Occupational Accident Claim Filing Instructions

In addition to the Occupational Accident Report of Injury claim forms please provide the following information. Failure to submit all of the requested information below will delay the processing of this claim.

- First Report of Injury/Accident Claim Form.
- Reimbursement Agreement / Right of Subrogation and Refund Authorization
- Medical Treatment Authorization (To be completed by Employer & Provider)
- Claim For Total Disability Benefits (To be completed by Employee)
- Attending Physician's Statement of Disability Form – to be completed by the treating physician.
- Job Description Form.
- If claiming disability, a copy of the injured employee's weekly payroll register showing your Company name, Gross Amounts, Deductions, Net Amounts and Check numbers from the previous 12 months through the week of the injury. **Including the actual date of injury.**
- If not claiming disability, a copy of the injured employee's weekly payroll register showing your Company name, Gross Amounts, Deductions, Net Amounts and Check Numbers from the previous 3 weeks through the week of the injury. **Including the actual date of injury.**
- Additionally, a copy of the claimant's most recent signed and dated government form. These forms should be one of the following; W-2, W-4, I-9 or 1099 form.
- Copy of the police report if the injury was the result of a motor vehicle accident, assault or other related crime.
- Copy of the drug or alcohol test results if one was conducted.
- **CONTRACT LABOR:** If the injured claimant is considered contract labor and is not included with your payroll records, please submit the W-9 form and photocopies of cancelled checks issued for service OR copies of Accounts Payable ledgers with detail of hours worked and hourly rate of pay. (Information must include week of injury and the prior 6 months of service.)
- **CONTRACT LABOR:** Copy of the signed document indicating the acceptance of Policy Benefits at the time of eligibility.

Mail to: NABCO
P.O. Box 3056
Southeastern, PA 19398-3056
Phone: 1-800-994-4277
Fax: 1-610-995-0181

OCCUPATIONAL ACCIDENT REPORT OF INJURY

Underwritten by: MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Administered by: North American Benefits Company

Mail to: NABCO
P.O. Box 3056
Southeastern, PA 19398-3056
Phone: 1-800-994-4277
Fax: 1-610-995-0181

All Reports of Injury must be submitted within 30 days from the Date of Injury

Please print

Employer Information

Group Name: | Group Policy Number:

Supervisor/Manager Name: | Supervisor/Manager Phone Number:

Employee Information

Injured Employee Name: | Social Security #: | Date of Birth:

Home Address (incl. city, state, zip): | Home Phone Number: | E-mail:

Employment Status:
☐ Active ☐ Disabled ☐ Terminated ☐ Retired

Job Title/Description:

Date Hired: | Date Last Worked: | Date Disability Began:

If unable to work, please submit 52 weeks PRE-INJURY payroll information or from date of hire if less than one (1) year

Accident Information

Date of Accident: | What time did the accident happen? (Specify am or pm): | Date of Report:

When was the accident reported to Supervisor? | Name of Supervisor in charge at the time: | Name of person filing report:

What was the CAUSE of the accident?

WHERE did the accident occur? (PHYSICAL ADDRESS)

What BODY PART(s) were injured?

What Type of Injury (ex.: Cut, Sprain, Fracture…)

Describe the DETAILS of the accident and how it happened: (at*tach additional paper if necessary)*

Did the injury require immediate emergency treatment? ______________________________

Did the Employee refuse medical attention and/or treatment? ______________________________

✱

Employee Signature ______________________ **Supervisor Signature** ______________________

Witnesses to Accident: Attach witness statements if taken.

Name | Address | Phone

(1)______________________________

(2)______________________________

(3)______________________________

Date of first medical treatment:

Treating physician and treating facility (name, address and phone number):

Has the employee ever been treated for this before? If yes, please explain:

Give full name, address and phone number of ALL other physicians consulted in the past three years:

The Employer agrees to make modified duty available for the Employee if he/ she is partially disabled and able to return to some form of work as agreed to by their treating physician. I certify that the injured individual is an Employee according to the provisions of our Occupational Injury Benefit Plan or Group Policy.

