MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

MS Institutions of Higher Learning
The University of Mississippi
Director of Human Resources
P. O. Box 1848
University, MS 38677

CARRIER/ADMINISTRATOR CLAIM NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION # | PHONE #

SIC CODE | EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

AmFed
P.O. Box 1380
Ridgeland, MS 39158

POLICY PERIOD

TO

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

AmFed
P.O. Box 1380
Ridgeland, MS 39158

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
☐ MALE (M)
☐ FEMALE (F)
☐ UNKNOWN (U)

MARITAL STATUS
☐ UNMARRIED/SINGLE/DIVORCED (U)
☐ MARRIED (M)
☐ SEPARATED (S)
☐ UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
NO MEDICAL TREATMENT (0) ☐
MINOR: BY EMPLOYER (1) ☐
MINOR CLINIC/HOSP (2) ☐
EMERGENCY CARE (3) ☐
HOSPITALIZED > 24 HRS (4) ☐
FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) ☐

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

SEE BACK FOR INSTRUCTIONS

Applicable in Alaska

A person who wilfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception.

Applicable in Arizona

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.

Applicable in Arkansas

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

Applicable in California

Any person who knowingly files a statement of claim containing any materially false or misleading information is subject to criminal and civil penalties.

Applicable in Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in Connecticut

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Applicable in Delaware and Oklahoma

Any person who knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. *Delaware Statutes Regulations: Del #C Section 913(B)

Applicable in Florida

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Applicable in Hawaii

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Applicable in Idaho

Any person who Knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a state ment of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kentucky, Maine, Michigan, New Jersey, New Mexico, New York, Pennsylvania and Virginia

Any person who knowingly and with intent to defraud any insurance company or another person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects the person to criminal and [NY: substantial] civil penalties. In Maine and Virginia, insurance benefits may also be denied.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insur ance fraud, as provided in RSA 638:20.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Tennessee

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

Applicable in Utah

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

EMPLOYEE SIGNATURE: _____

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

SIC CODE:

This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise deigned by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following the most recent disability period on which the employee returned to work.

Use the block below to enter any comments.

If you wish to receive an acknowledgement that this FROI was received, enter your e-mail address in the box below.

Employee:	Employer: The University of Mississippi
Claim #:	Date of Injury:

JOB DESCRIPTION: ☐ FULL DUTY JOB ☐ MODIFIED DUTY JOB AVAILABLE: ☐ FULL TIME ☐ PART TIME

BRIEF DESCRIPTION OF DUTIES:

Requirements:	Never	Occasionally .25-3 hours	Frequently 3-5 hours	Constantly 5-8 hours
Sit				
Stand				
Drive				
Walk				
Lift/Carry 1-10 lbs				
Lift/Carry 11-20 lbs				
Lift/Carry 21-50 lbs				
Lift/Carry 51-100 lbs				
Lift/Carry over 100 lbs				
Push/Pull				
Climbing				
Balancing				
Stooping				
Kneeling				
Crouching				
Crawling				
Reaching/All Planes				
Overhead Work				
Lift/Reach				
Fine Manipulation				
Grasping				
Repetitive Use of Foot				
Repetitive Use of Hand				

AMFED COMPANIES

P.O. Box 1380
Ridgeland, MS 39158
1-800-264-8085

Instructions:

Employer: Please complete both a full and modified duty job description.

Physician: Please indicate if this employee may return to work as outlined on this form by signing at the bottom.

Please fax the completed form to:
601-853-2727

Walk on Uneven Ground: ___Yes ___No
Dominant Hand Use: ____Right ___Left

Other Job Requirements:

This job would be classified as:

☐ **Sedentary Work:** Up to 10 lbs; a certain amount of walking and standing often occasionally necessary to perform job duties; other criteria are met, specifically the above outlined restrictions.
☐ **Light Work:** Up to 20 lbs with frequent lifting and or carrying of objects weighing up to 10 lbs.
☐ **Medium Work:** Up to 50 lbs with frequent lifting and/or carrying of objects weighing up to 25 lbs.
☐ **Heavy Work**: Up to 100 lbs with frequent lifting and/or carrying of objects weighing up to 50 lbs.
☐ **Very Heavy Work:** Max in excess of 100 lbs with frequent lift/carry objects weighing over 50 lbs.

Employer Contact:	Phone:	Title/Position:
Employer Signature:		Date:

☐ May return to work at the job described above on ___/___/___
☐ May not return to work. Anticipated release to work ___/___/___
Additional Comments:

Physician Signature:	Date:

STATEMENT OF CLAIMANT

Name Street Address City State Zip Code	Home Telephone Number: Area Code Number ( )

Date of Birth	Social Security Number	Height	Weight	Right or Left Handed?

Name and Address of Employer

The University of Mississippi, P.O. Box 1848, University, MS 38677

Wages Per Hour ( ) Per Month ( ) $ Per Week ( ) Per Day ( )	Hours Worked Per Day: Days Worked Per Week:	Regular Occupation	How Long Have You Worked For This Employer?

Date of Accident	Hour AM or PM	Place of Accident

Describe Exactly How The Accident Occurred (use back of sheet if necessary)

What Part of Your Body Was Injured? Describe Your Injury In As Much Detail As Possible.

Name of Your Immediate Supervisor	To Whom Did You First Report Your Injury? When?

Names, Addresses and Phone Numbers Of Any Witnesses

Name and Address of Your Doctor (#1) Who Selected or Chose This Doctor?	Name and Address of Your Doctor (#2) (Use back of sheet to list other doctors if necessary) Who Selected or Chose This Doctor?

Date of First Doctor Visit?	When Did You Last See The Doctor?	Are You Still Seeing The Doctor?	If Yes, When Is Your Next Visit?

What Date Did You Start Losing Time From Work?	Have You Returned To Work?	If Yes, Please Give Date	If No, When Do You Expect To Return to Work?

Have You Ever Hurt or Had Problems With This Part of Your Body Before? If Yes, Please Advise When, Where, and Other Details.

Have You Ever Filed A Workers= Compensation Claim Before? If Yes, Please Advise When, Where, and Other Details.

Are you currently a Medicare or Social Security Disability recipient?

Signed (Signature of Claimant)	Date

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COMPANIES

P.O. Box 1380
Ridgeland, MS 39158-1380
(601) 853-4949
(800) 264-8085
Fax: (601) 853-2727

Authorization for Release of Health Information

Name:	**Social Security #:**
Address:	
Employer Name: The University of Mississippi	**AmFed Claim #:**

Personal Health Information to Be Disclosed:
My complete medical file, including but not limited to: doctors' and nurses' notes, x-ray reports and films, lab reports, history and physicals, admission and discharge summaries, physical therapy notes/reports, consultation and operative reports, admission sheets, blood alcohol test results, drug screening test results, histories and profiles, psychiatric records, prescription records, computer data or compilations or reports, itemized bills, psychotherapy notes, physician assistants' notes, diagnostic test results, ambulance reports, patient questionnaires, and all other forms of documents pertaining to each and every admission, emergency room, treatment, and clinic visit of the undersigned.

Purpose of the Disclosure: To investigate and determine workers' compensation benefits, and to perform treatment, payment and health care operations.

Right to Revoke: I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. To revoke authorization, I will contact AmFed Companies, LLC at the address above.

Signature: I _____, have had full opportunity to read and consider the contents of the authorization, and I confirm that the contents are consistent with my direction. I understand this authorization is voluntary. I understand that I am entitled to receive a copy of this authorization after I sign it. I understand that the information disclosed may be subject to redisclosure by the recipient and no longer protected. I hereby give my permission to disclose my personal health information in the manner described herein to my employer, **AmFed Companies, LLC**, their agents, employees, or attorneys. I hereby agree that a copy of this authorization form shall have the same force and effect as the original thereof and further agree that this authorization shall remain valid so long as my claim against my above named employer is pending.

Signature: _____ Date: _____

Witness: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:
Personal Representative's Name: _____
Relationship to Individual: _____