WEST BEND
A MUTUAL INSURANCE COMPANY®

When replying, refer to: Customer Number
Policy Number
Policy Period

Dear Insured:

SUBJECT: WORKERS' COMPENSATION CLAIM INFORMATION

West Bend is pleased to provide you with …

1. Workers' Compensation reporting tips that are helpful when you must report a work-related injury.
2. Employer's First Report of Injury or Disease forms.
3. Supervisor's Incident Report.
4. A description of our cost containment initiatives.

The following forms are also available and are helpful in returning your employee to work …

1. **Job Analysis.** (WB 501) Use this form when working with the treating physician.
2. **Attending Physicians Return to Work Recommendations Record.** (WB 531) Send this with the injured employee to the initial treating doctor's appointment. You may ask the employee to return the form directly to you after initial medical treatment, or ask the doctor to fax it back to you.
3. **Return to Work Log.** (WB 603) Use this log as an efficient method to monitor and document the specific tasks your employees are performing while on light or modified duty.

We hope you find this information useful.

Sincerely,

Workers' Compensation Claim Department

WB 602 D 03 07

WORKERS' COMPENSATION REPORTING TIPS

– ATTENTION–
YOU MAY BE FINED IF YOU DO NOT REPORT ON–THE–JOB INJURIES ON TIME

You must complete an Employer's First Report of Injury IMMEDIATELY after an on–the–job injury occurs and forward the report to your claims administrator. **You may be fined if you do not submit the report on time.**

Send, fax, call, or e-mail the initial loss report immediately, even if you do not have all the information about the injury.

- Do not wait for medical bills.
- Do not withhold the loss report because you believe the claim is questionable. Reporting a loss is not an admission of liability.
- Be sure to include the policy number on all correspondence.

Please mail, fax, call, or e-mail the report to:

West Bend Mutual Insurance Company Claims:

All States

Workers' Compensation Claims Department
West Bend Mutual Insurance Company
1900 S. 18th Avenue
West Bend, WI 53095
Phone: 877-922-5246
FAX: 888-926-9299 or 262-334-6378
e-mail: directconnect@wbmi.com

General Questions:
Phone: 800-236-5004 or 334-6430
e-mail: wccentral@wbmi.com

NSI Claims:

Workers' Compensation Claims Department
8401 Greenway Blvd., Ste 1100
Middleton, WI 53562
Phone: 800-760-9250
Fax: 877-434-9585
e-mail: nsiclaims@wbmi.com

Do not withhold the loss report for any reason. Send, fax, call, or e-mail it **IMMEDIATELY** after the injury occurs. **You may be fined** if the claims administrator cannot make the initial lost time payment because you failed to send the Employer's First Report of Injury on time.

If you fax or e-mail the report, please do not send it. If you need to notify your agent, please send your agent a photocopy of the report. Direct reporting saves time.

If you have any questions, please call your claims administrator.

HOW TO WRITE INJURY DESCRIPTIONS

The following instructions will help you avoid some common errors and save time when describing an injury on the First Report of Injury form.

For most accidents, you can describe what happened in one or two sentences. "He strained his lower back lifting a box." "She bruised her left knee when she fell on a wet floor." However, your descriptions must be specific. "Hurt back working" does not provide enough information.

Answer the following questions when describing an injury:

1.What part of the body was injured?

- Lower back
- Upper right leg
- Right forearm
- Third toe on left foot

2. How did the accident happen?

- Did the person fall?
- Did they twist their body as they got out of a chair?
- Were they moving or stationary when the accident happened?

3. Was the injured person carrying anything?

Even if it probably didn't cause the injury, we need to know if the person was carrying anything. For example, "Carrying broom, stepped wrong and twisted left ankle."

4. What specifically appears to have caused the accident?

If someone hurt their back lifting a box, say that. Don't say:

- Lifting a unit of material
- Lifting equipment
- They hurt their back lifting product

Avoid jargon or trade names for equipment. Explain precisely what they were doing.

- Lifting an air conditioner
- Carrying magazines
- Pushing a cart
- Bending over to pick up a wrench

If a machine caused the injury, tell us what kind.

- A grinder
- A shear
- A hoist

Again, avoid jargon or trade names.

