Sedgwick Claims Kit
Arkansas

P.O. Box 14779 | Lexington, KY 40512 | Toll Free: 866-738-9201 | Fax: 859-280-3275

Dear Insured:

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

Where do I report a claim?

> **Phone:** **855-728-5277 (855-7ATLAS7)**
> **Email:** 6200AtlasGeneralInsurance@sedgwickcms.com
> **Fax:** 866-383-3296

Where do I send my injured employee for medical treatment?

> **Website:** www.sedgwickproviders.com/AG

Sedgwick Claim Kit Attachments:

- Workers' Compensation Instructions to Employers and Employees (AR-P) (English and Spanish)
- Employee's Notice of Injury (Form AR-N) (English and Spanish)
- Employer's First Report of Injury Form (Form IA-1)
- Wage Statement (Form AR-W)
- Arkansas Workers' Compensation – Questions & Answers
- Express Scripts First Fill Temporary Pharmacy Card and participating pharmacies

For additional information please visit the Arkansas Workers' Compensation Commission at www.awcc.state.ar.us/index.html.

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@Sedgwickcms.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

Form AR-P	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 Little Rock Office - 1-800-622-4472 / 501-682-3930 Springdale Office - 1-800-852-5376 / 479-751-2790	
Ark. Code Ann. §11-9-403, 407 AWCC Rule7 Updated: 06-16-14		

WORKERS' COMPENSATION INSTRUCTIONS TO EMPLOYERS AND EMPLOYEES

All employees of this establishment entitled to benefits under the provisions of the Arkansas workers' compensation laws are hereby notified that their employer has secured the payment of such compensation as may at any time be due employees or their dependents. This employer is required by state law to provide workers' compensation coverage or this employer has waived the exclusion or exemption from the operation of the workers' compensation laws, and the employer certifies by the display of this poster that workers' compensation coverage is now provided by a workers' compensation insurance policy or by enrollment in the Arkansas S elf-Insurance Program or by the Public Employee Claims Division of the Arkansas Insurance Department.

(Place label indicating Insurer's Name,
Claims Office Address, Claims Office Phone Number
and Policy Expiration Date)

IN CASE OF JOB-RELATED INJURIES OR OCCUPATIONAL DISEASES

The Employer Shall:

1. Provide all necessary medical, surgical and hospital treatment, as required by law, following the injury and for such additional time as ordered by the Workers' Compensation Commission.
2. Provide compensation payments in accordance with the provisions of the law. The first installment of compensation becomes due on the 15th day after the employer has notice of the injury or death, except in those cases where liability has been denied by the employer.
3. Provide prompt reporting of accidents to appropriate parties.
4. Keep a record of all injuries received by its employees.

The Employee Shall:

The employee shall report the injury to the employer on Form N and to a person or at a place specified by the employer, unless the injury either renders the employee physically or mentally unable to do so, or the injury is made known to the employer immediately after it occurs. The employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's notice of injury. All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements. The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

Failure to give such notice shall not bar any claim (1) if the employer had knowledge of the injury or death, (2) if the employee had no knowledge that the condition or disease arose out of and in the course of employment, or (3) if the Commission excuses such failure on the grounds that for some satisfactory reason such notice could not be given. Objection to failure to give notice must be made at or before the first hearing on the claim.

Statutory Information:

Ark. Code Ann. § 11-9-514(b) states: "Treatment or services furnished or prescribed by any physician other than the ones selected according to the foregoing, except emergency treatment, shall be at the claimant's expense."
Ark. Code Ann. § 11-9-514(f), however, indicates: When compensability is controverted, subsection (b) shall not apply if:

(1) The employee requests medical assistance in writing prior to seeking the same as a result of an alleged compensable injury; and
(2) The employer refuses to refer the employee to a medical provider within forty-eight (48) hours after such written request as provided above; and
(3) The alleged injury is later found to be a compensable injury; and
(4) The employer has not made a previous offer of medical treatment.

If you have any questions regarding your rights under the Arkansas workers' compensation laws, you may call an Arkansas Workers' Compensation Commission legal advisor at our toll-free number listed above.

All employers who come within the operation of the Arkansas workers' compensation laws and have complied with its provisions must post this notice in a **CONSPICUOUS** place in or about their place or places of business.

AWCC Form P
(Posting Notice)

A posting notice is mentioned in **Ark. Code Ann. §11-9-403**, **Ark. Code Ann. §11-9-407** and **AWCC Rule 7**. **AWCC Form P** satisfies all requirements.

Form P:

1. Is to be on display in a conspicuous place;

2. Tells employers what to do when an employee is injured;

3. Instructs employees to notify the employer immediately (or no later than the close of the next business day) when injured;

4. Lists the claims office that will be handling the insurance aspects of the case;

5. Gives the claims office telephone number;

6. Announces the expiration date of the insurance policy; and

7. Provides telephone numbers for Arkansas Workers' Compensation Commission legal advisors if either party needs assistance.

Employers without **Form P** may lose the use of **Form N** as a defense in litigation. Employees disobeying instructions on **Form P** may delay their benefits or jeopardize the awarding of any benefits in a contested case.