✱

Employer Signature ______________________ **Print Name** ______________ **Date** __________

Reimbursement Agreement

The undersigned may receive benefits under the Employer's Occupational Injury Benefit Plan or Group Policy for an injury sustained as a result of the accident identified in the Accident Report Form. The undersigned agrees to reimburse the insurance company carrier within 30 days for benefits paid under the Group Policy for recoveries he or she may receive from a third party other than the undersigned's Employer, in connection with the accident.

✱

Employee Signature ______________________ **Date** ______________________

Right of Subrogation and Refund

The injured Employee may incur expenses due to injuries for which benefits are paid by the Employer's Occupational Injury Benefit Plan or Group Policy. If the injuries are caused by the wrongful act or negligence of another person, then the Employee may have a claim against that other person for payment of expenses. We will be subrogated to all rights the Employee may have against the other person and the Employee must repay us out of the recovery made from: (a) the other person; or (b) the other person's insurer; or (c) any carrier providing uninsured or underinsured motorist coverage. The Employee agrees to assist us in any recoveries and not to take any action that would prejudice our subrogation rights. Our subrogation rights only apply to the amounts paid by the Occupational Injury Benefit Plan or Group Policy.

Name and address of third party or other party involved:

____

✱

Employee Signature ______________________ **Date** ______________________

Authorization

I certify that the information is true and correct to the best of my knowledge. I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, or other organization, institution or person that has any records or knowledge of me or my health to give to Madison National Life Insurance Company, Inc., North American Benefits Company, their legal representative, or designees any such information. Such release may include information that may be considered a communicable and/or venereal disease, hepatitis, HIV related, AIDS, AIDS related disorders, mental/nervous disorders, drug abuse and/or alcoholism.

I understand the information obtained by the use of this Authorization will be used by Madison National Life Insurance Company, Inc. or North American Benefits Company to determine eligibility for benefits under my Employer's Occupational Injury Benefit Plan or Group Policy. Any information will not be released to any person or organization except to an insurance company or reinsurer, or any other person(s) or organization(s) performing business or legal services in connection with my claim, or as may be otherwise lawfully required.

A photocopy of this Authorization shall be as valid as the original. I understand that I am entitled to a copy of this Authorization.

✱

Employee Signature ______________________ **Date** ______________________

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

Managed Care Program
Medical Treatment Authorization
Initial Treatment Form

To be completed by Employer:

Claimant (Patient):____Sex:__________________
Claimant's Address ____
____Telephone: _______________________
Occupation:____
Date of Birth:______________________________Social Security Number______________________
Company Name: ____ Group Number:____________________
Company Address: ____
____Telephone Number:.____________________________

Treatment Authorized By: ____
Provider Name: ____
Provider Address:____
____Telephone Number:_________________________

Contact Person: ____
Date of Loss Time Began: _____________ Time of Injury: _______ Place of Injury: ___________
Has the claimant received prior treatment for this injury? Yes: ________ No: _________
If yes, explain: ____
Is this a re-occurrence? Yes: __________ No: ____________
If so, what is the original injury date? ____
Drug Test: Yes: _______ No: _________

I understand that I may be required to submit to a drug test if involved in an accident which results in medical treatment, and that the results will be released to my employer or a physician designated by my employer.

________________________________ ________________________________
(Witness Signature) (Employee Signature)

________________________________ ________________________________
Date Date

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

I hereby authorize____to disclose to any party that is or may be liable for all or part of the medical charges, such diagnostic and therapeutic information as may be necessary to perform case management, to determine benefits entitlement and to process payment of claims for health services provided to me, the patient.

