INSUREDSOLUTIONS INC
Innovative Risk Management & Workers' Compensation Programs

Atlanta Corporate Office: 2 Ravinia Dr. Suite 270 Atlanta GA 30346
Toll Free: (877) 213-1999 Local: 678-262-3200
Fax: 678-262-3201 General Email: info@insuredsolutions.net

HOW TO REPORT A CLAIM

Print each of the following 6 pages prior to watching the Claim Reporting Video. This 11 minute video will take you through our claim reporting process as it tracks each form in order printed. Click link below- if you have trouble opening the link please cut & paste into your internet browser:

http://vimeo.com/highrevmedia/review/35618885/a2c4b4cf9d

(Note: Forms revised as of 4/2014 content will follow video.)

FOR EMERGENCIES

1. GET EMPLOYEE TO THE NEAREST EMERGENCY FACILITY. INFORM LOCATION TO ORDER POST-ACCIDENT DRUG SCREENING.
2. Immediately submit claim paperwork to: claims@insuredsolutions.net or fax 678-262-3201. Or notify us of the incidnet on our website: www.insuredsolutions.net.
3. Go to step #2 below.

FOR NON-EMERGENCIES

1. SEND OR TAKE EMPLOYEE TO APPROVED DOCTOR OR FACILITY. INFORM LOCATION TO ORDER POST-ACCIDENT DRUG SCREENING.
2. Report claim immediately by completing: State First Report of Injury, Investigation Forms (steps #3,4,5 below), & Carrier Supplemental Form.
3. Have Supervisor complete & sign: Supervisor Incident Investigation Report.
4. If Witness is available, have Witness Statement completed & signed.
   Note: Also, include statements which affirms the witness did *not* see or hear of the accident.
5. Have Injured Worker complete & sign: Injured Employee-Accident Investigation Report using the accompanying CHECKLIST guide parts A & B where shown.
6. EMAIL OR FAX THE ABOVE FORMS: CLAIMS@INSUREDSOLUTIONS.NET or FAX: 678-262-3201
7. Insured Solutions will review the completed State First Report of Injury and Investigation forms and will contact you if additional information is needed.

NOTE: Our Insured Solutions Nurse Case Manager will complete a Triage Summary for the carrier by contacting: 1) You the client 2) Medical Provider 3) injured employee

Remember:

1. If Employee refuses care, they must complete the REFUSAL OF DOCTORS CARE FORM. *Please send employee for post-accident drug screening.
2. If Employee refuses Drug Screen, notify our office and take action based on your written Drug Free Workplace Program guidelines. (Immediate Suspension without PAY is preferred.)

MISSING FORMS? Email request to: claims@insuredsolutions.net

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SUPERVISOR'S INCIDENT INVESTIGATION REPORT

These guidelines help organize the investigation of accidents and incidents involving employees, tools, equipment or material. All accidents and incidents should be investigated, no matter how minor. The same conditions that cause a minor incident could lead to a major accident.

The unsafe acts of workers and the unsafe conditions that cause accidents can be identified and corrected. It is your responsibility to find them, name them, and correct them. This form should be completed immediately.

EMPLOYEE DATA

NAME OF EMPLOYEE SOCIAL SECURITY#

DATE OF BIRTH JOB TITLE DEPARTMENT

SHIFT HOURS WORKING OVERTIME **YES** **NO**

INCIDENT DATA

DATE OF OCCURRENCE TIME OF OCCURRENCE

EXACT LOCATION DATE REPORTED

REPORTED TO WHOM TITLE

DID EMPLOYEE RETURN TO WORK **YES** **NO**

BRIEF DESCRIPTION OF INJURY/ILLNESS (BURN, FRACTURE, STRAIN, CUT, ETC.)

