior Court, or file a claim for workers' compensation benefits with the ICA. The ICA has a trust fund called the "Special Fund" which was set up to pay the medical and/or compensation benefits to workers injured during the course of employment with non-insured employers, these benefits are identical to those received by an injured worker covered by an insurance policy, however, the processing of the claims is different. The ICA's Special Fund Division will process your claim and conduct an investigation to determine if you were an employee or an independent contractor and whether the injury arose during the course and scope of your employment. Once that investigation is concluded (processing time is generally less than 30 days from filing), a Notice of Determination is sent to you and the employer informing you of the acceptance or denial of your claim.

Because of the unique legal requirements involving no-insurance claims, we ask that you contact representatives of the Special Fund and they will provide a detailed explanation of the processing of no-insurance claims.

If your employer is found to have employees and did not have workers' compensation coverage, then your employer is in violation of state laws. The ICA will be taking separate legal action against your employer.

INDUSTRIAL COMMISSION OF ARIZONA

PHOENIX OFFICE

800 W. WASHINGTON
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070
HOURS: 8:00 A.M. -- 5:00 P.M.

WORKERS' COMPENSATION CLAIMS DIVISION
602-542-4661

ADMINISTRATIVE LAW JUDGE DIVISION
602-542-5247

LABOR DEPARTMENT
602-542-4515

OCCUPATIONAL SAFETY & HEALTH
602-542-5795

LEGAL DEPARTMENT
602-542-5781

DIRECTOR'S OFFICE
602-542-4411

SPECIAL FUND DIVISION
602-542-3294

OMBUDSMAN
602-542-4538
1-800-544-6488 (In State)

TUCSON OFFICE

2675 E. BROADWAY
TUCSON, ARIZONA 85716-5342
HOURS: 8:00 A.M. -- 5:00 P.M.

WORKER'S COMPENSATION CLAIMS DIVISION
520-628-5188

ADMINISTRATIVE LAW JUDGE DIVISION
520-628-5188

LABOR DEPARTMENT
520-628-5459

OCCUPATIONAL SAFETY & HEALTH
520-628-5478

TO BE POSTED BY EMPLOYER **POLICY NUMBER** _____

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: _____

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

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PARA SER COLOCADO POR EL PATRON **NUMERO DE POLIZA** _____

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patron ha cumplido con las provisiones de la Ley de Compensacion para los Trabajadores de Arizona (Titulo 23, Capitulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las regias y ordenanzas de La Comision Industrial de Arizona hechas en cumplimiento de esta, y ha asegurado el pago de compensacion a los empleados garantizando el pago de dicha compensacion por medio de:

_____

Ademas, a todos los empleados se les notifica por este medio que en caso de que especificadamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerara bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensacion bajo estos terminos; tambien bajo estos terminos los empleados tienen el derecho de rechazar la misma por medio de una notificacion por escrito antes de que sufran alguna lesion, todos los formularios o formas en blanco para tal notificacion por escrito estaran disponibles para todos los empleados en la oficina de este patron.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

KEEP POSTED IN A CONSPICUOUS PLACE.

COLOQUESE EN LUGAR VISIBLE.

WORK EXPOSURE TO METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA), SPINAL MENINGITIS, OR TUBERCULOSIS (TB)

Notice to Employees

Employees are notified that a claim may be made for a condition, infection, disease or disability involving or related to MRSA, spinal meningitis, or TB within the provisions of the Arizona Workers' Compensation Law. (A.R.S. § 23-1043.04) Such a claim shall include the occurrence of a significant exposure at work, which is defined to mean an exposure in the course of employment to aerosolized MRSA, spinal meningitis or TB bacteria. Significant exposure also includes exposure in the course of employment to MRSA through bodily fluids or skin.

Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

1. The employee's regular course of employment involves handling or exposure to MRSA, spinal meningitis or TB. For purposes of establishing a claim under this section, "employee" is limited to firefighters, law enforcement officers, correction officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution;

2. No later than thirty (30) calendar days after a possible significant exposure, the employee reports in writing to the employer the details of the exposure;

3. A diagnosis is made within the following time-frames:

    a. For a claim involving MRSA, the employee must be diagnosed with MRSA within fifteen (15) days after the employee reports pursuant to Item No. 2 above;

    b. For a claim involving spinal meningitis, the employee must be diagnosed with spinal meningitis within two (2) to eighteen (18) days of the possible significant exposure; and

    c. For a claim involving TB, the employee is diagnosed with TB within twelve (12) weeks of the possible significant exposure.

Expenses for post-exposure evaluation and follow-up, including reasonably required prophylactic treatment for MRSA, spinal meningitis, and TB is considered a medical benefit under the Arizona Workers' Compensation Act for any significant exposure that arises out of and in the course of employment if the employee files a claim for the significant exposure or the employee reports in writing the details of the exposure. Providing post-exposure evaluation and follow-up, including prophylactic treatment, does not, however, constitute acceptance of a claim for a condition, infection, disease or disability involving or related to a significant exposure.

Employers must post this notice in a conspicuous place next to the Workers' Compensation Notice to Employees.

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. **AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. **NO LATER THAN TEN (10) CALENDAR DAYS** after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. **NO LATER THAN TEN (10) CALENDAR DAYS** after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.

4. **NO LATER THAN EIGHTEEN (18) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN SEVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES

THIS NOTICE IS APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

AVISO A LOS EMPLEADOS

Re: El Virus de la Inmunodeficiencia Humana (VIH),
Síndrome de la Inmundeficiencia Adquirida (SIDA) y Hepatitis C

Se les notifica a los empleados que se puede hacer una reclamación por una condición, infección, enfermedad o incapacidad relacionada con o derivada del Virus de Inmunodeficiencia Humana (VIH), Síndrome de Inmunodeficiencia Adquirida (SIDA), o Hepatitis C bajo lo provisto por la Ley de Compensación para los Trabajadores de Arizona y las reglas de La Comisión Industrial de Arizona. Tal reclamación debe incluír el suceso de una exposición importante en el trabajo, la que por lo general significa contacto de alguna ruptura de la piel o mucosa del empleado con la sangre, semen, fluido vaginal, fluido(s) quirúrgico(s) o cualquier otro fluido de una persona que contenga sangre. **EL EMPLEADO DEBE CONSULTAR A UN MEDICO PARA CONFIRMAR SU RECLAMACION.** Las reclamaciones no pueden resultar de actividad sexual o uso ilícito de drogas.

Ciertas clases de empleados pueden establecer más fácilmente una reclamación relacionada con el VIH, SIDA O Hepatitis C si reúnen los requisitos siguientes:

1. El curso regular del empleo del empleado requiere el manejo de o la exposición a sangre, semen, fluido vaginal, fluido(s) quirúrgico(s) o cualquier otro fluido que contenga sangre. Incluídos en esta categoría son los proveedores de cuidados de la salud, trabajadores de laboratorios forenses, bomberos, agentes policiales, técnicos médicos de emergencia, paramédicos y agentes correccionales.

2. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una possible exposición importante que resulta de y en el curso de su trabajo, el empleado reporta a su patrón por escrito los detalles de la exposición como lo proveen las reglas de la Comisión. Las formas de reporte están disponibles en la oficina de este patrón o de la Comisión Industrial de Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 o 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. Si un empleado elige no llenar la forma de reporte, ese empleado corre el riesgo de perder una reclamación de prima facie.

3. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una posible exposción importante el empleado va a que le saquen sangre, y **NO MAS DE TREINTA (30) DIAS DE CALENDARIO** la sangre es analizada para **VIH O HEPATITIS C** por medio de análisis de anticuerpos y el análisis resulta negativo.

4. **NO MAS DE DIECIOCHO (18) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevemente y los resultados del análisis son positivos por VIH o el empleado ha sido diagnosticado como positivo por la presencia de VIH, o **NO MAS DE SIETE (7) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por la presencia de Hepatitis C o el empleado ha sido diagnosticado como positivo por la presencia de Hepatitis C.