________________________________ ________________________________
Employee's Signature Date

To be completed by Provider:

Claimant's name: ______________________________

Claimant's S. S. #: ______________________ Claim#: ______________________

Date of This Report ______________________ Date of First Visit: ______________________

The summary report below refers to: First Visit __ Follow-up __ Final __

Nature and Location of Injury or Disease (Describe Fully, including Parts of Body Affected):

How did the injury occur: (Describe Fully)

Results of Physical Examination:

Diagnosis (ICD-9 Code, if known): ______________________

Treatment Rendered: ______________________

X-rays: ______________________

Treatment Plan/Recommendations: ______________________

Next Visit Date: ______________________

Diagnostic Test(s) Needed: ______________________

Projected Return-to-work Date: ______________________

If date unknown at this time, is it likely to be more than four (4) weeks from today? Yes _____ No _____

Patient will return to: Full Duty _____ Alternate Duty _____

Restrictions: ______________________

Claimant Job Assessment Needed: Yes ___ No _____

Job Title (if known): ______________________

Comments: ______________________

PHYSICIAN'S SIGNATURE: ______________________ DATE: ______________

Provider should notify the Texas Healthcare Foundation of any treatment or service at

1-800-716-6777

Both sides of this form should be faxed or a copy mailed to:

North American Benefits Co., P.O. Box 3056, Southeastern, PA 19398-3056·

Phone: 1 800-994-4277 Fax: 610-995-0181

CLAIM FOR TOTAL DISABILITY BENEFITS

Employee Statement & Authorization

c/o North American Benefits Company
P.O. Box 3056
Southeastern, PA 19398-3056

NOTE: THIS STATEMENT MUST BE MADE BY THE EMPLOYEE. EVERY QUESTION MUST BE FULLY ANSWERED. THE COMPANY RESERVES THE RIGHT TO ASK FOR ADDITIONAL STATEMENT IF DEEMED NECESSARY FOR PROPER DISPOSITION OF THE CLAIM.

Your Full Name:	Date of Birth:	SSN:
Current address:	Phone:	Email:
City:	State:	ZIP Code:

EMPLOYMENT INFORMATION

Employer Name:			
Employer Address:			
City:	State:	ZIP Code:	Phone:

Job Title and Specific Duties:		Date Hired:
	Length of time in Position:	Earnings:

INJURY INFORMATION

Date of Injury or beginning of illness leading to disability:	Date you last worked:	If returned to work, give date:	Approximate Future return to work date:

Describe fully your present disability and its cause, with a complete history to date:

Is the condition work related?

List all Physicians Consulted and Hospital Confinements in the Last Five Years (Use separate paper if needed)

Name of Doctors	Specialty	Mailing Address	Date of 1st Treatment

Name of Hospitals	Mailing Address

DESCRIBE OTHER INCOME YOU ARE RECEIVING:

Yes	No	Type	Amount	Date Began	Date Terminated
____	____	Social Security (disability or retirement)	$____________	_____________	______________
____	____	State Disability	$____________	_____________	______________
____	____	Retirement (normal, early or disability)	$____________	_____________	______________
____	____	Workers' Compensation	$____________	_____________	______________
____	____	Group Disability Benefits	$ ___________	_____________	______________
____	____	Other (describe)	$____________	_____________	______________

AUTHORIZATION

TO ALL PHYSICIAN, HOSPTIALS, MEDICAL SERVICE PROVIDERS, DRUGGISTS, EMPLOYERS, CONSUMER REPORTING AGIENCIES, LAW ENFORCEMENT AGENCIES, AND ANY OTHER AGENCIES, AND ANY OTHER AGENCIES OR ORGANIZATION (INCLUDING OTHER INSURANCE COMPANIES, BLUE CROSS-BLUE SHILED, SELF INSURED AND PREPAID HEALTH PLANS.)

You are authorized to permit Madison National Life Insurance Company, Inc. and its authorized representatives to view and obtain a copy of all RECORDS including employment, law enforcement, tax, financial, insurance claim records, Social Security Administration records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric, drug or alcohol treatment and disease.