BODY PARTS AFFECTED

TREATMENT PROVIDE BY: DOCTOR EMERGENCY ROOM PLANT NURSE SUPERVISOR

DID EMPLOYEE RECEIVE FULL PAY FOR THE DAY OF INJURY? **YES** **NO**

LIST ANY WITNESSES

HAS THE EMPLOYEE EXPERIENCED LOST TIME OR REDUCED WAGES AS A RESULT TO THE INJURY? **YES** **NO**

DATE LOST TIME OR REDUCED WAGES BEGAN FOR THIS INJURY? RETURNED TO WORK DATE:

WHAT CAPACITY DID EMPLOYEE RETURN TO WORK?LIGHT DUTY-FULL PAY LIGHT DUTY REDUCED WAGES

INCIDENT DETAILS

JOB OR ACTIVITY AT THE TIME OF ACCIDENT

WHAT ACT/FAILURE TO ACT OR CONDITION(S) CONTRIBUTED MOST DIRECTLY TO THIS HAPPENING? PLEASE DESCRIBE ANY UNSAFE ACTS OR UNSAFE CONDITIONS

CORRECTIVE ACTIONS

RECOMMENDATIONS FOR CORRECTIVE ACTION TO PREVENT SIMILAR OCCURRENCE

STATUS OF RECOMMENDATIONS

EXPECTED DATE OF COMPLIANCE

(Supervisor) (Date) (Manager) (Date)

Date form completed and by whom

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WITNESS STATEMENT INJURY/ACCIDENT INVESTIGATION

EMPLOYEE DATA

NAME OF EMPLOYEE DATE OF INJURY

NAME OF WITNESS DEPARTMENT

DID YOU SEE THE ACCIDENT HAPPEN? [❑]YES [❑]NO

WERE YOU IN THE AREA WHERE THE ACCIDENT HAPPENED? [❑]YES [❑]NO

INCIDENT DATA

WHERE EXACTLY DID THE ACCIDENT HAPPEN?

EXPLAIN WHAT HAPPENED

WAS IT OBVIOUS THAT THE EMPLOYEE WAS HURT? [❑]YES [❑]NO

WHAT BODY PART WAS INJURED (BE SPECIFIC)?

INCIDENT DETAILS

WAS THE EMPLOYEE USING A TOOL OR MACHINERY WHEN INJURED? [❑]YES [❑]NO

DESCRIBE THE EQUIPMENT

HAVE YOU EVER HEARD THE EMPLOYEE COMPLAIN OF SIMILAR INJURY OR ILLNESS? [❑]YES [❑]NO

HAVE YOU EVER HEARD THE EMPLOYEE TALK ABOUT THE JOB INJURY BEFORE? [❑]YES [❑]NO

ARE YOU AWARE OF ANY OTHER ACCIDENTS, PERSONAL OR ON-THE-JOB, THAT THIS EMPLOYEE HAS HAD?

[❑] Y E S

IF SO, DESCRIBE

DID THE EMPLOYEE VIOLATE A KNOWN SAFETY RULE? [❑]YES [❑]NO

DO YOU KNOW FOR A FACT THE EMPLOYEE WAS AWARE OF THE SAFETY RULE? [❑]YES [❑]NO

DO YOU KNOW IF THE EMPLOYEE WAS EVER CAUTIONED BY A SUPERVISOR OR ANYONE ELSE ABOUT UNSAFE WORK HABITS? [❑]YES [❑]NO

WHAT DO YOU THINK CAUSED THE INCIDENT/ACCIDENT?

[❑]UNGUARDED EQUIPMENT [❑]NON-EMPLOYEE

[❑]EMPLOYEE CARELESSNESS [❑]HORSEPLAY

[❑]DELIBERATE VIOLATION OF SAFETY RULE [❑]POORLY MAINTAINED EQUIPMENT

[❑]ANOTHER EMPLOYEE [❑]PRESSURE TO WORK FASTER

WHAT CAN BE DONE TO PREVENT A SIMILAR ACCIDENT IN THE FUTURE?