MANTENER FIJO EN UN LUGAR SOBRESALIENTE JUNTO AL AVISO A LOS EMPLADOS SOBRE COMPENSACION PARA TRABAJADORES

ESTE AVISO HA SIDO APROBADO POR LA COMISION INDUSTRIAL
DE ARIZONA PARA USO DE LAS ASEGURADORAS

Este documento es una traduccion del texto original escrito en ingles. Esta traduccion no es oficial y no es vinculante para este estado o para una subdivision politica de este estado.

This document is a translation from original text written in English. This translation is unofficial and is not binding on this state or a political subdivision of this state.

EMPLOYEE SAFETY AND HEALTH PROTECTION

The Arizona Occupational Safety and Health Act of 1972 (Act), provides safety and health protection for employees in Arizona. The Act requires each employer to furnish his employees with a place of employment free from recognized hazards that might cause serious injury or death. The Act further requires that employers and employees comply with all workplace safety and health standards, rules and regulations promulgated by the Industrial Commission. The Arizona Division of Occupational Safety and Health (ADOSH), a division of the Industrial Commission of Arizona, administers and enforces the requirements of the Act.

As an employee, you have the following rights:

You have the right to notify your employer or ADOSH about workplace hazards. You may ask ADOSH to keep your name confidential.

You have the right to request that ADOSH conduct an inspection if you believe there are unsafe and/or unhealthful conditions in your workplace. You or your representative may participate in the inspection.

If you believe you have been discriminated against for making safety and health complaints, or for exercising your rights under the Act, you have a right to file a complaint with ADOSH within 30 days of the discriminatory action. You are also afforded protection from discrimination under the Federal Occupational Safety and Health Act and may file a complaint with the U.S. Secretary of Labor within 30 days of the discriminatory action.

You have the right to see any citations that have been issued to your employer. Your employer must post the citations at or near the location of the alleged violation.

You have the right to protest the time frame given for correction of any violation.

You have the right to obtain copies of your medical records or records of your exposure to toxic and harmful substances or conditions.

Your employer must post this notice in your workplace.

The Industrial Commission and ADOSH do not cover employers of household domestic labor, those in maritime activities (covered by OSHA), those in atomic energy activities (covered by the Atomic Energy Commission) and those in mining activities (covered by the Arizona Mine Inspector's office). To file a complaint, report an emergency or seek advice and assistance from ADOSH, contact the nearest ADOSH office:

Phoenix:
800 West Washington
Phoenix AZ. 85007
602-542-5795
Toll free: 855-268-5251

Tucson:
2675 East Broadway
Tucson, AZ. 85716
520-628-5478
Toll free: 855-268-5251

Industrial Commission web site: www.ica.state.az.us

Note: Persons wishing to register a complaint alleging inadequacy in the administration of the Arizona Occupational Safety and Health plan may do so at the following address:

U.S. Department of Labor – OSHA
230 N. 1st Ave., Ste. 202
Phoenix, AZ 85003
Telephone: 602-514-7250

Revised 10/11

PROTECCION DE SEGURIDAD Y SANIDAD PARA EL EMPLEADO

El Acta de Seguridad y Sanidad Ocupacional de 1972 (Acta) provee protección de seguridad y sanidad para los empleados en Arizona. El Acta requiere que cada patron les ofrezca a sus empleados un lugar de empleo libre de riesgos reconocidos que puedan causar daño o muerte. El Acta también requiere que los patrones y empleados cumplan con las normas, y los reglamentos de seguridad y sanidad promulgados por la Comisión Industrial. La ejecución de esta ley se lleva a cabo por la División de Seguridad y Sanidad Ocupacional, un brazo de la Comisión Industrial de Arizona.

Como empleado, Ud. tiene los derechos siguientes:

Tiene el derecho de notificar a su patron o a ADOSH sobre peligros en su lugar de trabajo. Puede pedir a ADOSH que mantenga su nombre confidencialmente.