5. What injury appears to have resulted?

- Strain
- Bruise
- Fracture
- Cut

Please be sure to include the injured person's birthdate or age and Social Security number. Also, indicate the geographical location of the accident (city, county and state).

Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS **Jurisdiction Code** _____ **Jurisdiction Claim Number** _____

CLAIM ADMIN

Claim Administrator Name: **West Bend Mutual Insurance Company**		Claim Representative Business Phone Number: **800-236-5004**	Insurer Name (if different than claim administrator):
Mailing Address, City, State, & Postal Code: **1900 S. 18th Avenue** **West Bend, WI 53095** **Fax: 262-334-6378**		Claim Administrator Claim Number:	Insurer FEIN:
		Claim Administrator FEIN: **39-0698170**	Claim Type Code:

EMPLOYER

Employer Name:		Employer FEIN:	Insured Report Number:	Employer Type Code: __ Employer (E) __ Lessor (L)
Physical Address, City, State, & Postal Code:		Mailing Address, City, State, & Postal Code:	Industry Code:	
			Insured Location Number:	Employer UI Number:
Nature of Business:		Employer Contact Name and Business Phone Number:		

POLICY

Insured Name (parent co. if different than employer):	Insured FEIN:	Insured Postal Code:	Policy/Contract Number:	Coverage Effective Date: Coverage Expiration Date:	Self Insurance License/ Certificate Number:

EMPLOYEE

Employee Name (First, Middle, Last, & Suffix):	Date of Birth:	Gender: __ Male (M) __ Female (F)	Tax Filing Status (check one) __ Single (A) __ Single/Head of Household (B) __ Married/Filing Joint (C) __ Married/Filing Separate(D)	
Mailing Address, City, State, & Postal Code:	Date of Hire:	Educational Level (grade completed): _____ [GED = 12]		Marital Status: (check one) __ Unmarried (U) __ Married (M) __ Separated (S)
Phone Number (include area code):	Employment Status (check one): __ Piece Worker __ Volunteer __ Seasonal __ Apprenticeship/Full-Time __ Apprenticeship/Part-Time __ Regular Employee/Full-Time __ Part-Time __ Other	Employee ID Number (check one): ID # _____ __ Social Security Number __ Employment VISA Number __ Passport Number __ Green Card __ Employee ID Assigned by Jurisdiction		Employee's Authorization to Release the Following: Medical Records __ yes __ no Social Security Number __ yes __ no
Occupation Description:				
Manual Classification Code:				
Department Where Regularly Worked:				

WAGE

Average Wage $ _____ (check one): ___ hourly ___ daily ___ semi-monthly ___ monthly ___ bi-weekly ___ annual ___ weekly	Salary Continued In Lieu of Compensation: __ yes __ no Full Wages Paid for Date of Injury: __ yes __ no	Employee Number of Dependents: _____ Employee No. of Exemptions: _____(check one) ___ Entitled ___ Withholding
Number of Days Regularly Worked Per Week: _____	Discontinued Fringe Benefits: $ _____	

ACCIDENT/INJURY

_____ Date of Injury _____ Date Employer Had Knowledge of the Injury _____ Date Claim Admin. Had Knowledge of the Injury _____ Initial Date Last Day Worked _____ Initial Return to Work Date (if applicable) _____ Employee Date of Death (if applicable)	Describe the nature of the injury. (ex. amputation, burn, cut, fracture):
_____ Time of Injury _____ Time Employee Began Work	Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):
Pre-Existing Disability Code: ___ Yes ___ No ___ Unknown	Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):
Accident Premises Code: ___ Employer (E) ___ Lessee (L) ___ Other (X)	Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):
Accident Site Organization Name:	
Accident Site Street, City, State, & Postal Code:	Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties:
Accident Location Narrative (if no street address):	
Accident Site County/Parish:	Witness Name & Business Phone Number:

MEDICAL

Initial Treatment Code (check one): ___ no medical treatment (0) ___ minor/on-site treatment (1) ___ clinic/hospital visit (2) ___ emergency care (3) ___ hospitalization > 24 hours (4) ___ future medical treatment/lost time anticipated (5)	Initial Medical Provider Name:	Managed Care Organization Name or ID Number:
	Initial Medical Provider Physical Address, City, State, & Postal Code:	ICD Primary Diagnostic Code (if known):

Preparer's Name & Title:	Preparer's Company Name:	Phone Number:	Date:

IAIABC FORM 1.2 (12/98)

Mail to: DIVISION OF WORKERS' COMPENSATION
1000 E GRAND
DES MOINES, IOWA 50319
(515)281-5387

STATE OF IOWA
EMPLOYERS WORK INJURY REPORT
EMPLOYERS FIRST REPORT OF INJURY

DIVISION OF LABOR SERVICES
1000 E GRAND
DES MOINES, IOWA 50319
(515)281-3606

This section is to provide information valuable in handling this claim.
The Iowa Occupational Safety and Health Act

The following is a summary of the recordkeeping, reporting and posting responsibilities of employers under Iowa's Occupational Safety and Health Act.

RECORDKEEPING REQUIREMENTS

Regulations issued under the Iowa Occupational Safety and Health Act of 1972 require establishments subject to the Act to maintain records of recordable occupational injuries and illness. Such records must consist of: (a) a log and summary of occupational injuries and illnesses and (b) a supplementary record of each occupational injury and illness.

LOG AND SUMMARY OF OCCUPATIONAL INJURIES AND ILLNESSES. Each recordable occupational injury and occupational illness must be entered on a log and summary of cases (0SHA Form No. 200) as early as practicable but no later than 6 working days after receiving information that a recordable case has occurred. A multi-unit employer may maintain the log and summary of occupational injuries and illnesses at a place other than the establishment if there is a copy of the log and summary available in the establishment complete and current to a date within 45 calendar days. If an equivalent of OSHA Form No 200 is used, such as a printout from data-processing equipment, the information shall be as readable and comprehensible to a person not familiar with the data-processing equipment as the OSHA Form No. 200 itself. Logs must be kept current and retained for 5 years following the end of the calendar year to which they relate.

SUPPLEMENTARY RECORD OF OCCUPATIONAL INJURIES AND ILLNESSES. To supplement the Log and Summary of Occupational Injuries and Illnesses, each employer must have available a record for each occupational injury or illness at each establishment within 6 working days after receiving information that a recordable case has occurred, OSHA Form No. 101 may be used for this purpose. State of Iowa Form No 14-0001 (7-99), workers' compensation or other reports are acceptable as records if they contain the information required on OSHA Form No 101. These records must be available in the establishment without delay and at reasonable times for examination by representatives of the Iowa Division of Labor Services, the U.S. Department of Labor and the U.S. Department of Health, Education and Welfare. The records must be maintained for a period of not less than 5 years following the end of the calendar year to which they relate.

ANNUAL SUMMARY. Each employer subject to the recordkeeping requirements must prepare a summary of the occupational injury and illness experience of the employees in each of the employer's establishments at the end of each year based on the information contained in the log and summary of occupational injuries and illnesses for the particular establishment. OSHA Form No. 200 shall be used for this purpose. The summary shall be signed and posted in a place accessible to the employees no later than February 1 and shall remain in place until March 1. For employees who do not report to work at a single establishment, or who do not report to any fixed establishment on a regular basis, employers shall satisfy the posting requirement by presenting or mailing a copy of the annual summary during the month of February to all such employees who receive pay during that month. Summaries must be retained for 5 years following the end of the calendar year to which they relate.

EMPLOYEES NOT IN FIXED ESTABLISHMENTS. Employers of employees engaged in physically dispersed operations such as occur in construction, installation, repair or service activities who do not report to any fixed establishment on a regular basis but are subject to common supervision may satisfy the recordkeeping provisions with respect to such employees by:

(a) Maintaining the required records for each operation or group of operations which is subject to common supervision (field superintendent, field supervision, etc.) in an established central place;

(b) Having the address and telephone number of the central place available at each worksite; and

(c) Having personnel available at the central place during normal business hours to provide information from the records maintained there by telephone and by mail.

(Note: This regulation does not automatically apply to all construction, installation, repair or service activities. If in doubt about applicability to your operations, contact the Iowa Division of Labor Services.)

Records for personnel who do not primarily report or work at a single establishment, and who are generally not supervised in their daily work, such as traveling salespersons, technicians, engineers, etc., shall be maintained at the location from which they are paid or the base from which personnel operate to carry out their activities.

REPORTING REQUIREMENTS

Regulations issued under the Iowa Occupational Safety and Health Act require all employers subject to the Act to report in writing to the Iowa Workers' Compensation Commissioner any occupational injury or illness which temporarily disables an employee for more than three days or which results in permanent total disability, permanent partial disability, or death. State of Iowa Form No. 14-0001 is to be used, and is to be filed with the Iowa Division of Workers' Compensation within four days from such event when the injury or illness is alleged by the employee to have been sustained in the course of the employee's employment. A report to the Iowa Division of Workers' Compensation is considered to be a report to the Iowa Division of Labor Services. The Iowa Division of Workers' Compensation shall forward all such reports to the Iowa Division of Labor Services.

In addition, employers must report to the Iowa Labor Commissioner within 8 hours each accident or health hazard that results in one or more fatalities or hospitalization of three or more employees. The toll free number that is available 24 hours a day, including weekends and holidays, to use to report is 1-877-2-IA-OSHA (1-877-242-6742).

Those establishments selected to participate in the annual Occupational Injuries and Illnesses Survey will be required to prepare a report (OSHA Form No 200-S) based on entries contained on the Log and Summary of Occupational Injuries and Illnesses.

POSTING REQUIREMENTS

The Iowa Occupational Safety and Health Act requires that employees be informed of the job safety and health protection provided under the Act. The poster, "Safety and Health Protection on the Job," is to be used for this purpose, and must be posted in a prominent place in the establishment to which the employees usually report to work. The poster briefly states the intent and coverage of the Act and the responsibilities of employers and employees to maintain safe and healthful working conditions.

EMPLOYERS WHO MUST KEEP OSHA RECORDS

Employers with 11 or more employees (at any one time in the previous calendar year) in the following industries must keep OSHA records. The industries are identified by name and by the appropriate Standard Industrial Classification (SIC) code:

- Agriculture, forestry, and fishing (SIC's 01-02 and 07-09)
- Oil and gas extraction (SIC 13 and 1477)
- Construction (SIC's 15-17)
- Manufacturing (SIC's 20-39)
- Transportation and public utilities (SIC's 41-42 and 44-49)
- Wholesale trade (SIC's 50-51)
- Building materials and garden supplies (SIC 52)
- General merchandise and food stores (SIC's 53 and 54)
- Hotels and other lodging places (SIC 70)
- Repair services (SIC's 75 and 76)
- Amusement and recreation services (SIC 79)
- Health services (SIC 80), and
- State and local government (Above SIC's plus 91-97).

If employers in any of the industries listed above have more than one establishment with combined employment of 11 or more employees, records must be kept for each individual establishment.

All employers, including small employers and those in exempted SIC's, must continue to meet the requirement to report fatalities or multiple (3 or more) hospitalizations and all occupational injuries or occupational illnesses that result in a workers' compensation case.

If an employer is notified in writing by the Bureau of Labor Statistics about having been selected to participate in a statistical survey, such employer, including small employers, and those in exempted SIC's, must maintain a log and summary of all occupational injuries and illnesses for that year. The notification will contain the necessary form and instructions to comply with the survey requirements.

The Iowa Workers' Compensation Act

The following is a summary of the recordkeeping and reporting responsibilities of employers under the Iowa Workers' Compensation Act.

RECORDS AND REPORTS

Every employer shall keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day. An employer with notice or knowledge of an injury which temporarily disables an employee for more than three (3) days or results in permanent total disability, permanent partial disability or death is required to file a report with the Workers' Compensation Commissioner, on State of Iowa Form No. 14-0001, within four (4) days from such event when such injury is alleged by the employee to have been sustained in the course of employment.

All books, records and payrolls of an employer are required to be open for inspection by the Workers' Compensation Commissioner for purposes of administration of the Iowa Workers' Compensation Act.

The Workers' Compensation Commissioner may require an employer to appear and show cause why the employer should not be subject to a civil penalty of $100.00 per occurrence for failure to comply with the reporting or inspection requirements. Upon hearing, if the facts indicate, the commissioner may enter an order requiring payment of such penalty. Unless voluntarily paid, the commissioner may petition the district court for entry of judgment on the order. The employer's insurance carrier shall be responsible in the same manner and to the same extent as the employer when a report of injury has been submitted to the employer's insurance carrier and not filed by them with the Workers' Compensation Commissioner.

The employer is required to furnish to an employee, on request, one statement of earnings, wages or salary for the year preceding the injury. An employer may be subject to a civil penalty of $25.00 per offense for refusal to furnish such wage statement.

INSTRUCTIONS

An employer with notice or knowledge of an injury which temporarily disables an employee for more than THREE (3) days or results in permanent total disability, permanent partial disability or death is required to file a copy of this report with the Iowa DIVISION OF WORKERS' COMPENSATION within **FOUR (4)** days from such event when such injury is **alleged** by the employee to have been sustained in the course of the employee's employment. A report to the Iowa DIVISION OF WORKERS' COMPENSATION is considered to also be a report to the Iowa DIVISION OF LABOR SERVICES. The Iowa DIVISION OF WORKERS' COMPENSATION shall forward this report to the Iowa Division of Labor Services. Employers should also report ALL injuries to their insurance carrier. **ALL REPORTS MUST BE FILLED IN COMPLETELY AND SIGNED. PLEASE TYPE OR PRINT LEGIBLY.**

This form contains all items requested on OSHA form No 101, "Supplementary Record of Occupational Injuries and Illness."

THE INFORMATION PROVIDED WILL BE OPEN FOR PUBLIC INSPECTION UNDER Iowa Code § 22.11.

Iowa Form 14-0001 (10-99)

SUPERVISOR'S INCIDENT REPORT

☐ Injury (work related) ☐ Illness (work related) ☐ Property Damage ☐ Incident

Employee Name (First, Middle, Last)	Social Security Number	Sex ☐ Male ☐ Female	Employee Home Telephone Number

Employee's Street Address	City	State	Zip

Age	Birthdate Mo. Day Yr.	Job Title	Department

Employee's Scheduled Work Week When Injured	Start Time AM PM	End Time AM PM	Hrs. Per Day	Hrs. Per Wk.	Days Per Wk.	Normal Full-Time Schedule for Injured's Work	Start Time AM PM	End Time AM PM

Injury Date Mo. Day Yr.	Hour of Day AM PM	Last Day Worked Mo. Day Yr.	Start Date Mo. Day Yr.	☐ No Lost Time ☐ Date Returned to Work Mo. Day Yr. ☐ Estimated Date of Return

Did employee seek medical attention? ☐ Yes ☐No If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will the employee complete a drug screening? ☐ Yes ☐No

Names of Witnesses (Attach witness statements.)

1. _____ 2. _____

Injured Employee's statement of what happened. (Identify circumstances and equipment involved.)

_____

_____

_____

How could this incident have been prevented?

_____

_____

_____

What corrective action has been taken?

_____

_____

_____

What is the injury/illness? (Be specific.)

Part of Body Affected

☐ Eye
☐ Head
☐ Neck
☐ Back
☐ Arm
☐ Shoulder
☐ Fingers
☐ Leg
☐ Knee
☐ Hip
☐ Foot
☐ Wrist
☐ Hand
☐ Toes
☐ Ankle
☐ Elbow
☐ Trunk (Other than back)
☐ Other

Type of Injury

☐ Cut/Abrasion
☐ Bruise/Contusion
☐ Foreign Object
☐ Burn
☐ Break
☐ Sprain/Strain
☐ Exposure
☐ Repetitive Motion
☐ Other

I believe that the answers to the above questions are true to the best of my knowledge.

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____
Notified

WORKERS COMPENSATION
COST CONTAINMENT INITIATIVES

West Bend Mutual Insurance Company participates in several medical cost containment initiative programs. The use of these programs helps reduce your workers' compensation expenses. A brief summary of each program is outlined below.

If you have any questions about any of the programs we offer, please call our Workers' Compensation Claim Department at 1-800-236-5004.

PHARMACY PROGRAM

This program is designed to provide discounts on workers' compensation prescriptions submitted by your injured employees. This service is provided by a national pharmaceutical management company using a network of retail pharmacies.

How the program works:

1. The injured employee files a workers' compensation claim with employer, seeks medical treatment, and receives a prescription from a physician.
2. The injured employee presents the prescription along with the temporary ID form to a participating pharmacy where the claim is electronically submitted by the pharmacy to our vendor.
3. Once West Bend receives notification of the claim from the employer, an employee-specific ID drug card is issued, along with a list of participating pharmacies and instructions on the use of the program.
4. The injured employee presents the ID drug card to a participating pharmacy for any future workers' compensation prescriptions.
5. High-cost/long-term-use medications are conveniently supplied through our vendor's mail service pharmacy.

DIAGNOSTIC TESTING PROGRAM

Using the services of a diagnostic management vendor, we can save money on any diagnostic test (i.e., CT scans, MRIs, EMGs, etc…) the treating doctor orders for injuries an employee sustains in a work-related injury. Our vendor will schedule the test, then notify the injured employee of the date and time. Once the test is performed, the films/x-rays will be forwarded to the referring physician.

To make this program successful, we ask that you encourage your employees to contact their West Bend claim representative as soon as they know a test will be ordered. We will handle it from there.

MEDICAL COST CONTAINMENT

Strong medical management brings about the early and safe return to work of your employees and reduces claim costs. To accomplish this, we contract with a medical bill review service. All of our medical provider charges (hospital, physician, physical therapist, chiropractor, and pharmaceutical) are verified for the appropriateness of the charge, and to determine if they adhere to state mandated fee schedules or local usual and customary (U&C) reimbursement levels. This process often reduces our medical expenses by 10-30%.

Another way we are containing costs is through the use of a PPO Network. The Preferred Providers have agreed to discount their billings for the treatment of your industrially injured employees. This in turn keeps your premium costs down.

Your support in encouraging your injured workers to use a PPO provider is important. It sends an important message to the medical care providers that we support them in their effort to offer quality, cost effective care to patients.

For a list of PPO's in your area, please visit our website, www.thesilverlining.com for a link to the PPO list. Click on "Claims" and then on "How to Report A Claim" for the link to our vendor.

QUALITY MEDICAL CARE (Applicable in Indiana and Iowa only)

As your workers' compensation insurer, we share your goal of providing quality medical care to your injured workers so that they may return to the work force as soon as possible. In Indiana and Iowa, the employer and its insurance carrier have the responsibility for providing reasonable and necessary medical care when there is an injury and the ability to choose which physician or other medical practitioner that will provide the service. **In other words, it is the employer and insurance carrier who select the physician to treat an injury, not the injured employee.** If the employee refuses to accept medical services as instructed by the carrier, the right to receive compensation may be suspended during the period of refusal.

It has been our experience that one of the most effective ways to carry out our mutual responsibilities under the Indiana and Iowa Workers' Compensation Laws for an injured worker is for you, as an employer, to designate a company physician who is authorized to treat work-related injuries. This designation should be part of our internal procedure for reporting on-the-job injuries. Each employee should be instructed, particularly when first hired, on how to report an on-the-job injury and what physician is authorized for treatment. It should be made clear that except in cases of an emergency, no other medical or chiropractic care is authorized and charges incurred for those services will not be honored. Many of our employers put this policy in writing and have the employee sign and date this document.

There are many benefits to this policy. First, injured employees know exactly where to go for medical care when needed. Second, a good working relationship is established between the physician, you as an employer, and us as an insurance company. We find we get prompt answers to our questions and are able to better manage both medical costs and claims for weekly benefits. Referrals, particularly when an independent medical exam is needed, are greatly simplified. Where rehabilitation is needed, company physicians can assist our rehabilitation nurses and our vocational counselors.

We will be happy to work with you in designating a company physician and helping you implement this program. Please feel free to call the Workers' Compensation Claim Department with any questions or comments.

WEST BEND MUTUAL INSURANCE COMPANY
WORKERS' COMPENSATION PRESCRIPTION INFORMATION

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

Employee Name:	
Group #:	10602270
Member ID (SSN):	
Date of Injury:	
Claim Number:	
Processor:	myMatrixx
Bin #:	014211
Day supply is limited to 3 days for a new injury	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:

Injured Worker:

West Bend has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. ***myMatrixx*** has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call ***myMatrixx*** toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATIONS(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist: Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling ***myMatrixx*** for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All other will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

AUTHORIZATION TO RELEASE INFORMATION
REGARDING CLAIMANTS SEEKING WORKERS' COMPENSATION BENEFITS

Name of Patient: _____ Date of Birth: _____

Social Security No: _____

SECTION I. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR REDISCLOSURE

I authorize _____

to disclose and deliver to: West Bend Mutual Insurance Co., 1900 South 18th Avenue, West Bend, WI 53095

the following information related to me: Any and all information EXCEPT substance abuse (drug or alcohol), mental health, and AIDS-related information, unless specifically authorized to be released in section II of this form.

NOTE: If the information includes mental health treatment, substance abuse treatment, or HIV-related information it will not be released unless the undersigned patient agrees to the release on the reverse side of this form.

I understand the information is being disclosed and may be used only for legal and/or litigation purposes relating to claims and/or suit against _____

I understand that this Authorization may be used to obtain information from health care providers, schools, former and current employers, providers of vocational rehabilitation services, the Social Security Administration, and the Iowa Department of Workforce Development. I understand that I have a right to inspect the disclosed information at any time. This authorization is effective until the conclusion of a contested case on the claim. I understand that I may revoke this Authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper. I also understand that if I revoke, the revocation will take effect on the day it is received in writing by the entity from whom disclosure is sought.

I understand that the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

Iowa and Federal law provide that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below. I understand that the Recipient of this Authorization, WITHOUT FURTHER AUTHORIZATION, may redisclose this information to:

Parties and their legal counsel, insurers, experts, potential experts, but only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information; Agents, employees or representatives of the parties, but only after they are involved in conducting the prosecution or defense of the case, and only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information; Administrative agency and court officials hearing the claim, and their support staff.

I SPECIFICALLY AUTHORIZE AND CONSENT TO ANY SAID DISCLOSURE AND REDISCLOSURE DESCRIBED ABOVE.

_____ _____

Claimant or Legal Representative Date

_____

Printed Name and Relationship of Claimant's Legal Representative

SECTION II. SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT OR AIDS-RELATED INFORMATION

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Place "YES" or "NO" in ALL applicable boxes:]

_____ Substance Abuse (Drug or Alcohol) information from all health care providers and facilities and any other person or entity in possession of records concerning me.

_____ Mental Health information from all health care providers and facilities and any other person or entity in possession of records concerning me.

_____ HIV or AIDS-related information, Diagnosis, and test results from all health care providers and facilities and any other person or entity in possession of records concerning me.

Furthermore, I SPECIFICALLY AUTHORIZE disclosure and re-disclosure of this confidential information to all of the persons referred to in the REDISCLOSURE Section I.

In order for the above information to be released you must sign here AND at the end of Section I

Signature of Claimant or Legal Representative _____ Date _____

Street Address _____ City/State/ Zip Code _____

Printed Name and Relationship of Claimant's Legal Representative _____

Federal and/or State law specifically require that any disclosure or REDISCLOSURE of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

See also Chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.

14-0043 (11/04) This form may be used in connection with claims under the jurisdiction of the Iowa Workers' Compensation Commissioner.

JOB ANALYSIS

Name	Claim Number
Employer	Address

Date of Hire	Date of Injury	Job Title	Check One ☐Skilled ☐Unskilled
Training Required to Learn Job			

Was Employee Working as a Supervisor? ☐Yes ☐No	If Yes, Number of People Supervised	Employee Worked: ☐Alone ☐Small Group (3-5) ☐Large Group

Days Worked Per Week (Circle) M Tu W Th F Sat Sun	Hours Worked During Week From To Shift

Work Breaks (Daily Rest Periods and Lunch)		
Morning	Lunch	Afternoon
— Minutes	— Minutes	— Minutes

Overtime Per Week Number of Hours	How Often	Was Employee Hired With Any Restrictions? (Check) ☐Yes ☐No
If Yes, Specify		

Body Movements – Amount Spent Each Day

Sitting % Standing % Walking %

Check Appropriate Column	None	Occasionally (1/3 or Less)	Frequently (1/3 – 2/3)	Continuously (2/3 or more)
Reaching above shoulder length				
Working with body bent over at waist				
Working in kneeling position				
Crawling				
Bending, stooping, squatting				
Repetitive foot movements as in foot controls – L/R or both				
Climbing stairs				
Climbing Ladders				
Working with arms extended at shoulder level				
Working with arms above shoulder height				

Height from floor of object to be reached and/or worked on (use space for drawing, if needed):

Object Height

Weights Handled	Item	Alone or Assisted	Push, Pull Or Lift	Times Per Hour	Times Per Day	Times Per Week	Times Per Month
1 – 10 lbs.							
15 – 20 lbs.							
25 – 35 lbs.							
45 – 60 lbs.							
65 – 80 lbs.							
85 – 100 lbs.							

