Sedgwick Claims Kit
Colorado

Dear Insured:

We would like to welcome you as a policyholder of Falls Lake Insurance Companies. Sedgwick is your Claims Administrator, and we are pleased to be able to provide you w ith workers' compensation claims handling services. Please follow the below instructions for filing a new claim. .

Where do I report a claim?

>Phone: 855-728-5277 (855-7ATLAS)
>Email: 6200AtlasGeneralInsurance@sedgwick.com
>Fax: 866-383-3296

Where do I send my employee for medical treatment?

>Sedgwick will send a customized medical panel within the next 30 days. For interim needs access the website below.
>Website: www.sedgwickproviders.com

Claim Kit Attachments:

>Sedgwick Provider Panel Guide
>Employer Insurance Coverage Notice (WC49 & WC49S)
>Workers' Compensation Posting Notice (WC50)
>Employer's First Report of Injury (WC1)
>Express Scripts first fill temporary pharmacy card and participating pharmacies

For additional information please visit the Colorado Department of Labor and Employment at https://www.colorado.gov/pacific/cdle/dwc.

Need a loss run?

> Email us: Lossruns@atlas.us.com

Have more questions?

Contact the Atlas Customer Care Team at Sedgwick - One of our friendly Client Services Associates will be happy to assist you.

> Phone: 866-738-9201
> Email: AtlasTeam@Sedgwick.com

We appreciate your business and believe that communication is critical for successful claims administration. We encourage you to contact us if you have any questions.

www.Atlas.us.com/claims

Provider Panel Guide

Atlas General Insurance Agency has shared your Workers' Compensation policy information with Sedgwick Claims Management. Within 30 days, Sedgwick will deliver a panel of medical providers to be utilized in the event of an employee work injury that utilizes state mandated forms and specified provider types for ***Colorado.***

The purpose of utilizing a provider panel is to ensure your employee is being treated by a top medical provider that is in-network and accepting Workers' Compensation injuries. You will receive a separate panel for each physical location that you have covered under your policy. If you do not receive a panel for a specific location that is covered, please email AtlasTeam@Sedgwickcms.com with the policy number, name, and address of the missing panel location. Once received a panel will be created and delivered to the email address on file for your policy within 30 days. Upon renewal of your policy, a re-validated panel will be delivered within 30 days.

If during your policy effective dates, a panel provider's information is no longer accurate, please email and attach the outdated panel to AtlasTeam@Sedgwickcms.com and request an updated panel. Failure to have a valid provider panel can result in the loss of medical care direction and lead to higher claim costs.

We encourage you to reach out to the providers on the panel to foster a relationship with the clinical staff, provide light duty availability, and help the staff understand the type of business you are engaged in.

Instructions are provided to ensure the specific rules on panel posting are followed along with instructions on the notice necessary at the time of injury. Also provided is the state's website for additional information.

✓ ***Colorado***

- Each physical location must post the panel for employees to see, typically in a breakroom or near a time clock
- The panel should be provided to the employee upon notice of an injury or within 7 days of traumatic emergency injury to choose a physician from the panel
- If the panel is not provided, the employee may select the health care provider of their choice

- The states' website for additional information: https://cdle.colorado.gov/employers/designating-a-medical-provider

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Colorado Workers' Compensation Information

Your employer has workers' compensation coverage for employees through:

Workers' compensation is a type of insurance coverage that employers must provide to their employees. The cost of workers' compensation insurance is paid entirely by the employer and may not be deducted from an employee's wages.

If you are injured or sustain an occupational disease while at work, you may be entitled to compensation benefits as provided by law. WRITTEN NOTICE MUST BE GIVEN TO YOUR EMPLOYER WITHIN 4 WORKING DAYS OF THE ACCIDENT. If you don't report your injury or occupational disease promptly your benefits may be reduced.

If you are unable to work as the result of a work-related injury or occupational disease, compensation (wage replacement) benefits will be based on 2/3 of your average weekly wage up to a maximum set by law. No compensation is payable for the first 3 days' disability unless the period of disability exceeds two weeks.