Tiene el derecho de solicitar una inspección por parte de ADOSH si cree que existen condiciones peligrosas o poco saludables en su lugar de trabajo. Usted o su representante puede participar en la inspección.

Si cree que su patron lo ha discriminado por presentar reclamos de seguridad y sanidad o por ejercer sus derechos bajo el Acta, puede presentar una queja a ADOSH durante un plazo de 30 dias después de la acción de discriminación. También tiene protección de discriminación bajo el acta federal de seguridad y sanidad ocupacional y puede archivar una queja con el Secretario de Labor de los Estados Unidos dentro de 30 dias después de la discriminación alegada.

Tiene el derecho de ver las citaciones enviadas a su empleador. Su empleador debe colocar las citaciones en un lugar visible en el sítio de la supuesta infracción o cerca de el.

Tiene el derecho de protestar el tiempo dado para correjir una violación.

Tiene el derecho de recibir copias de su historial médico o de los registros de su exposición a sustancias o condiciones tóxicas y peligrosas.

Su empleador debe colocar este aviso en su lugar de trabajo.

La ley de seguridad y sanidad en el trabajo no aplica a aquellos patrones que emplean a servicio doméstico, a patrones de actividades marítimas (protejidos bajo OSHA), a patrones en actividades de energia atómica (protegidos bajo la Comisión de Energia Atómica), o a patrones en actividades mineras (protegidos por la Oficina del Inspector de Minas del Estado de Arizona). Para registrar una queja, reportar una emergencia o pedir asistencia de ADOSH, póngase en contacto con la oficina más cercana :

Phoenix:
800 West Washington
Phoenix AZ. 85007
602-542-5795
Llamada gratis: 855-268-5251

Tucson:
2675 East Broadway
Tucson, AZ. 85716
520-628-5478
Llamada gratis: 855-268-5251

Industrial Commission web site: www.ica.state.az.us

Nota: Personas que deseen registrar quejas alegando falta de adecuadez en la administración del plan de seguridad y sanidad ocupacional de Arizona pueden dirigirlas a la siguiente dirección:

U.S. Department of Labor – OSHA
230 N. 1st Ave., Ste. 202
Phoenix, AZ 85003
Teléfono: 602-514-7250

Revisado 10/11

SPECIAL NOTE

There is a specific limitation to the release duration for this state, which is incorporated at page number 3 on the release form.

Scroll to Next Page for Release Form

AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION

I authorize each of the parties identified below to use and disclose any and all of my individually identifiable medical or health information, as described below, for purposes of administering my claim or request for reasonable accommodation. I understand that the information about me that I authorize to be used or disclosed may be redisclosed in accordance with the terms of this Authorization by the recipient thereof and may no longer be protected by federal or state privacy laws or regulations.

I specifically authorize physicians, nurses and hospitals to communicate my individually identifiable medical or health information by any means, including written or telephonic communications or by direct interview, whether or not I am present during, or notified of, such communications, and I hereby authorize Sedgwick Claims Management Services, Inc. ("Sedgwick") to initiate and conduct such communications whether or not I am present or have received notice thereof.

1. **What Information is covered by this Authorization?** This authorization applies to all medical, health, psychological, and/or psychiatric information, records and reports, including information regarding pre-existing health or medical conditions or illnesses (a) that are in existence while this authorization is valid (see Item 3) and (b) that are related to any of the following: my request for reasonable accommodation; my workers' compensation claim; my claim for disability benefits; my claim for bodily injury; my claim for personal injury; my claim for FMLA or my claim for dental benefits.