The AWCC furnishes samples, not supplies, of **Form P**. Carriers are to send their insureds an adequate number, and self-insureds must arrange with a printer for the supply they need. Carriers and employers may enlarge **Form P** for posting purposes.

Information about Form P is available from the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing 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 any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

Form ulario AR-P	COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS 324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 Oficina de Little Rock: 1-800-622-4472 / 501-682-3930 Oficina de Springdale: 1-800-852-5376 / 479-751-2790	**P**
Autoridad: Ark. Code Ann., apartado 11-9-403, 407 AWCC, Norma 7 Actualizado: 06-16-2014 En Español: 10-15-2004		

INSTRUCCIONES SOBRE LA COMPENSACIÓN DE LOS TRABAJADORES PARA EMPLEADORES Y EMPLEADOS

Todos los empleados de este centro que tengan derecho a beneficiales en virtud de lo dispuesto en la legislación de compensación de los trabajadores son informados en virtud del presente documento de que su empleador ha organizado el pago de las compensaciones que puedan tener que abonarse a los empleados o sus dependientes. Este empleador debe, en virtud de la legislación estatal, ofrecer a sus emp leados cobertura por com pensaciones o ha renunciado a la exención o exclusión de la ejecución de la legislación en materia de com pensaciones a los trabajadores y certifica m ediante la mu estra de este cartel que en la actualidad ofrece cob ertura a sus trabajadores den tro de una pó liza de seguro de compensación de los trabajadores o por su participación en el Programa d e Auto-seguros de Arkansas o la División Pública de Reclamaciones de los Empleados del Departamento de Seguros de Arkansas.

(Pegar la etiqueta con el nombre de la aseguradora,
la dirección de la oficina de reclamaciones, el número de teléfono de la oficina
de reclamaciones y la fecha en que expira la póliza).

EN CASO DE PRODUCIRSE UNA LESIÓN VINCULADA AL TRABAJO O UNA ENFERMEDAD PROFESIONAL

El empleador deberá:

1. Ofrecer todo el tratamiento médico, quirúrgico y hospitalario que sea preciso en virtud de la legislación, tras la lesión y durante el tiempo adicional que establezca la Comisión de Compensación de los trabajadores.
2. Ofrecer pagos de compensación de acuerdo con lo dispuesto en la legislación. El primer plazo vencerá al cabo de 15 días desde que el empleador sea informado de la lesión o fallecimiento, excepto en los casos en el empleador haya denegado su responsabilidad.
3. Informar inmediatamente de los accidentes a los interesados.
4. Mantener un registro de todas las lesiones de las que sea informado por sus empleados.

El empleado deberá:

El empleado deberá informar de la lesión al empleador en el formulario N y a una persona o en un lugar indicado por este último, a menos que se trate de una lesión que impida mental o físicamente al empleado hacerlo o si la lesión se comunica al empleador inmediatamente después de producirse. El empleador no será responsable de las beneficiales de discapacidad, médicas o de otro tipo anteriores a la recepción del informe del accidente. Todos los procedimientos de notificación que especifique el empleador deberán ser razonables y éste deberá notificar razonablemente a todos los empleados los requisitos de notificación. Lo anterior no será de aplicación si el empleado precisa tratamiento médico de urgencia fuera del horario de trabajo habitual del empleador; sin embargo, en ese caso, el empleado deberá hacer que se notifique el accidente al empleador el siguiente día laborable habitual.

La falta de notificación no anulará las reclamaciones si: (1) El empleador tiene conocimiento del fallecimiento o lesión; o (2) El empleado no tenía conocimiento de que la afección o enfermedad se produjo en el transcurso de su empleo; o (3) La Comisión exime esta omisión basándose en que la notificación no pudo realizarse por un motivo justificado.
Las objeciones relativas a la falta de notificación deberán plantearse antes o en el momento de celebrarse la primera vista de la reclamación.

Información legal:

El artículo 11-9-514(b) del Ark. Code Ann. establece que: “El tratamiento o los servicios prestados por un médico distinto de los seleccionados de acuerdo con lo anterior, con excepción de los tratamientos urgentes, correrán a cargo del demandante.”
El artículo 11-9-514(f) del Ark. Code Ann., sin embargo, establece que: Cuando la compensación sea causa de controversia, el subapartado (b) no será de aplicación si:
(1) El empleado solicita asistencia médica por escrito antes de buscarla como consecuencia de una posible lesión compensable; y
(2) El empleador se niega a remitir al empleado a un proveedor médico en el plazo de cuarenta y ocho (48) horas desde dicha solicitud escrita; y
(3) Posteriormente se descubre que la supuesta lesión es compensable; y
(4) El empleador no ha hecho ninguna oferta anterior de tratamiento médico.

Si tiene alguna pregunta relativa a sus derechos en virtud de la legislación en materia de compensaciones de los trabajadores de Arkansas, puede llamar al asesor legal de la Comisión de Compensación de los Trabajadores de Arkansas al número gratuito que se indica más arriba.

Todos los empleadores que se vean afectados por la ejecución de la legislación en materia de compensaciones de los trabajadores de Arkansas y que hayan cumplido estas disposiciones deberán colocar esta notificación en un lugar **PREEMINENTE** en su centro de trabajo o las cercanías.

Formulario P de la AWCC
(Notificación)

En los **apartados 11-9-403 y 11-9-407 del Ark. Code Ann. y la Regla 7 de la AWCC** se menciona una notificación. El **form ulario P de la AWWC** cumple todos esos requisitos.

Formulario P:

1. Debe mostrarse en un lugar preeminente;

2. Dice a los empleados qué deben hacer cuando un trabajador se lesiona;

3. Instruye a los empleados para que notifiquen las lesiones inmediatamente al empleador (o no más tarde del final del siguiente día laborable);

4. Enumera la oficina de reclamaciones en la que se tratarán los aspectos vinculados a seguros del caso;

5. Anuncia la fecha en que expira la póliza de seguros;

6. Ofrece números de teléfono del asesor legal de la Comisión de Compensaciones de los Trabaj adores de Arkansas por si alguien necesita ayuda.

Los empleadores que no cuenten con un **formulario P** podrán perder el derecho a utilizar el **formulario N** como defensa en un litigio. Los empleados que desobedezcan las instrucciones del **formulario P** podrán sufrir retrasos en el beneficio de cualquier prestación en los casos que se impugnen o corren el riesgo de perderlos.

La AWCC ofrece copias de muestra pero no suministra el **formulario P**. Las aseguradoras deben enviar a sus asegurados un número adecuado de copias y los auto-asegurados deben contratar el suministro con una imprenta. Las aseguradoras y los empleadores pueden ampliar el **formulario P** para publicarlo.

Puede obtenerse información sobre el formulario P de la División de Servicios de Soporte (1-800-622-4472 o 501-682-3930).

Ark. Code Ann., apartado 11-9-106(a): "Cualquier persona o entidad que realice consciente y voluntariamente una declaración o afirmación sustancial falsa o que omita u oculte consciente y voluntariamente un dato sustancial, o que utilice consciente y voluntariamente un dispositivo, sistema o artificio para: obtener una prestación o pago, engañar o aumentar o reducir ilegítimamente cualquier reclamación de beneficiales o pagos, u obtener o evitar la cobertura de compensación para los empleados o evitar el pago de la prima de seguro correspondiente, o que ayude e induzca a cualquiera de estos fines, será, en virtud del presente capítulo, culpable de un delito de Clase D. El cincuenta por ciento (50%) de cualquier multa penal impuesta y cobrada en virtud de... este artículo se pagará y adjudicará de acuerdo con la legislación aplicable al Fondo de Discapacidad Total Permanente y Fallecimiento administrado por la Comisión de Compensaciones de los Trabajadores."

Form AR-N

Ark. Code Ann.
8811-9-703 508, 514
AWCC Rule 09933
Revised:1-1-2001
Updated: 8-1-2006

ARKANSAS WORKERS' COMPENSATION COMMISSION

324 Spring Street, Little Rock, AR 72201 Mail:
P. O. Box 950, Little Rock, AR 72203-0950
501-682-3930 / 1-800-622-4472

N

EMPLOYEE'S NOTICE OF INJURY

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	MI	Social Securit Number	Home Phone No.
Street Address or P.O. Box	City		State	Zip Code

Child Support Obligation: ❑ Current ❑ Past Due Payable to:

EMPLOYER INFORMATION (Please Print)

Employer's Name	Supervisor's Name		
Employer's Street Address or P.O. Box	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

			Date /Time
Place of Accident	Date of Accident	Time of Accident	Employer Notified of Accident

What part of your body was injured?

Briefly discuss the cause of injury:

Name/address of witness(es):

Thereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to famish the bearer any information, written or cual, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change-of-physician. (See additional information on back side of form)

Date Signature

Assistance with AWCC ForinN is available from the AVVCC Legal.Advisor .vision(1-800-250-2511 501-682-3930). Information is supplied by the Support Services Division (1-800-622-4472 or 501-682-3930)

Ark. Code Ann §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim forbenefit or payment; or obtaining or avoiding workers' compensation coverage or avoidingpayment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fiftypercent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

Form AR-N Ark. C ode Ann. §§ 11-9-701, 508, 514 AWCC Rule 33 Revised: 1-1-2001 Updated: 8-1-2006	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	N

EMPLOYER'S NOTICE TO EMPLOYEE

NOTICE TO EMPLOYEE - Fill out this form to give to your employer immediately. Employer: Be sure the employee receives a copy of this form [Ark. Code Ann. § 11-9--514 (c)]

Ark. Code Ann. § 11-9-701. Notice of injury or death.

(a)(1) Unless an injury either renders the employee physically or mentally unable to do so, or is made known to the employer immediately after it occurs, the employee shall report the injury to the employer on a form prescribed or approved by the Workers' Compensation Commission and to a person or at a place specified by the employer, and the employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's report of injury.

(2) All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements.

(3) The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

(b)(1) Failure to give the notice shall not bar any claim:
(A) If the employer had knowledge of the injury or death;
(B) If the employee had no knowledge that the condition or disease arose out of and in the course of the employment; or
(C) If the commission excuses the failure on the grounds that for some satisfactory reason the notice could not be given.
(2) Objection to failure to give notice must be made at or before the first hearing on the claim.

CHOICE/CHANGE OF PHYSICIAN

Rights and responsibilities. Treatment or services furnished or prescribed by any physician other than the ones selected according to the provisions below, except emergency treatment, shall be at the claimant's/employee's expense.

Ark. Code Ann. § 11-9-508. Medical services and supplies.

"(e)... [T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions."

1. Your employer shall have the right to select the initial primary care physician from among those associated with certified MCOs.

2. You may request a change-of-physician. You should initially request a change from the insurance carrier or employer. Within five business days of your initial request for a change-of-physician, the insurance carrier or employer shouldnotify you of its decision to grant or denythe change-of-physician.

3. If your request for change of physician is denied you may send a petition to the Clerk of the Arkansas Workers' Compensation Commission for a one (1) time only change-of-physician.

4. If your employer has contracted with a certified MCO, you shall be allowed to change physicians by petitioning the conunission one (1) time only for a change-of-physician to a physician who must also either be associated with the certified MCO chosen by your employer or who is your regular treating physician. (Your "regular treating physician" is one who maintains your medical records and with whom you have a history of regular treatment before the onset of your compensable injury.) The health care provider to whom you change must agree to refer you to the certified MCO chosen by your employer for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by the MCO initially chosen by your employer.

5. If your employer does not have a contract with a certified MCO, you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must either be associated with any certified MCO or who is your regular treating physician. (See definition above.) The health care provider to whom you change must agree to refer you to a physician associated with any certified MCO for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by any certified MCO.

Back side / Two-sided form

Formulario AR-N	COMISION DE COMPENSACION DE LOS TRABAJADORES DE ARKANSAS	N
Autoridad: Ark. Code Aim. apartado 11-9-702, 508, 514 AWCC Non 33 Revisado: 1-1-2001 En Espanol: 10-15-2004 Actualizada: 8-1-2006	324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

NOTIFICACION DE ACCIDENTE DEL EMPLEADO

DATOS DEL EMPLEADO (utilizar tinta y maynsculas)

Apellido	Nombre	Inicial del N[6]nornbre	# de la Seguridad Soc.	Fecha de nacirniento	(Prefijo), nfirnero de telefono particular

Direccion o apartado de correos	Ciudad	Estado	Codigo postal

yTlene obligation de pagan manutencion de sus hijos? ❑ Estoy al corriente ❑ E toy atrasado/a ❑ Pagaderos a:

DATOS DEL EMPLEADOR (utilizar ma sculas)

Nombre del empleador (denomination con h que opera)	(Prefijo), chtnero de telefono del empleador

Direction del empleador	Ciudad del empleador	Estado	Codigo postal

INFORMACION SOBRE EL ACCIDENTE (utilizar ma tisculas)

Lugar del accidente	Fecha del accidente	Hora del accidente	Dia /Horn Empleador informado del accidente

hQue parte del cuerpo se ha lesionado?

Describa brevemente las causas del accidente:

TESTIGOS

Nombre y direction de los testigos, si procede:

Por la presente autorizo a cualquier hospital, medico, psicotenpeuta o profesional sanitario a suministrar al portador cualquier dato, oral o escrito, incluidos, entre otros, copias de los registros medicos relativos a mi estado fisico, mental() emocionalpasado, presente o futuro. Por la presente innuncio a mi privilegio m€dico (ypsicoterapeuta oprofesional sanitario)-paciente. Una copia fotostatica *de* la presente autorizacion sera tan valida como y efectiva como el original. Mi firma a continuation tambien indica que se me ha ofrecido el ejercicio de mis derechos relativos al cambio de m€dico. (Vease la information adicional al ("ono.)

Fecha:_____ Firma:_____

Puede obtenerse ayuda con respect() al formulario N de la AVVCC de la Division (Id Asesor Legal)(14mo-520-2511 o S01-682-3930). Puede obtenerst informacion de la Division de Servicios de Soporte (1-800-622-4472 u 501-682-3930).

Ark. Code Ann., apartado 11-9-106(a): "Cualquier persona o entidad que realice consciente y voluntariamente 'ma declaracion o afinnacion sustancial falsa o que omita u oculte consciente y voluntariamente un dato sustancial, o que utilice consciente y voluntariamente un dispositivo, sistema o artificio para: obtener 'ma prestacion o pago, enganar o aumentar o reducir ilegitimamente cualquier reclamation de prestaciones o pagos, u obtener o evitar la cobeitura de compensation pan los empleados o evitar el pago de la prima de seguro correspondiente, o que ayude e induzca a cualquiem de estos lines, sera, en virtud del presente capitulo, culpable de un delito de Clase D. El cincuenta por ciento (50%) de cualquier multa penal impuesta y cobrada en virtud de... este articulo se pagara y adjudicara de acuerdo con la legislation aplicable al Fondo de Discapacidad Total Pennanente y Fallecimiento administrado por la Comision de Compensaciones de losTnbajadores."

Forma lario AR-N	COMISION DE COMPENSACION DE LOS TRABAJADORES DE ARKANSAS	
Autoridad: Ark. Code Aim., apartado 11-9-702 Revisado: 1-1-2001 En Espanol: 10-15-2004	324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	N

NOTIFICACION DE ACCIDENTE DEL EMPLEADO

NOTIFICACION AL EMPLEADO - Cum limente este formulario Para entregarlo a su empleador inmediatamente.

Ark. Code Ann., apartado 11-9-701. Notificacion de fallecimiento o lesion.

(a) (1) A menos que se trate de una lesion que impida mental o fisicamente al empleado hacerlo, o si se comunica al empleador inmediatamente despues de producirse, el empleado debera informar del accidente a su empleador en una forma establecida o aprobada por la Comision de Compensacion de los trabajadores y a una persona yen un lugar especificado por el empleador, y el empleador no sera responsable de las beneficiales de discapacidad, medicas o de otro tipo anteriores a la recepcion del informe del accidente.

(2) Todos los procedimientos de notificacion que especifique el empleador deberan ser razonables y este debera notificar razonablemente a todos los empleador los requisitos de notificacion.

(3) Lo anterior no sera de aplicacion si el empleado precisa tratamiento medico de urgencia fuera del horario de trabajo habitual del empleador; sin embargo, en ese caso, el empleado debera hacer que se notifique el accidente al empleador el siguiente dia lab orable habitual.

(b) (1) La falta de notificacion no anulara las reclamaciones si:

(A) El empleador tiene conocimiento del fallecimiento o lesion; o

(B) El empleado no tenia conocimiento de que la afeccion o enfermedad se produjo en el transcurso de su empleo; o

(C) La Comision exime esta omision basandose en que la notificacion no pudo realizarse por un motivo jus cado.

(2) Las objeciones relativas a la falta de notificacion deberan plantearse antes o en el moment() de celebrarse la pr era vista de la reclamacion.

ELECCION/CAMBIO DE MEDICO

Derechos y **responsabilidades. El tratamiento o los servicios suministrados o prescritos por un medico distinto del seleccionado de acuerdo con las siguientes disposiciones, excepto el tratamiento de urgencia, correran a cargo del solicitante/empleado.**

Ark. Code Ann., apartado 11-9-508. Servicios y **suministros medicos.**

"(e) empleado lesionado podra tener acceso directo a cualquier proveedor de servicios oftalmologicos u optometricos que acepte suministrar servicios de acuerdo con las normas y condiciones relativas a los servicios prestados por la entidad de atencion gestionada inicialmente elegida por el empleador para el tratamiento y control de lesiones o afecciones de los ojos."

1. Su empleador podra seleccionar al medico de atencion primaria inicial de entre los asociados con MCOs certificadas.

2. Podra solicitar un cambio de medico. Inicialmente deberia solicitar un cambio a la aseguradora o el empleador. En el plazo de cinco dial laborables desde su solicitud inicial de cambio de medico, la aseguradora o el empleador deberian notificarle su decision de concederle o denegarle el cambio de medico.

3. Si su solicitud de cambio de medico es denegada podra enviar una peticion al Secretario de la Comision de Compensacion de los trabajadores para un (1) Unico cambio de medico.

4. Si su empleador tiene an contrato con una MCO certificada, podra cambiar de medico solicitando a la Comision un (1) Unico cambio de medico por un facultativo que tambien debera estar asociado a la MCO certificada elegida por su empleador o que sea el medico que le atiende regularmente (Por "medico que le atiende regularmente" se entiende el facultativo que mantiene sus registros medicos y con el que cuente con un historial de tratamiento habitual anterior a la lesion para la que se puede solicitar la compensacion"). El proveedor de atencion sanitaria por el que cambie debera aceptar remitirlo a la MCO certificada elegida por el empleador para cualquier tratamiento especializado, incluida la terapia fisica, y debera aceptar cumplir todas las normas y condiciones relativas a los servicios prestados por la MCO certificada inicialmente elegida por su empleador.

5. Si su empleador no tiene an contrato con una MCO certificada, podra cambiar de medico solicitando a la Comision un (1) fmico cambio de medico por un facultativo que tambien debera estar asociado a una MCO certificada o que sea el medico que le atiende regularmente (vease la definicion anterior). El proveedor de atencion sanitaria por el que cambie debera aceptar remitirlo a una MCO certificada para cualquier tratamiento especializado, incluida la terapia fisica, y debera aceptar cumplir todas las normas y condiciones relativas a los servicios prestados por cualquier MCO certificada.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG CASE #	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE O SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX M MALE F FEMALE UNKNOWN	MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	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 ( ) CANNOT BE DETERMINED	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

DEPARTMENT OR LOCATION 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 THE 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 OR OFF SITE TREATMENT (NAME & ADDRESS)	INJURY TREATMENT
		0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

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

AWCC Form 1

(Employer's First Report of Injury or Illness)

Ark. Code Ann. § 11-9-529 allows employers 10 days to report injuries. Those involving either more than 7 days of lost time or indemnity payments require **Form 1**. Also, a Form 1 is required for all controversions including a medical-only case. Self-insured employers file **Form 1** with the AWCC; other employers send it to their insurance representatives.

Employers do **NOT** fill in the shaded areas.

On **Form 1**, employers/carriers must:

1. In the **Occurrence Section** list the date the employer first knew of the injury. The 10 days to report begin either on the date of disability **or** the date the employer was notified, whichever date is later.

2. Give the name of the carrier. An insurance agency or third party administrator should be listed in the **Preparer's Section**. A carrier can pre-print its name and address in the **Carrier Section** to help clients properly report.

3. Specify the carrier Federal Employer Identification Number (FEIN) in the **Carrier Section**.

4. Type or print in ink. An illegible, incomplete **Form 1** will be returned.

   Neglect of **Form 1**: Late employee benefits, exposing employers to fines.

   Lack of **Form 1**: Delays in insurance investigation.

General inquiries on Form 1 can be answered by the AWCC Support Services Division. Questions on a specific Form 1 may be directed to the Research and Statistics Section, which processes the accident reports. (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing 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 any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

(Revised 1-1-2001)

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:
Enter all dates in MM/DD/YY format.

INDUSTRY CODE:
This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, 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 designated 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.

EMPLOYER'S INSTRUCTIONS – cont'd

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

Form AR -W	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	W
Authority: Ark. Code Ann. §11-9-518 Revised: 1-1-2001		

WAGE STATEMENT IMMEDIATELY PRECEDING INJURY DATE

Weeks	Straight Time Worked		Wages Paid For Straight Time	Overtime Hours Worked		Wages Paid for Overtine
	Days	Hours		Days	Hours	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
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43						
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45						
46						
47						
48						
49						
50						
51						
52						
Total						

AWCC No.

Carrier Claim No.

Employee Name:

Employee S.S.No.:

Employer Name:

Employer FEIN No.:

Carrier or Self-Insured Name:

Carrier NAIC No.:

INSTRUCTIONS FOR
COMPLETING WAGE STATEMENT
(To be completed only if claimant receives less than maximum benefits)

In completing the Wage Statement, in week one give information for the week prior to the injury and follow with preceding weeks. Days and hours of straight time work should be given in all cases.

Explanation of time lost by employee:

W

AWCC Form W
(Wage Statement)

1. The **AWC C Advisory 88-1** requires respondents to file **Form W** (with the AWCC file number for the case, obtained from **AWCC Form A-110)** if the claimant receives less than the maximum compensation rate.

2. The average weekly wage of the injured worker shall "[I]n no case...be computed on less than a full-time workweek in the employment." **[Ark . Code Ann. § 11-9-518(a)(1)]**

Information on Form W is available from the Office Services Section. General Information is available from the Support Services Division. **(1-800-622-4472 or 501-682-3930)**

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing 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 any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

Arkansas Workers' Compensation
Questions & Answers

What is Workers' Compensation?

Arkansas' no-fault com pensation law was created by an initiated act in 1939 to guarantee prompt, automatic benefits to workers injured on the job. Before the Workers' Compensation Law, an injured worker had to sue the employer to recover medical costs and lost wages. Lawsuits took months and sometimes years. Juries and judges had to decide who was at fault and how much, if anything, would be paid. It was a costly, time consuming and unfair system.

If an employee is unable to work because of a job injury, the employer's workers' compensation policy takes care of the medical expenses and pays the employee money to live on until he/she is able to go back to work. In most cases, these benefits are started automatically, without delay or red tape.

Effective July 1, 1993, reform legislation was enacted and Act 796 of 1993 became the law for workers' compensation claims. The following questions and answers concern injuries occurring after July 1, 1993.

Who is covered?

Almost every working Arkansan is protected by the Workers' Compensation Law, but there are a few exceptions. Businesses where there are two or fewer employees may not be covered. Railroad and maritime workers are covered by federal laws. The Arkansas Workers' Compensation Law does not apply to employment of agricultural farm labor, domestic help, or employment by non-profit, religious, charitable or relief organizations. Also exempt from the law are personnel covered exclusively by federal law.

How do I know if my employer has workers' compensation coverage?

If a notice is not displayed at the work place, then ask your employer; if you are not satisfied with your employer's answer, contact the Arkansas Workers' Compensation Commission.

What is covered?

Workers' compensation covers accidental injuries which arise out of, and in the course of employment, cause internal or external harm to the body, are caused by a specific incident and are identifiable by time and place of occurrence. There are three exceptions to the specific incident, and time and place requirement: (1) rapid repetitive motion injuries, including carpal tunnel; (2) gradual on-set back injuries; and (3) hearing loss. These three injuries are compensable only in those cases in which the resultant condition is the "major cause" of the need for treatm ent and/or disability or death. Major cause is defined as more than 50% of the cause.

Mental injuries and heart attacks are addressed by specific statutory provisions. A mental injury must be caused by a physical injury to the employee's body, and disability benefits are limited to 26 weeks. However, the physical injury requirement shall not apply to any victim of a crime of violence.

A heart attack is compensable only if an accident is the major cause of the physical injury. The exertion of work which caused the heart attack must have been extraordinary and unusual in comparison to the employee's regular employment. Or, some unusual and unpredicted incident must have occurred which was the major cause of the physical harm.

The law also provides coverage for occupational diseases which arise out of and are in the course of employment. Ordinary diseases of life to which the general public is exposed are not covered as a general rule.

When is coverage effective?

Coverage begins the first minute on the job and continues during employment. You do not have to work a certain length of time, and there is no need to earn a certain amount in wages before being protected.

How do I get the benefits?

You should report the injury to the your employer or supervisor imm ediately. You should give the employer written notice of the time, place and nature of the injury and such additional information to

enable the employer to arrange medical treatment and to complete all necessary reports. Prompt reporting is the key. Benefits are automatic, but nothing can happen until the employer knows about the injury. Protect your rights to benefits by giving the employer notice of the injury, no matter how slight. Even a cut finger can be disabling if an infection develops.

How is medical care provided?

The employer or insurer should provide you with a copy of your rights to medical care (WCC Form AR-N). The law obligates the employer to provide all reasonably necessary medical care. It also entitles the employer who has contracted with a certified managed care organization or has obtained internal managed care certification to designate the initial provider of that care. The employer and insurer may not be required to pay for treatment you seek on your own without their knowledge. However, the employer and insurer may authorize you to see your own doctor. You should check with the employer or the insurance company about any medical treatment you need. Problems concerning treatment can be solved by cooperation between the worker and the employer or insurer in most cases.

If the claim for benefits is denied, the employer or insurance carrier may still be responsible for treatment of services if: (1) you request medical assistance in writing prior to seeking medical attention; (2) the employer refuses to refer you to a medical provider within 48 hours after the written request; (3) the alleged injury is found to be compensable; and (4) the employer has not made a previous offer of medical treatm ent.

What if I need emergency treatment immediately and am unable to seek the medical treatment provided by the employer and insurer?

In an emergency requiring immediate treatment, you may seek emergency treatment and the employer or insurer may be required to pay for such treatment.

How can I change physicians?

The Arkansas Workers' Compensation Law sets forth specific procedures which must be followed to determine if a change of physician is appropriate. If the employer or insurance carrier has not approved your change of physician request, you may contact the Legal Advisor Division of the Workers' Compensation Commission regarding the change of physician procedure. Failure to follow the change of physician rules could result in denial of payment for medical treatment from that physician. Change of Physician requests cannot be approved over the telephone by the Legal Advisor Division.

If unable to work as a result of an accidental injury on the job, how long must I be off before I am entitled to disability benefits?

Disability benefits are not paid for the first seven days of disability, commencing the day after the injury, if the disability does not last fourteen (14) calendar days. If the disability does last fourteen (14) calendar days, benefits are payable beginning the day following the injury.

What are the benefits?

The law provides three kinds of workers' compensation benefits:

(1) Medical care to treat the injury - not just doctor bills, but also medication, hospital costs, fees for lab tests, x-rays, crutches and so forth. There is no deductible and all costs for reasonably necessary services are paid directly to the provider by the employer's insurance company or the self-insured em ployer;

(2) Rehabilitation services. Sometimes this is just an extension of medical treatment, for exam ple, physical therapy to strengthen muscles. However, if the injury results in permanent disability, you may qualify for vocational rehabilitation; and

(3) Cash payments. More often than not, cash payments made to injured workers are in the form of temporary total disability benefits. These payments are made during the healing period while the employee suffers a total incapacity to earn wages. If the injury results in a permanent impairment, such as the amputation of a finger or loss of use of the shoulder, you will be paid permanent partial disability benefits after being released to return to work. If your impairment has affected your pre-injury wages, you may be entitled to wage loss. If the injury resulted in death, payments may be made to surviving dependents.

How much are the cash payments?

The benefits provided for temporary total disability are calculated at sixty-six and two-thirds percent (66-2/3%) of the injured worker's average weekly wage - not to exceed a maximum rate as set by state law. Workers' compensation payments are tax-free. Should you have any questions about your benefit rate, you can contact the adjuster at the insurance company or a Legal Advisor at the Arkansas Workers' Com pensation Commission.

How often should compensation for lost time be paid?

Every other week, normally.

When are the cash payments made?

If you report the injury promptly, you should receive the first compensation check within fourteen (14) days, not including the date of injury. After that, you should receive a check every two weeks until you are no longer disabled. In extremely serious injuries, the payments may continue for life.

Do I need to apply for benefits with the Workers' Compensation Commission?

No. Employers or insurers should provide medical treatment, appropriate disability payments and file the required reports and notices with the Workers' Compensation Commission. If they do not, you should call the Workers' Compensation Commission regarding your legal rights.

What if there is a problem?

Most claims are handled routinely. After all, workers' compensation benefits are automatic and the amounts are set by the Legislature. But mistakes and misunderstandings do happen. If you think you have not received all benefits due, you can contact the employer or the insurance company. Many questions can be cleared up with a phone call. If still not satisfied with the explanation, they may get advice from the Workers' Compensation Commission office (phone numbers listed in the back of this brochure). The Commission staff includes trained persons who are ready, willing, and qualified to advise you about your rights and benefits under our law. These persons can also arrange preliminary conferences where you can meet with the employer or the employer's representative to discuss any problems in getting benefits. Many problems and disputes can be resolved by Legal Advisors through the Preliminary Conference procedure or mediation, saving the parties litigation costs.

