If Your Employee Is Injured At Work

Prompt reporting of work-related injuries and illnesses and the use of Travelers national Medical Network Providers can achieve better outcomes and lower your overall workers compensation claim costs!

Whenever an Employee suffers a work-related injury or illness, the Employer should:

1. Seek appropriate medical care for the Employee.
2. If the injury or illness is acute, the Employer should always send the Employee to the nearest medical emergency department.
3. If the injury or illness is not acute, the Employer may suggest that the Employee seek treatment from the nearest Medical Network Provider. Medical Network Providers understand work-related illnesses and injuries, are credentialed to help assure quality care, and cooperate to achieve a medically appropriate return to work for the Employee. Medical Network Providers (hospitals, initial care clinics, specialists, testing, therapy, etc.) are available in all 50 States and the District of Columbia. Even before an illness or injury occurs, it may be helpful for the Employer to build a relationship with a convenient Medical Network Clinic or Hospital that will provide initial treatment for ill or injured Employees.
4. The Employee's Supervisor should gather pertinent facts about the work-related illness or injury and may use the Worksheet For Workers' Compensation Telephone Reporting provided by Travelers as a guide.
5. As soon as possible, the Employer should report all work-related illnesses or injuries to Travelers by,
   - using Travelers business insurance online reporting web site at travelers.com
   - dialing our toll free number, 1-800-832-7839. If needed at that time, Travelers Customer Service Representative can provide the name of a convenient Medical Network Provider. Prompt reporting of work-related illnesses and injuries is key in helping to reduce total claim costs. At the conclusion of the phone call, the Travelers Customer Service Representative will provide a claim number that should be retained for the Employer's reference and also provided to the ill or injured Employee.

The card below contains information that may be helpful in reporting work-related illnesses and injuries to Travelers and should be kept in a convenient location for use by the Employer when needed.

TRAVELERS WC Claim Reporting

- Promptly report your work-related injuries to Travelers:
  - Travelers.com
  - 800-832-7839
- Learn about Travelers unique Claim Services and find a convenient medical network provider by logging on to www.travelers.com then *Select:*
  - Claim
  - Workers Compensation claim resources
  - Find a network Medical Provider

NOTICE TO EMPLOYEES

Longshore and Harbor Workers' Compensation Act

U.S. Department of Lab
Employment Standards Administration
Office of Workers' Compensation Programs

(Employer) STATE OF VERMONT, DEPT OF
LABOR, WORK FORCE INVESTMENT
5 GREEN MOUNTAIN DRIVE
MONTPELIER VT 05633

This employer is insured to provide compensation benefits (including medical and hospital care) to its employees, or monetary benefits to eligible survivors, in case of work-connected injury, occupational illness or death, in accordance with the provisions of the above law and rules of the Office of Workers' Compensation Programs.

WHAT TO DO WHEN INJURED AT WORK

- NOTIFY YOUR EMPLOYER IMMEDIATELY. If possible, complete Form LS-201, Notice of Injury, available from your employer. You should give notice of Injury to the following person(s):

- MEDICAL TREATMENT. Request authority (Form LS-1) from your employer for treatment by the physician you choose. You may not select a physician that is not authorized by the Office of Workers' Compensation Programs to provide medical care under the Act. Your employer has a list of physicians who are not authorized. In an emergency or if unable to contact your employer, go to the nearest hospital or physician, but be sure to let your employer know as soon as possible.

- DISABILITY. If you are disabled more than 3 days, contact your employer or the insurance company indicated below for payment of compensation, payable 14 days after your employer has knowledge of injury.

- IMPORTANT! The law requires you to give written notice of injury (Form LS-201) to your employer and to the Office of Workers' Compensation Programs within 30 days. Additional time may be allowed for certain hearing loss and occupational disease claims. The address of the Office of Workers' Compensation Programs District Office for this area is:

  JFK FEDERAL BUILDING, ROOM E-260
  BOSTON, MA 02203
  PHONE: (617) 624-6750, FAX: (617) 624-6603

Insurance Carrier for This Employer	For Further Assistance and Information
Name THE TRAVELERS INSURANCE COMPANIES	On request, the Office of Workers' Compensation Programs will explain benefits and proceedings under the above Act. In addition, the Office of Workers' Compensation Programs will inform employees receiving compensation about medical and vocational rehabilitation services, and will assist in obtaining such services.
Address P.O. BOX 3556 ORLANDO, FL 32802-3556	
Telephone 800-443-4404	
Policy Number (6JUB-9974M70-8-16)	Expiration Date of Policy 10-01-17

Authorized Signature for the Employer — Date Signed

This Notice must be posted and maintained in a conspicuous place in and about the place of business. (33 U.S.C. 934)

Important Notice

Section 31(a)(1) of the Longshore Act, 33 U.S.C. 931(a)(1), provides as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or by both.

WORKERS' COMPENSATION TELEPHONE REPORTING WORKSHEET

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:
Call the Telephone Reporting Center to quickly and easily report all Workers' Compensation injuries. We will be asking you the following questions, so please have the information handy. We will produce and submit the necessary state forms.

DO NOT DELAY IN CALLING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.

ACCOUNT/ACCIDENT INFORMATION

CALLER'S PHONE NUMBER/EXTENSION	CALLER'S TITLE	CALLER'S NAME	REPORTING STATE
( )			

SUBSIDIARY NAME	SUBSIDIARY'S ADDRESS (STREET, CITY, STATE & ZIP)	SUBSIDIARY'S MAILING ADDRESS (STREET, CITY, STATE & ZIP)
		☐ SAME

DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS?