   My claim or request for reasonable accommodation involves the following condition: _____

   My information to be disclosed may include, but is not limited to, medical or health history, chart notes, prescriptions, diagnostic test results, x-ray reports, and records received from other health care providers. If directly related to my claimed condition or illness, this information may include the following, **Please check yes or no and initial**:

HIV test results, HIV or AIDS information.	YES ☐	NO ☐	Initial here	_____
Psychiatric information.	YES ☐	NO ☐	Initial here	_____
Information related to drug or alcohol abuse.	YES ☐	NO ☐	Initial here	_____

   The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

2. **Who may disclose and receive Information under this Authorization?**

   A. Any person or facility that attends, treats or examines me, including but not limited to _____ _____ (specific name, if needed) is to make this information available to Sedgwick or any of its agents, representatives or independent contractors; and

   B. When relevant to my claim, Sedgwick may re-disclose (without my further authorization) any and all of my individually identifiable medical or health information (whether obtained pursuant to this authorization or otherwise from any person or entity) to any of the following, (a) Any person or facility that attends, treats or examines me; (b) Any person or facility that impacts determination of my claim or that coordinates my benefits; (c) My employer and its affiliates and their representatives, independent contractors and service providers that may receive any such information from my employer to the extent permitted by state or federal law; or (d) The Social Security Administration or a social security or vocational rehabilitation vendor. Sedgwick may use my information obtained pursuant to this authorization in any other claim matter that Sedgwick may administer or handle related to me.

3. **How Long this Authorization is Valid?** This authorization is valid during the duration of my claim(s) and any future related claims, unless a different period is required under applicable federal or state law. HIV-related releases are limited to one hundred eighty (180) days.

4. **Revocation of this Authorization.** Unless otherwise provided by federal or state law, I understand that I may revoke this authorization at any time by notifying, in writing, Sedgwick at _____of my revocation and that my revocation shall be effective upon Sedgwick receipt of my notice of revocation. I also understand that my revocation of this Authorization will not have any effect on any actions taken by Sedgwick before its receives my revocation.

5. **Processing of Claims.** I understand that this Authorization is generally necessary for the processing of my claim or request for reasonable accommodation. Failure to sign this Authorization may impair or impede the processing of my claim or request for reasonable accommodation.

6. **Refusal To Sign**. I further understand my health care providers will not condition my treatment, payment, enrollment or eligibility on my refusal to sign this Authorization.

I understand that I have the right to request and receive a copy of this authorization. I understand that I have the right to inspect the disclosed information at any time. A photocopy of this authorization shall be valid and is to be accepted with the same effect as the original.

Signature of Patient or Patient's Representative	Patient's Address
Printed Name of Patient or Patient's Representative	Patient's Social Security Number
Representative's Relationship to Patient, if applicable	First Day Absent
Date Signed	Date of Birth

NOTICE OF STATE FRAUD REQUIREMENTS

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AUTORIZACIÓN PARA USO Y DIVULGACIÓN DE INFORMACIÓN MÉDICA

Yo, autorizo a cada una de las partes identificadas a continuación, para usar y divulgar cualquier y toda información médica y de salud inidentificable individualmente como mía, como se describe más adelante, para propósitos de administración de mi solicitud o petición para un acomodo razonable. Entiendo que la información sobre mí, que yo autorizo para uso y divulgación, puede estar sujeta a divulgación posterior, de acuerdo con los términos de esta Autorización, por parte del destinatario de ésta y que es posible que ya no esté protegida por las leyes y regulaciones federales o del estado sobre privacidad.

Autorizo, específicamente, a médicos, enfermeras y hospitales para comunicar la información de salud o médica identificable individualmente como mía, a través de cualquier medio, incluidas comunicaciones escritas o telefónicas, o por entrevista directa, sea que este presente o se me haya notificado o no, de dichas comunicaciones, y por la presente, autorizo a Sedgwick Claims Management Services, Inc. ("Sedgwick") para iniciar y realizar dichas comunicaciones, sea que este presente o haya recibido notificación de esto o no.

1. **¿Qué información está incluida en esta Autorización?** Esta autorización se aplica a toda la información, registros e informes médicos, de salud, sicológicos y/o psiquiátricos, incluida información sobre condiciones o enfermedades médicas o de salud pre-existentes (a) que estén en existencia durante la validez de esta autorización (ver Punto 3) y (b) que estén relacionadas con cualquiera de las siguientes solicitudes: mi solicitud de acomodo razonable, mi solicitud de compensación del trabajador; mi solicitud de prestación por invalidez, mi solicitud por lesión corporal, mi solicitud por accidentes personales, mi solicitud de FMLA o mi solicitud de prestaciones dentales.