You are entitled to reasonable and necessary medical treatment of compensable injuries or occupational diseases. If you notify your employer of an injury or occupational disease and are not offered medical care, you may select the services of a licensed physician or chiropractor.

You may file a Worker's Claim for Compensation with the Division of Workers' Compensation. To obtain forms or information regarding the workers' compensation system, you may call Customer Service at 303-318-8700 or toll-free at 1-888-390-7936 or visit our website at www.colorado.gov/cdle/dwc.

COLORADO DIVISION OF WORKERS' COMPENSATION
633 17th Street, Suite 400, Denver, CO 80202-3626

Any information provided below comes from your employer and is specific to this place of employment:

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Información De Indemnización Por Accidentes Laborales De Colorado

Su empleador tiene cobertura de indemnización por accidentes laborales para empleados completamente:

La indemnización por accidentes laborales es un tipo de cobertura de seguro que los empleadores deben proveer a sus empleados. El coste del seguro de indemnización por accidentes laborales es pagado completamente por el empleador y no puede ser deducido de los sueldos de un empleado.

Si usted sufrió un accidente o mantiene una enfermedad profesional en su trabajo, usted puede calificar para los beneficios de compensación. Usted tiene la obligación de NOTIFICAR POR ESCRITO A SU EMPLEADOR DENTRO DE 4 DÍAS DEL ACCIDENTE. Si usted no informa sobre su accidente o enfermedad profesional inmediatamente sus beneficios podrían ser reducidos.

Si usted no puede trabajar por el resultado de su accidente de trabajo o la enfermedad profesional, los beneficios de compensación serán pagados sobre la base de 2/3 de su sueldo semanal hasta un máximo fijado por ley. Los primeros 3 dias no son cubiertos por la aseguranza.

Usted está autorizado para el tratamiento médico que sea razonable y necesario si usted sufrió lesiones en el trabajo o enfermedades profesionales. Si usted notifica a su empleador sobre una lesión o la enfermedad profesional y no le ofrecen atención médica adecuada, usted puede seleccionar los servicios de otro médico que tenga licencia o que sea quiropráctico.

Usted puede reportar su propio reclamo si su empleador no lo ha hecho. Para obtener formularios o información acerca de accidentes laborales usted puede puede llamar al servicio de asistencia al numero 303-318-8700 o sin costo a 1-888-390-7936 o visitar nuestro sitio web en www.colorado.gov/cdle/dwc.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
633 17th St. Suite 400, Denver, CO 80202-3660

Cualquier información proveída abajo viene directamente de su empleador y es exclusivo de este lugar del empleo:

WARNING

IF YOU ARE INJURED ON THE JOB, WRITTEN NOTICE OF YOUR INJURY MUST BE GIVEN TO YOUR EMPLOYER WITHIN FOUR WORKING DAYS AFTER THE ACCIDENT, PURSUANT TO SECTION 8-43-102(1) AND (1.5), COLORADO REVISED STATUTES.

IF THE INJURY RESULTS FROM YOUR USE OF ALCOHOL OR CONTROLLED SUBSTANCES, YOUR WORKERS' COMPENSATION DISABILITY BENEFITS MAY BE REDUCED BY ONE-HALF IN ACCORDANCE WITH SECTION 8-42-112.5, COLORADO REVISED STATUTES.

AVISO

SI SE LASTIMA EN EL TRABAJO, DEBE DARLE UN AVISO POR ESCRITO A SU EMPLEADOR DENTRO DE CUATRO DÍAS LABORABLES DEL ACCIDENTE, SEGÚN A LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-43-102(1) Y (1.5).

SI EL ACCIDENTE RESULTA DEBIDO AL USO DE ALCOHOL O UNA SUSTANCIA CONTROLADA, SUS BENEFICIOS DE LA INCAPACIDAD DE LA COMPENSACIÓN DE LOS TRABAJADORES PUEDEN SER REDUCIDOS POR UN MEDIO EN ACUERDO DE LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-42-112.5.