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS ARE ANSWERED TRUTHFULLY.

SWORN TO ME THIS DAY OF 20 .

(Witness) (Date) (Manager/Supervisor) (Date)

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INJURED EMPLOYEE – ACCIDENT INVESTIGATION REPORT

THIS FORM IS FOR REPORTING TO MANAGEMENT AND MAY BE SUBMITTED TO THE INSURANCE COMPANY IF PETITIONED TO DO SO. (To assist with the following questions please refer to the CHECKLIST on the next page sections labeled A & B)

WHO WAS INJURED?

NAME OF EMPLOYEE OCCUPATION

DEPARTMENT

TIME AND PLACE:

DATE OF OCCURRENCE TIME OF OCCURRENCE

EXACT LOCATION

INCIDENT DETAILS:

DESCRIBE INJURY

A. DETAIL ACTIONS PRIOR AND UP TO INJURY. WHAT HAPPENED? USE REVERSE SIDE TO EXTEND COMMENTS

B. WHAT UNSAFE CONDITION(S) OR ACT(S) CAUSED THIS ACCIDENT?

HOW COULD SIMILAR ACCIDENTS BE AVOIDED?

WHAT ACTION HAVE YOU TAKEN TO PREVENT SIMILAR ACCIDENTS?

(Employee) (Date) (Manager) (Date)

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CHECKLIST

This list of sample questions needs to be addressed during the investigation and will help you document many aspects of the accident scene. NOTE TO EMPLOYEE: Take the time to ANSWER each and every question.

A. ACCIDENT INVESTIGATION

WHO...
- Was involved in the accident?
- Was injured?
- Witnessed the accident?
- Reported the accident?
- Notified emergency medical services personnel?

WHEN...
- Did the accident happen?
- Was it discovered?
- Was the accident reported?
- Did the employee begin the task?
- Were hazards pointed out to employee?
- Did supervisor check employee progress?

WHERE...
- Did the accident happen?
- Was the employee's supervisor when accident occurred?
- Were witnesses when accident occurred?
- Does this condition exist elsewhere on site?
- Is the evidence of investigation to be kept?

WHY...
- Did the accident happen?
- Were employees injured?
- Did the employee behave that way?
- Wasn't protective equipment used?
- Weren't specific instructions given?
- Was the employee in that specific place or position?
- Was the employee using that machine/tool?
- Didn't employee check with supervisor?
- Wasn't the supervisor there at the time?

WHAT....
- Company property was damaged?
- Evidence was found?
- Was done to secure the accident scene?
- Was done to prevent the recurrence of the accident?
- Level of medical care did the victims require?
- Was being done at the time of the accident?
- Tools were being used?
- Was the employee told to do?
- Machine was involved?
- Operation was being performed?
- Instructions had been given?
- Protective equipment should have been used?
- Did others do to contribute to the accident?
- Did any witnesses see?
- Safety rules were violated?
- Safety rules were lacking?
- New safety rules or procedures are needed?

HOW...
- Did the accident happen?
- Was the accident discovered?
- Were employees injured?
- Was equipment damaged?
- Could the accident have been avoided?
- Could the supervisor have prevented the accident from happening?
- Could co-workers avoid similar accidents?

B. ACCIDENT INVESTIGATION FORM EMPLOYEE GUIDE

SELECT FROM THE LISTINGS BELOW THE ITEM(S) YOU FEEL CAUSED YOUR ACCIDENT.

THE UNSAFE CONDITION
- Unguarded or inadequately guarded machinery, floor openings, etc.
- Defective tools, ladders, etc.
- Hazardous arrangement, procedure, etc. (unsafe storage, congestion, etc.)
- Improper illumination (insufficient light, glare, etc.)
- Improper ventilation (insufficient air change, impure air source, etc.)
- Unsafe dress or apparel (absence of or defective gloves, aprons, shoes, respirators, etc.)