   Mi solicitud o petición para acomodo razonable involucra las siguientes condiciones: _____

   Mi información, que será divulgada, puede incluir, pero no se limita a, historia médica o de salud registros médicos, prescripciones, resultados de evaluaciones de diagnóstico, informes de rayos X y registros recibidos de otros prestadores de salud. Esta información puede incluir lo siguiente, si está directamente relacionada con las condiciones o enfermedades demandadas. **Por favor, marque sí o no e inicial**:

resultados de pruebas de VIH, información sobre VIH o SIDA	SÍ ☐	NO ☐	Inicial aquí _____
Información siquiátrica.	SÍ ☐	NO ☐	Inicial aquí _____
Información relacionada con abuso de drogas o alcohol.	SÍ ☐	NO ☐	Inicial aquí _____

   La Ley contra la discriminación de información genética de 2008 (GINA, por sus siglas en inglés) prohíbe a los empleadores y otras entidades que abarca el Título II de la GINA solicitar o requerir información genética de un individuo o miembro de la familia del individuo, excepto en los casos específicamente permitidos por esta ley. Para cumplir con esta ley, le solicitamos no brindar ninguna información genética cuando responda a esta solicitud de información médica. “Información genética”, como lo define la GINA, incluye la historia médica de la familia de un individuo, los resultados de pruebas genéticas del individuo o la de un miembro de su familia, el hecho de que un individuo o un miembro de la familia del individuo buscó o recibió servicio genéticos e información genética de un feto que el individuo o un miembro de la familia del individuo está gestando o un embrión en el vientre legalmente en el individuo o un miembro de la familia del individuo que recibe servicios reproductivos de asistencia.

2. **¿Quién puede divulgar y recibir información bajo esta Autorización?**

   A. Cualquier persona o entidad que me atienda, trate o examine, incluida, pero no limitada a _____ (nombre específico, si es necesario) para poner esta información _____ a disposición de Sedgwick o cualquiera de sus funcionarios, representantes o contratistas independientes; y

   B. Cuando sea pertinente a mi solicitud, Sedgwick puede divulgar posteriormente (sin autorización ulterior) cualquier o toda información médica o de salud identificada individualmente como mía (fuese obtenida de acuerdo con esta autorización o, de lo contrario, de otra persona o entidad) a cualquiera de los siguientes: (a) cualquier persona o institución que me atienda, trate o examine; (b) cualquier persona o institución que influya en la determinación de mi solicitud o que coordine mis beneficios; (c) mi empleador y sus afiliados y sus representantes, contratistas independientes y prestadores de servicios que puedan recibir tal información de mi empleador hasta al grado que permite la ley federal o estatal, o (d) la Dirección del Seguro Social o el proveedor de seguro social o rehabilitación vocacional. Sedgwick puede usar mi información, obtenida de acuerdo con esta autorización, en cualquier otra materia de solicitud que Sedgwick pueda administrar o manejar en relación a mí.

3. **¿Por cuánto tiempo es válida esta Autorización?** Esta autorización es válida por el período de duración de mi(s) petición(es) y de cualquier petición relacionada futura; a menos que se requiera un período diferente de acuerdo con la ley federal o estatal correspondiente. Las revelaciones de información relacionada con el VIH se limitan a ciento ochenta (180) días.

4. **Revocación de esta Autorización.** A menos que la ley federal o estatal establezca otra cosa, entiendo que puedo revocar esta autorización en cualquier momento al notificar, por escrito, a Sedgwick a_____ de mi revocación y que ésta entrará en efecto una

vez que Sedgwick haya recibido mi notificación de revocación. También entiendo que mi revocación de esta Autorización no tendrá ningún efecto sobre las acciones tomadas por Sedgwick antes del recibo de mi revocación.