☐ YES ☐ NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED

PARENT COMPANY/INSURED'S NAME

LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS

DATE OF INJURY	TIME OF INJURY

ACCIDENT DESCRIPTION

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER
		☐ MALE ☐ FEMALE

DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS

EMPLOYEE'S HOME PHONE NUMBER	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)
( )	

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE	INJURED WORKER TYPE	REGULAR OCCUPATION
☐ FULL-TIME ☐ PART-TIME ☐ OTHER _____		

OCCUPATION WHEN INJURED

EMPLOYEE'S WORK SCHEDULE

REGULAR WORK HOURS HOURS/DAY DAYS/WEEK

EMPLOYEE'S WAGE INFORMATION

$_____/HOUR OR $_____/ANNUAL OR $_____/WEEKLY OVERTIME: $_____ ADDITIONAL BENEFITS: $_____

DATE OF HIRE OR LENGTH OF EMPLOYMENT

SUPERVISOR'S NAME	SUPERVISOR'S PHONE NUMBER:	BEST HOURS TO CONTACT
	( )	

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK?	IS THE EMPLOYEE BACK AT WORK?
	☐ YES ☐ NO	☐ YES ☐ NO IF YES, DATE RETURNED TO WORK?

RETURN TO WORK STATUS	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH
☐ LIGHT ☐ MODIFIED ☐ REGULAR		☐ YES ☐ NO

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)

EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED

DO YOU QUESTION THE VALIDITY OF THE CLAIM?

☐ YES ☐ NO

WITNESS INFORMATION/OTHERS INVOLVED

NAME (FIRST, MI, LAST) ADDRESS PHONE NUMBER

CONTINUED ON REVERSE SIDE

INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY)

☐ FIRST AID —	TREATMENT AND DATE OF 1st TREATMENT
☐ HOSPITAL/ CLINIC —	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1st TREATMENT, LENGTH OF STAY AMBULANCE USED? WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATENT? ☐ YES ☐ NO
☐ PHYSICIAN —	

SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS FOR YOUR INDIVIDUAL STATE.

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION

WORKERS' COMPENSATION – FIRST REPORT OF INJURY – STATE SPECIFIC QUESTIONS

If Yes, Name of Provider:
Is there a written safety program in force (Y/N):
Is there an active safety committee (Y/N):
Employee•s Legal First Name (please validate):

New Jersey - No Additional State Questions

New Mexico - No Additional State Questions

New York
Did you provide medical care (Y/N):
If Yes, When:
Returned to work (Y/N):
If Yes, at what Weekly Wage $:
Injured workers Work Week (indicate days regularly worked):
Fatal (Y/N):
If Yes, Name and Address of nearest relative:
Relationship:

North Carolina
Regular Wages per Day $:
Average Weekly Wages with Overtime $:
Returned to work (Y/N):
If Yes, at what Time: AM/PM
If Yes, what Date:
Return to work at what Wage $: Per (Day, Week or Month):
Return to work at what Occupation:

North Dakota - No Additional State Questions

Ohio
Time Accident Reported to employer: AM/PM:
Has employee ever filed a previous application for this injury (Y/N):
Has employee filed any other claims with the Bureau or Industrial Commission (Y/N):
If Yes, specify Claim Number and Body Parts:
Employee's County:
Current Employer's Risk Number:

Oklahoma
Was employment agreement made in Oklahoma (Y/N):
SIC Number:
Type of Ownership (P=Private, S=State Government, C=County Government, L=Local Government):

Oregon
Hospitalized overnight as inpatient (if emergency room only, answer N) (Y/N):
Was accident caused by failure of machinery or product (Y/N):
Did someone (not worker) cause accident (Y/N):
Time worker left work: AM/PM:

Pennsylvania
Employee's County:
Bureau Code:
NAICS Code:
Employer•s County:
Are you aware of a 'Panel of Physicians' for your Employer? (Y/N)

Rhode Island
Federal ID Number:
First Full Day Lost from work:
Unemployment Insurance Number:
State of Hire:
Was this injury previously an "Incident Only" with no medical treatment and no lost time (Y/N):
If Yes, Date Employer first Notified of medical treatment or lost time:
Category of Injury or Illness ("X" all that apply):
Injury: Illness: Occupational Disease: Repetitive Trauma:
Occupational Hearing Loss: Unknown:

South Carolina - No Additional State Questions

South Dakota
Federal ID Number:
Number of employees:
Body Part Injured Code (2 digits):
Cause of Injury Code (2 digits):
Nature of Injury Code (2 digits):
Was employee hired for temporary employment (Y/N):
Carrier Code:

Tennessee - No Additional State Questions

Texas - No Additional State Questions

Utah - No Additional State Questions

Vermont
Federal ID Number:
Was employee hired in Vermont (Y/N):
Does the employer regularly employ 10 or more employees (Y/N):
Returned to work (Y/N): If Yes, at what Weekly Wage $:
Was injured paid in full for the date disability began (Y/N):
Was employee injured at his/her regular occupation (Y/N):
Fatal (Y/N):
If Yes, Name, Address and Relationship of Nearest Relative:
Last Date Paid in Full:

Virginia
Returned to work (Y/N): If Yes, at what Wage $:
Federal Tax ID Number:

Washington - No Additional State Questions

West Virginia
Has the employee been given "The Employees and Physicians Report of Injury Form" (Y/N)

Wisconsin - No Additional State Questions

Wyoming - No Additional State Questions

U.S. Longshoreman (USDOL) - No Additional State Questions