Instructions for Completing the

First Report of Injury

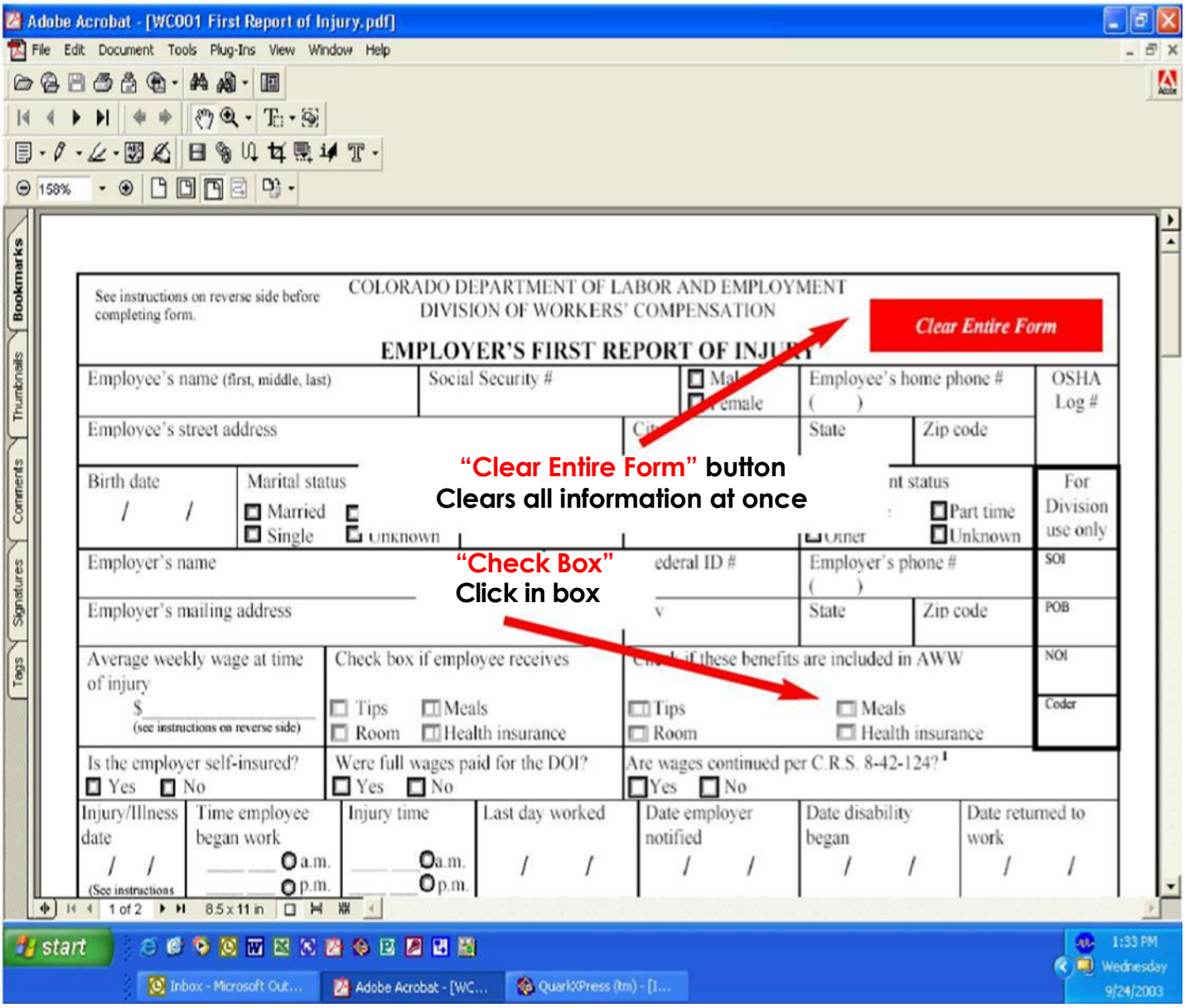
Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will *not* be able to save the form onto your computer's hard drive.

When you open the form, click in the "Employee's Name" box (field), complete the information, and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you *cannot* continue to type information into a field if it doesn't fit into the space provided.