5. **Procesamiento de una Solicitud.** Entiendo que esta Autorización, generalmente, es necesaria para el procesamiento de una solicitud o petición de acomodo razonable. El no firmar esta autorización puede perjudicar o impedir el procesamiento de mi solicitud o petición de acomodo razonable.

6. **Denegación de Firma** Además, entiendo que mis prestadores de atención médica no condicionarán mi tratamiento, pago, inscripción o elegibilidad, en caso de negarme a firmar esta Autorización.

Entiendo que tengo derecho a solicitar y recibir una copia de esta autorización. Entiendo que tengo derecho de inspeccionar la información divulgada en cualquier momento. Una fotocopia de esta autorización será válida y aceptada con el mismo efecto que el original.

Firma del Paciente o Su Representante	Dirección del Paciente:
Nombre del Paciente o Su Representante	Número del Seguro Social del Paciente
Parentesco del Representante con el Paciente, si corresponde	Primer Día Ausente
Día de Firma	Fecha de Nacimiento

AVISO DE REQUISITOS DE FRAUDE ESTATAL

Para su protección, la ley de Arizona requiere que la siguiente declaración aparezca en este formulario. Cualquier persona que a sabiendas presente una reclamación falsa o fraudulenta para el pago de una pérdida está sujeta a sanciones civiles y penales.

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 1-866-590-5882.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 1-866-590-5882.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 1-866-590-5882.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control A4

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____
MM/DD/YYYY

Group #: GJC6200

Employee Date of Birth: _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ ____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

sedgwick

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

EXPRESS SCRIPTS®

Designated Vendor List

Dear Policyholder:

In order to provide the best possible medical care for your injured worker, Titan Claims Management has developed partnerships with national ancillary treatment providers due to their proven performance with workers' compensation cases. Please provide this list to your preferred clinic or urgent care. injured worker's initial treatment provider. **The below services shall be coordinated through the claim adjuster or directly with the vendor at the contact information provided below.**

Diagnostic Testing

Careworks will assist with finding local providers to conduct your **MRI, CT scan, EMG, x-rays**, and other diagnostic testing requested by your primary treating physician.

Phone: (866) 888-6724 **Email: titanclaims@careworks.com**

Durable Medical Equipment (DME)

Careworks will assist with obtaining equipment requested by your primary treating physician including **braces, canes, crutches, walkers, slings, commode chairs, etc.**

Phone: (866) 888-6724 **Email: titanclaims@careworks.com**

Pharmacy / Medication

myMatrixx has partnered with Titan Claims Management for filling **prescriptions** for your claim. Most pharmacies, including Walgreens and all major chains such as CVS, Rite-aid, Lucky, Costco, Walmart, and more are included in the network. **Help Line: (866) 590-5882**

Physical Medicine

Streamline has a nationwide network of providers to handle your **physical therapy, chiropractic, occupational therapy, and acupuncture** treatments. Contact them to schedule an appointment with the nearest provider.

Phone: (855) 877-9292 **Email: physicaltherapy@streamlineworkcomp.com**

Transportation

iLingo has a nationwide network of providers to handle your **transportation** needs. Contact them to find the nearest provider. **Phone: (800) 311-8331** **Email: titan@ilingo2.com**

Dental

HeadsUp Health Care has a nationwide network of providers to handle your **dental** needs. Contact them to schedule an appointment with the nearest provider. **Phone: (855) 474-9872**

Lista de proveedores designados

Estimado/a titular de la póliza:

Para brindar la mejor atención médica posible a su trabajador asegurado, Titan Claims Management ha desarrollado asociaciones con proveedores nacionales de tratamiento auxiliar debido a su rendimiento probado en casos de indemnización por accidentes de trabajo. Proporcione esta lista al proveedor de tratamiento inicial de indemnización por accidentes de trabajo de su clínica o atención de urgencia de preferencia. **Los siguientes servicios se coordinarán a través del perito de seguros o directamente con el proveedor en la información de contacto que se proporciona a continuación.**

Pruebas de diagnóstico

Orchid Medical/Careworks lo ayudará a encontrar proveedores locales para realizarse **resonancias magnéticas, tomografías computarizadas, electromiografías, radiografías** y otras pruebas de diagnóstico solicitadas por su médico tratante principal.