☐No lifting required for this job.

Hand Coordination Activities (Check Appropriate Column)				
Movement Required	Tool/Machine	Right	Left	Both
Major hand				
Fine Manipulation				
Gross Manipulation				
Simple Grasping				
Power Grip				
Hand Twisting				
Pushing				
Pulling				

Tools Used By Worker	Weight	No. of Hands Needed To Move

Objects Worker Must Move During Day	Weight	Distance	No. of Workers Needed To Move

Physical Surroundings Does Employee Work ☐Inside ___% ☐Outside ___%	Does Employee Walk On Uneven Ground? ☐Yes ☐ No

Does Employee Work Around Moving Machinery? ☐Yes ☐No
Does Employee Drive Automotive Equipment? ☐Yes ☐No
If yes, describe:

Does the Employee Come In Contact With The Following? (Indicate Type)	Yes	No	Type
Fumes			
Dust			
Mist			
Steam			
Strong Odors			
Poor Ventilation			
Air Conditioning			

Characteristics Of Job That Cannot Be Modified By Employer For This Employee

Comments And/Or Observations

☐Job Site Evaluation Done	☐Narrative Discussion Only
Name(s) of Person(s) Interviewed	Title

Person Completing Analysis	Title	Date

West Bend Mutual Insurance Company
West Bend, Wisconsin 53095

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Claim No.

Patient's Name (First) (Middle Initial) (Last) | Date of Injury/Illness

TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK

Diagnosis/Condition (Brief Explanation)

I saw and treated this patient on _____ (date) and based on the above description of the patient's current medical problem:

1. ☐Recommend his/her return to work with no limitations on _____ (date)

2. ☐He/She may return to work on _____ (date) **capable of performing the degree of work checked below with the following limitations:**

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8 hour work day patient may:
   a. Stand/Walk
      ☐None ☐1-4 hours ☐4-6 hours ☐6-8 hours
   b. Sit
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
   c. Drive
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
2. Patient may use hand(s) for repetitive:
   ☐Single Grasping
   ☐Pushing & Pulling
   ☐Fine Manipulation
3. Patient may use foot/feet for repetitive movement as in operating foot controls:
   ☐Yes ☐No
4. Patient is able to:

	Frequently	Occasionally	Not At All
a. Bend	☐	☐	☐
b. Squat	☐	☐	☐
c. Climb	☐	☐	☐
d. Twist	☐	☐	☐
e. Reach	☐	☐	☐

Other Instructions and/or Limitations Including Prescribed Medications:

These restrictions are in effect until _____ (date) or until patient is re-evaluated on _____ (date)

3. ☐He/She is totally incapacitated at this time. Patient will be re-evaluated on _____ (date)

Physician's Signature | Date

West Bend Mutual Insurance Company
1900 South 18th Avenue
West Bend, Wisconsin 53095

RETURN TO WORK LOG

EMPLOYEE NAME _____ SUPERVISOR _____

Date	Hours Worked In	Hours Worked Out	Tasks Performed	Comments Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
Sunday / /						
Monday / /						
Tuesday / /						
Wednesday / /						
Thursday / /						
Friday / /						
Saturday / /						

I clearly understand, take responsibility for, and acknowledge the limitations my physician, Dr. _____ has placed on me while participating in this temporary transitional work program.

_____ _____
Employee Signature Date

RETURN TO WORK LOG INFORMATION

The Return To Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty. It helps eliminate potential conflicts should the question arise regarding the employee performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employee's restrictions to the log.
- Have employee write name on top of log and the Supervisor write their name.
- Remind employee it is their responsibility to follow the restrictions.
- Remind employee that the restrictions apply to occupational AND non-occupational activities.
- Employee and supervisor review all tasks completed each day, indicate any concerns and everyone signs the form.