Use numbers *only* to fill in the fields for Social Security #, phone numbers and dollar amounts. If a dollar amount contains cents, *do* type the period. To fill in a check box, click inside the box with your mouse. Some check boxes require you to select only one answer; you cannot check both. The "Injury Description", "Name of Witness", and "Name of Doctor" fields have a gray border to indicate how many lines you have to type in. Use the tab key to navigate to the next field.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To change the information in one field, use the backspace or delete key.


Adobe Acrobat - [WC001 First Report of Injury.pdf]
File Edit Document Tools Plug-Ins View Window Help
See instructions on reverse side before completing form.
COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
Clear Entire Form
EMPLOYER'S FIRST REPORT OF INJURY
"Clear Entire Form" button
Clears all information at once
"Check Box"
Click in box
Employee's name (first, middle, last)
Social Security #
Employee's home phone #
OSHA Log #
Employee's street address
State
Zip code
Birth date
Marital status
Married
Single
Part time
Unknown
For Division use only
Employer's name
Employer's phone #
Employer's mailing address
State
Zip code
SOI
POB
NOI
Coder
Average weekly wage at time of injury
(see instructions on reverse side)
Check box if employee receives
Tips
Meals
Room
Health insurance
Is the employer self-insured?
Yes
No
Were full wages paid for the DOI?
Are wages continued per C.R.S. 8-42-124?
Injury/Illness date
Time employee began work
Injury time
Last day worked
Date employer notified
Date disability began
Date returned to work
a.m.
p.m.
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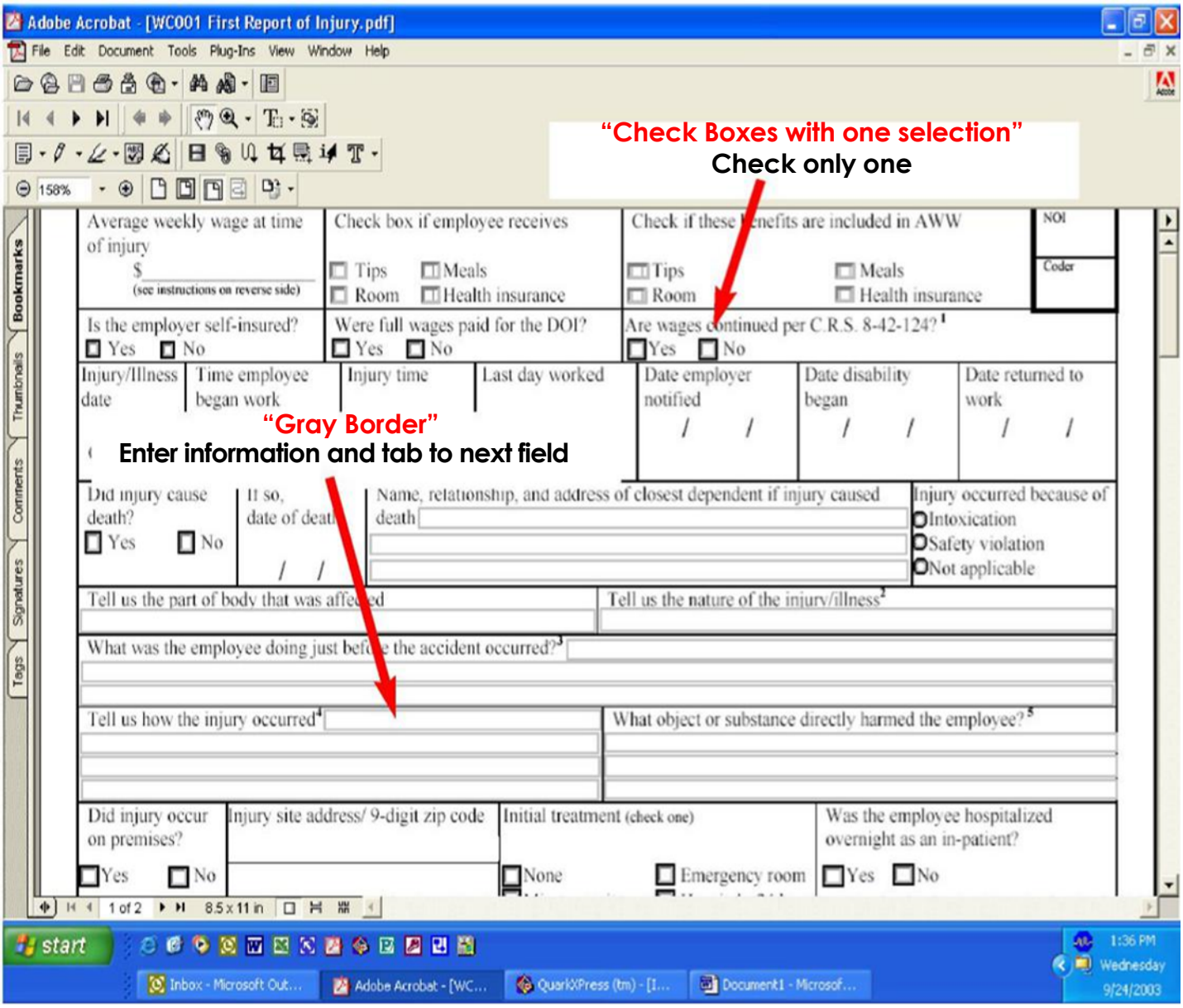
9/24/2003