If the problem still cannot be resolved, it may be necessary to file a "Form C" with the Workers' Compensation Commission. This state agency reviews cases when you believe you have been denied benefits unjustly. The claim should be filed on W CC Form AR-C. Claim for Compensation, which may be obtained at any Workers' Compensation Commission office or by contacting the Arkansas Workers' Compensation Commission, P.O. Box 950, Little Rock, Arkansas 72203-0950.

When must the claim be filed?

The law requires that your claim be filed within two (2) years from the date of injury or death, or one year from the date of last payment of compensation.

What happens after I file a claim?

If the dispute cannot be resolved at a preliminary conference or mediation, the case will be assigned upon request, to an Administrative Law Judge of the Commission, who will conduct further proceedings in the matter. Either party may hire an attorney to represent them at the hearing.

What will the attorney's fees be for handling a workers' compensation claim?

Under the Workers' Compensation Law, fees for legal services are not valid unless approved by the Commission. In contested cases, one-half (1/2) of the attorney's fee is paid by the employer or the insurance carrier and one-half (1/2) by you out of compensation awarded. This means that under normal circumstances, unless you are awarded benefits, you do not owe an attorney's fee.

What compensation is provided if I receive an anatomical impairment rating from my physician as a result of the accident or injury?

You are entitled to receive permanent partial disability benefits for a prescribed number of weeks. The Arkansas Legislature has assigned values in terms of weeks of compensation to various

parts of the body and to the entire body.

The value assigned by the Legislature is multiplied by the impairment assigned by the physician to determine the number of weeks of benefits to which you are entitled.

What if I am not satisfied with the amount of disability reported by the physician?

You do not have to accept an impairment rating from a physician or a settlement proposed by the employer or its representatives. You may, as with any dispute which arises in the case, request a preliminary conference or mediation with a Legal Advisor of the Workers' Compensation Commission regarding your legal options.

While temporarily unable to work as a result of the injury, for how long can I receive disability payments?

The workers' com pensation Law provides for tem porary total disability benefits while you are in your healing period and unable to earn wages.

Must the employer keep the job open until I return?

Although the Workers' Compensation Law provides that an employer cannot discharge or discriminate against you for exercising your rights under the Workers' Compensation Law, there is no specific requirement that an employer keep a job open while you are off work. However, any employer who, without reasonable cause, refuses to return you to work may be responsible for paying the difference in your average weekly wage and any benefits received for a period not to exceed one (1) year.

What if I am permanently and totally disabled as a result of an accidental injury on the job? If permanently and totally disabled, then you are entitled to benefits for life.

What if I want to settle my case with the employer and insurer?

All final settlements must be approved by the Arkansas Workers' Compensation Commission, and the case can only be settled if so approved.

Am I entitled to any reimbursement for travel expenses for medical treatment?

In the normal case, you are allowed mileage for medical travel. If a dispute arises as to what expenses shall be provided, the Workers' Compensation Commission may determine the expenses to be paid.

What if I have an accidental injury on the job with an employer who is required to have workers' compensation coverage, but has not been approved as a self-insurer or obtained a workers' compensation insurance policy?

You may still file a claim with the Commission under the Workers' Compensation Law or file a civil lawsuit against the employer in Circuit Court.

What is required for vocational rehabilitation?

The injury must result in a permanent impairment, and the rehabilitation plan proposed must be reasonable in relation to the disability.

How does the payment for physical and/or vocational rehabilitation affect other compensation?

The payment of the additional benefits for physical or vocational rehabilitation is in addition to any other compensation which you may be entitled to.

What happens to any employee or employer who misrepresents a work-related injury?

Anyone who makes false statements for obtaining or defeating the payment of benefits can be found guilty of a Class D Felony and subject to a fine of up to ten thousand dollars ($10,000.00).

I have a question about workers' compensation not answered in this pamphlet. What should I do? Contact the Arkansas Workers' Compensation Commission and ask to speak with a Legal Advisor.

Where are the Workers' Compensation Commission Offices?
Main Office Location:
324 Spring Street
Little Rock, AR 72201
501-682-3930
Legal Advisor Division
501-682-2707

Mailing Address:
P.O. Box 950
Little Rock, AR 72203-0950

Branch Office:
Springdale Division
244 South 40th
Springdale, AR 72762-3845
479-751-2790

You may call the Commission at no cost by using our toll-free numbers listed below:
1-800-622-4472 - Little Rock
1-800-250-2511 - Legal Advisor Division, L. R.
1-800-852-5376 - Springdale
1-800-285-1131 - Deaf Access

NOTICE

This pam phlet is not intended to be a detailed or definitive statement of the law. If you have specific questions about your rights or obligations under the Arkansas Workers' Compensation Act, you may wish to employ a private attorney.

This Commission does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services.

REVISED 06-14

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

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