Teléfono: (855) 894-1674 **Correo electrónico: referrals@orchidmedical.com**

Equipos médicos duraderos

Orchid Medical/Careworks ayudará a obtener los equipos solicitados por su médico tratante principal, incluidos **aparatos ortopédicos, bastones, muletas, andadores, cabestrillos, sillas con inodoro, etc.**

Teléfono: (866) 888-6724 **Correo electrónico: referrals@orchidmedical.com**

Farmacia/Medicación

myMatrixx se ha asociado con Titan Claims Management para surtir **recetas** para su siniestro. La mayoría de las farmacias, incluidas Walgreens y todas las cadenas importantes, como CVS, Rite-aid, Lucky, Costco, Walmart y más, están incluidas en la red. **Línea de atención telefónica: (866) 590-5882**

Medicina física

Streamline tiene una red nacional de proveedores para manejar sus tratamientos de **fisioterapia, quiropráctica, terapia ocupacional y acupuntura**. Comuníquese para programar una cita con el proveedor más cercano.

Teléfono: (855) 877-9292 **Correo electrónico: physicaltherapy@streamlineworkcomp.com**

Transporte

iLingo tiene una red nacional de proveedores para manejar sus necesidades de **transporte**. Comuníquese para encontrar el proveedor más cercano.

Teléfono: (800) 311-8331 **Correo electrónico: titan@ilingo2.com**

Odontología

HeadsUp Health Care tiene una red nacional de proveedores para manejar sus necesidades **odontológicas**. Comuníquese para programar una cita con el proveedor más cercano.

Teléfono: (855) 474-9872

Workers' Compensation Treatment Referral

To Be Completed By Supervisor:		Date .	
Medical Facility / Doctor		Phone ( )	
Address	City	State	ZIP Code
Employee Name		Soc. Sec. No	
Occupation	Date of Injury	Time of Injury	AM PM
Employer Name	Policy Number	Phone ( )	
Address	City	State	ZIP Code
Supervisor Authorizing Treatment			

Instructions to Medical Facility/Doctor

This authorization is issued to you to provide ***initial*** medical treatment to the employee named above who has reported an occupational injury.

1. Call the supervisor named above immediately if the employee can return to work (full or modified duty).
2. Send the original completed doctor's first report to Sedgwick:

Mail the first report of injury to:
Sedgwick

P.O. Box 14779

Lexington, KY 40512

Telephone Number
(855) 728-5277

Fax Number
(866) 383-3296

Email
6200AtlasGeneralInsurance@sedgwickcms.com

Referencia de tratamiento de indemnización por accidentes de trabajo

Para ser completado por el supervisor:		Fecha .	
Centro médico/médico		Teléfono ( )	
Dirección	Ciudad	Estado	Código postal
Nombre del empleado		N.º de seguro social Seguro Social	
Ocupación	Fecha de la lesión	Hora de la lesión	a. m. p. m.
Nombre del empleador	Número de póliza	Teléfono ( )	
Dirección	Ciudad	Estado	Código postal
Supervisor que autoriza el tratamiento			

Instrucciones para el centro médico/médico

Esta autorización le permite que usted proporcione tratamiento médico ***inicial*** al empleado mencionado anteriormente que ha informado de una lesión laboral.

1. Llame al supervisor indicado anteriormente de inmediato si el empleado puede regresar al trabajo (a tiempo completo o con horario modificado).
2. Envíe el primer informe original completo del médico a Sedgwick:

Envíe el primer informe de lesión a:
Sedgwick

P.O. Box 14779

Lexington, KY 40512

Número de teléfono

(855) 728-5277

Número de fax

(866) 383-3296

Correo electrónico

6200AtlasGeneralInsurance@sedgwickcms.com