Adobe Acrobat - [WC001 First Report of Injury.pdf]
File Edit Document Tools Plug-Ins View Window Help
"Check Boxes with one selection"
Check only one
Average weekly wage at time of injury
$
(see instructions on reverse side)
Check box if employee receives
Tips
Meals
Room
Health insurance
Check if these benefits are included in AWW
Tips
Meals
Room
Health insurance
NOI
Coder
Is the employer self-insured?
Yes
No
Were full wages paid for the DOI?
Yes
No
Are wages continued per C.R.S. 8-42-124?
Yes
No
Injury/Illness date
Time employee began work
Injury time
Last day worked
Date employer notified
Date disability began
Date returned to work
"Gray Border"
Enter information and tab to next field
Did injury cause death?
Yes
No
If so, date of death
Name, relationship, and address of closest dependent if injury caused death
Injury occurred because of
Intoxication
Safety violation
Not applicable
Tell us the part of body that was affected
Tell us the nature of the injury/illness
What was the employee doing just before the accident occurred?
Tell us how the injury occurred
What object or substance directly harmed the employee?
Did injury occur on premises?
Yes
No
Injury site address/ 9-digit zip code
Initial treatment (check one)
None
Emergency room
Was the employee hospitalized overnight as an in-patient?
Yes
No
Bookmarks
Thumbnails
Comments
Signatures
Tags
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See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY

Employee's name (first, middle, last)	Social Security #	☐ Male ☐ Female	Employee's home phone # ( )	OSHA Log #
Employee's street address	City	State	Zip code	
Birth date / /	Marital status ☐ Married ☐ Separated ☐ Single ☐ Unknown	Date of hire /	Occupation	Employmentstatus ☐ Full time ☐ Part time ☐ Other ☐ Unknown	For Division use only
Employer's name	Employer's Federal ID #	Employer's phone # ( )	SOI
Employer's mailing address	City	State	Zip code	POB
Average weekly wage at time of injury $ (see instructions on reverse side)	Check box if employee receives ☐ Tips ☐ Meals ☐ Room ☐ Health insurance	Check if these benefits are included in AWW ☐ Tips ☐ Meals ☐ Room ☐ Health insurance	NOI / Coder
Is the employer self-insured? ☐ Yes ☐ No	Were full wages paid for the DOI? ☐ Yes ☐ No	Are wages continued per C.R.S. 8-42-124? ☐ Yes ☐ No	

Injury/Illness date / / (See instructions on reverse side)	Time employee began work ____ ___ ☐ a.m. ____ ___ ☐ p.m.	Injury time ____ ___ ☐ a.m. ____ ___ ☐ p.m. ☐ unknown	Last day worked / /	Date employer notified /	Date disability began / /	Date returned to work / /

Did injury cause death? ☐ Yes ☐ No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death	Injury occurred because of ☐ Intoxication ☐ Safety violation ☐ Not applicable

Tell us the part of body that was affected	Tell us the nature of the injury/illness[2]
What was the employee doing just before the accident occurred?[3]	
Tell us how the injury occurred[4]	What object or substance directly harmed the employee? [5]

Did injury occur on premises? ☐ Yes ☐ No	Injury site address/ 9-digit zip code	Initial treatment (check one) ☐ None ☐ Emergency room ☐ Minor on-site ☐ Hospital >24 hrs ☐ Clinic/hospital	Was the employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Names of witnesses	Name of employer representative notified
Name and address of treating doctor or other health care professional	Name and address of facility where treated

Completed by (name)	Title	Phone # ( )	Date completed / /

The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.