THE UNSAFE ACT
- Operating without authority, failure to secure, failure to place warning signs, signals, tags, etc.
- Operating or working at unsafe speed (too slow/fast, jumping from vehicles/platforms, throwing materials)
- Making safety devices inoperative (removing, mis-adjusting, disconnecting, etc.)
- Using unsafe equipment, hands instead of equipment, etc.
- Unsafe loading or placing (overloading, crowding, arranging or placing objects/materials unsafely)
- Taking unsafe position or posture (under suspended loads, lifting with bent back, exposed to falling or sliding objects, riding in unsafe position, riding on apparatus designed only for materials)
- Working on moving or dangerous equipment (cleaning, adjusting, oiling etc.)
- Distracting, teasing abusing, startling, etc. (quarreling, horseplay, practical jokes, etc.)
- Failure to use safe attire or personal protective equipment (goggles, safety shoes, masks, etc.)
- Improper use of safety equipment or failure to use provided safety equipment

UNSAFE PERSONAL FACTORS
- Improper attitude (disregard of instructions, rules and customs, showoff, defiant, etc.)
- Lack of knowledge or skill (unaware of safe practice, unskilled, inexperienced, etc.)
- Physical defects (fatigue, drugs/alcohol, unable to understand, excitable, nervous, visual/hearing)

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WORKERS' COMPENSATION CARRIER SUPPLEMENTAL QUESTIONS

DO YOU HAVE A WRITTEN JOB DESCRIPTION?

DUTIES:

HOURLY RATE/HRS WORKED/PAID HOURLY OR SALARY/ RECEIVE TIPS OR COMMISSION?

CONCURRENT EMPLOYMENT?

PRIOR EMPLOYMENT?

DOMNINANT HAND? **RIGHT** **LEFT**

IS THERE SURVEILLANCE VIDEO? **YES** **NO**

TREATING DOCTOR INFORMATION:

AMBULANCE? **YES** **NO**

DOES EMPLOYER HAVE ANY REASON TO QUESTION OR DOUBT THE VALITY OF THE CLAIM? YES/NO

EXPLAIN:

INTERNAL INVESTIGATION COMPLETED? **YES** **NO** DRUG TESTED? **YES** **NO**

CAN YOU ACCOMODATE MODIFIED/LIGHT WORK? **YES** **NO**

WAS THE INJURED WORKER PAID FOR THE FULL DAY ON THE DATE OF INJURY? **YES** **NO**

ANY PERSONAL ISSUES? **YES** **NO** GOOD EMPLOYEE? **YES** **NO**

PRIOR INJURES/CLAIMS/HEALTH CONDITIONS?

ANY SUBROGATION POTIENTIAL? FAULTY MACHINARY/ OTHER PERSONS INVOLVED?

OVERWEIGHT? **YES** **NO** SMOKER? **YES** **NO**

ACTIVITIES/HOBBIES OUTSIDE OF WORK THAT COULD RESULT IN INJURY OR ACCIDENT?

PLEASE PROVIDE NAME & PHONE NUMBER OF SUPERVISOR:

Additional notes or Comments:

___

___

___

___

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REFUSAL OF DOCTORS CARE

I, ______________________________, HEREBY STATE ON ______________

(YOUR NAME) (DATE)

I , ____

(DESCRIPTION OF INJURY)

I UNDERSTAND THAT I AM REQUIRED TO UNDERGO A POST ACCIDENT DRUG/ALCOHOL TEST AT THE TIME OF THE ABOVE INCIDENT/INJURY.

____

____

I MISSED LESS THAN 4 HOURS FROM WORK. <(6 N2

I RETURNED TO REGULAR WORK ON ____________________ / ____________________ /

(DAY) (MONTH) (YEAR)

EMPLOYEE SIGNATURE PRINT NAME DATE

____________________________________ ____________________________________

SUPERVISOR SIGNATURE PRINT NAME DATE