I understand the information obtained will be used only by Madison National Life Insurance Company, Inc. to determine eligibility for insurance and benefits claimed under the Insured's policy. I consent to re-disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred or relayed to any other person not specified in this form without my written consent.

I understand this authorization may be revoked by written notice to Madison National Life Insurance Company Inc., but this will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I may request a copy of this authorization and also agree that a photographic copy of this form shall be as valid as the original.

Employee Signature ______________________________ **Date** ______________________________

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

c/o North American
Benefits Company
P.O. Bo 3056
Southeastern, PA 19398-3056

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Name of Patient	Date of Birth
Present Address	
Employers Name	Group Policy No.

We must have comprehensive medical information in order to evaluate the patient's claim for Disability Benefits. Any fee required for completion of this form is the patient's responsibility.

1. HISTORY

When did symptoms first appear or accident happen? Mo. Day Yr.

Date disability commenced Mo. Day Yr.

Has patient ever had same or similar condition? ☐ Yes ☐ No

If "Yes", state when and describe ______

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

2. DIAGNOSIS (including any complications)

Diagnosis (including any complications)______

Subjective symptoms ______

Objective findings (including current X-rays, EKG's Laboratory Data and any clinical findings)

3. DATES OF TREATMENT

Date of fist visit Mo. Day Yr.

Date disability commenced Mo. Day Yr.

Frequency

☐ Weekly ☐ Monthly ☐ Other(specify)______

4. NATURE OF TREATMENT

Please describe course of treatment. ______

5. PROGRESS

Give prognosis with reasonable estimate of return to work date. ______

Has patient been hospital confined? ☐ Yes ☐ No

If "Yes" Give Name and Address of Hospital | Confined from | through

6. CARDIAC (If Applicable)	Functional capacity (American Heart Association)	☐ Class 1 (No limitation) ☐ Class 3 (Marked limitation)	☐ Class 2 (Slight limitation) ☐ Class 4 (Complete limitation)
	Blood Pressure (last visit)________		
	Results of stress test ________		

7. LIMITATION (If there is a limitation, check and describe)					
	☐ Standing	☐ Climbing	☐ Bending	☐ Use of Hands	☐ Sitting
	☐ Walking	☐ Stooping	☐ Lifting	☐ Other	

8. PHYSICAL IMPAIRMENT **(as defined in Federal Dictionary of Occupational Titles)**

☐ Class 1 – No limitation of functional capacity; capable of heavy work * No restrictions (0-10%)
☐ Class 2 – Medium manual activity * (15-30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work * (35-55%)
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)

Remarks:________

9. MENTAL/ NERVOUS IMPAIRMENT **(if applicable)**

Please define "stress" as it applies to this claimant.

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:________

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐ Yes ☐ No

10. EXTENT OF DISABILITY		**From Any Occupation**			**From Patients Regular Occupation**		
	Is Patient now totally disabled?	☐ Yes ☐ No			☐ Yes ☐ No		
	If yes, when do you think patient will be able to resume any work? *Approximate Date*	Mo.	Day	Yr.	Mo.	Day	Yr.

11. REHABILITATION		**Patient's Job**			**Any Other Work**		
	When could trial employment commence?	Mo.	Day	Yr.	Mo.	Day	Yr.

Describe rehabilitation needs:________

12. REMARKS:

Attending Physician Signature Date

Name of Physician (please print): Telephone

Address (Street, City or Town, State or Province, Zip Code)

Job Description

Name: ____________________________ SS#:______________ Hire Date: __________

Policy #:_______________ Class Code:__________________ Salary:_____________

Occupational Title:_________________________________

List in order of importance, all duties performed

Description Of Duties	**% Of Time**	**Hours Per Day**

Lifting And Physical Requirements:_______________________________________

____

____

____

____

Educational Requirements:____

____

____

Special Skills:____

____

Can this job be modified for light duty? ______ Yes ______ No

If yes, How can it be modified?____

____

____

____

____________ ____ ____________________

Date **Signature (Person completing form)** **Title**