Name of insurance company	Address
Name of third party administrator (if applicable)	Address
Adjuster name	Adjuster phone #

Policy #	Carrier claim #	Date insurer received first report / /	Block #	Adj. Code

INSTRUCTIONS
This form contains all items requested on OSHA Form No. 301,
"Injuries & Illnesses Incident Report"

General

- All injuries no matter how trivial must be reported to your insurance company.
- All injuries or occupational diseases which result in lost time from work in excess of three shifts or calendar days, or in permanent physical impairment, must be reported to your insurance carrier on this form within ten days after notice or knowledge of the injury or disease. Fatalities must be reported to your insurance carrier immediately.
- Forms should be typed or printed legibly.
- All questions must be answered completely to meet requirements of the Colorado Workers' Compensation Act and to conform to the OSHA requirements for Form No. 301.
- The employer has the right in the first instance, to select the physician who attends the injured employee.

Calculation of Average Weekly Wage

- Determine the weekly wage rate.
- Add the average weekly amount of any overtime wages, tips or commissions.
- Add the average weekly value of any board, rent, housing, or lodging provided by the employer *if the employer will not be paying such benefit during the period of disability.*
- If the employee is covered by group health insurance *and* the employer does not continue the employee's health insurance coverage during the period of disability, add the employee's cost of conversion to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Compute the total from the above categories and insert in the *Average weekly wage at time of injury* field.

Injury Date Information

In the case of an occupational disease, use the date of the last injurious exposure.

Notes

Are Wages continued per C.R.S. 8-42-124?[1]
(Subject to application with and approval of the Director of the Colorado Division of Workers' Compensation)

1 Any employer who, by separate agreement, working agreement, contract of hire, or any other procedure, continues to pay a sum in excess of the temporary total disability benefits to an employee temporarily disabled as a result of a work related injury or disease**,** and has not charged the employee with any earned vacation leave, sick leave, or other similar benefits, shall be reimbursed if insured by an insurance carrier or shall take credit if self-insured, to the extent of all moneys that such employee may be eligible to receive as compensation for temporary partial or temporary total disability subject to the approval of the Director of the Colorado Division of Workers' Compensation.

Injury Description (Tell us the part of body that was affected. Tell us the nature of the injury/illness [2]; What was the employee doing just before the accident occurred? [3]; What happened? [4]; What object or substance directly harmed the employee?[5])

2 Be more specific than ""hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
3 Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."
4 Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
5 Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank

Notices

You are hereby notified that if a child support obligation is owed, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S. YOU ARE FURTHER NOTIFIED that you must provide written notice of any award for social security, pension, disability or other source of income that might reduce your compensation benefits. This notice must be sent to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in suspension of your benefits pursuant to section 8-42-113.5, C.R.S.

C.R.S. Section 10-1-128(6) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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."

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 1-866-590-5882.

Atencion Trabajador Lesionado:

Este form ulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 1-866-590-5882.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 1-866-590-5882.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control A4

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____
MM/DD/YYYY

Group #: GJC6200

Employee Date of Birth: _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

sedgwick

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource
Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale
Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dom inicks
Drug
Emporium
Drug Fair Drug
Town Drug
World Eckerd
Econofoods
EPIC
Pharmacy
Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City Food
Lion Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School
Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network
Pharmaceuticals
Northeast
Pharmacy Services
Osco
P & C Food
Markets
Pamida
Park Nicollet
Pathm ark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's Shop
'N Save
Shopko
ShopRite
Snyder Stop
& Shop Sun
Mart Super
Fresh Super
Rx Target
Texas
Oncology
Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United
Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie