Sedgwick Claims Kit

Connecticut

Service American Indemnity Company

Atlas General Insurance Services

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 Service American Indemnity 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:

- Employer's First Report of Occupational Injury or Illness
- Notice to Employee's
- Notice of Claim for Compensation (form 30C)
- Mileage Worksheet for Medical Treatment
- Express Scripts First Fill Temporary Pharmacy Card and participating pharmacies.

For additional information please visit the State of New Jersey Department of Labor and Workforce Development at https://wcc.state.ct.us/download/forms.htm

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

State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Date filed in Chairman's Office

(for WCC use only)

Employer *(Name, Address & Zip)* | Phone #

SIC Code | FEIN

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ❑ Check, if Self-Insured

Policy Period *(MM/DD/YY)*
FROM: TO:

Employee: Last Name First Name Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender
❑ Male
❑ Female

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ _____ . _____ per
❑ Hour ❑ Day ❑ Week ❑ Bi-Weekly ❑ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ❑ a.m. ❑ p.m.

Time of Occurrence ❑ cannot be determined ❑ a.m. ❑ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Contact Name

Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ❑ Yes ❑ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ❑ Yes ❑ No

If provided, were they used? ❑ Yes ❑ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

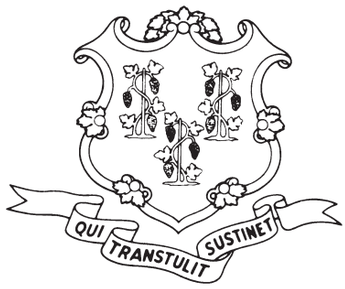
Initial Treatment

❑ No Medical Treatment
❑ Emergency Care
❑ Minor — by Employer
❑ Hospitalized More Than 24 Hours
❑ Minor — by Clinic / Hospital
❑ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

NOTICE
TO EMPLOYEES



State of Connecticut Workers' Compensation Commission **Revised 10-01-2017**

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,

_____

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the commissioner may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name _____

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

Approved Medical Care Plan ☐ **Yes** ☐ **No**

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.

If your employer has listed a location below, you <u>MUST</u> file your compensation claim there.
When filing your claim, you are also required – by law – to send it by certified mail.

If blank below, ask your employer where to file your claim.

Employer Name _____

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted: _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).

State of Connecticut Workers' Compensation Commission

This form prepared by the WCC is proper for ordinary use and is recommended, but any other notice complying with Section 31-294c shall be deemed sufficient.

Rev. 07-01-2019

30C

Notice of Claim for Compensation

(Employee to Commissioner and to Employer)

Notice is hereby given that the injured worker, while in the employ of the employer, sustained injuries arising out of and in the course of his/her employment as follows, and makes claim for compensation benefits.

Please TYPE or PRINT IN INK

WCC File #

Date filed in District

(for WCC use only)

INJURED WORKER

Name _____
(first) *(middle)* *(last)*

D.O.B. *(required)* _____

Check, if a Minor ❑ *(under 18 yrs. of age)*

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

EMPLOYER

Employer _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

Was Injury ON Premises of Employer? ❑ YES ❑ NO

If NO, where? _____

Address _____

Town _____

Zip Code _____ Tel.# _____

INJURY

Date of Injury _____

Town of Injury _____

Body Part(s) _____

Describe Injury and How It Happened:

❑ Check, if an Occupational Disease or a Repetitive Trauma

❑ Check, if you have MORE THAN ONE Employer

❑ Check, if PTSD pursuant to P.A. 19-17 (police officer, parole officer, firefighter)

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

Signature _____

Date _____

Print name & address below, if other than injured worker:

Name _____

Name of Firm _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

This notice must be served upon the Commissioner and *Employer by personal presentation or by registered or certified mail. For the protection of both parties, the employer should note the date when this notice was received and the claimant should keep a copy of this notice with the date it was served.

* *Persons employed by the State of Connecticut must serve the employer by serving this notice upon the Commissioner of Administrative Services, 450 Columbus Boulevard, Hartford, CT 06103.*

* *Persons employed by a municipality must serve the employer by serving this notice upon the town clerk of the municipality in which he or she is employed.*

* *If your employer pursuant to statute has posted the location where this notice is to be filed, it is your obligation to file it at that location, using certified mail.*

WARNING: If an employer does not file a notice contesting liability (e.g. Form 43) for this claim OR begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date when this claim is received by personal delivery or by registered or certified mail, COMPENSABILITY SHALL BE PRESUMED and cannot thereafter be contested. If an employer chooses to begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date of receipt of this claim and still wishes to contest this claim, it must do so by filing a notice contesting liability for this claim within one year from receipt of this claim [See Sec. 31-294c(b)] OR, in the case of a claim for PTSD pursuant to P.A. 19-17, within 180 days.

A 30C Form should be filed promptly after a work-related injury or illness takes place. There is a statute of limitation for filing workers' compensation claims: within **one** year of the date of an accidental injury or within **three** years from the first manifestation of a symptom of an occupational disease.

[**NOTE**: If, within the applicable time period described above, (1) there has been a hearing or a written request for a hearing or an assignment for a hearing or (2) your employer's insurance carrier has already signed a Voluntary Agreement, you do **NOT** need to file a 30C Form for the injury or illness it covers.]

You Should File A 30C Form Because . . .

- There will be no doubt that you are claiming that you have a work-related injury or occupational disease.
- It is the best way to insure that you have met the statute of limitations for filing a workers' compensation claim.
- A simple "accident report" filed with the employer is not an official claim for workers' compensation.
- Your claim will be more likely to receive prompt attention from your employer or insurance carrier.
- Once your employer receives an official claim, they have only 28 calendar days in which to either deny your claim or to begin making workers' compensation benefit payments "without prejudice." If an official denial is not issued within 28 calendar days or if benefit payments are not initiated within 28 calendar days, your employer must accept the compensability of your claim. (If your employer has opted to post a location where you must file your claim, this 28-day period begins when your employer has received your claim *at the location posted* per statute.)

Directions for Completing the 30C Claim Form

Please pay close attention to these directions. Remember to Type or Print Neatly In Ink (except for signatures).

In filling out the 30C Form, please note the following:

1. **In the "INJURED WORKER" box** at the upper left side of the form, **type or neatly print the name of the injured worker (If YOU are the injured worker, print YOUR name here.). Also fill in the injured worker's D.O.B.** (date of birth), **put a check in the box if the worker is a minor** (under the age of 18), **and fill in the injured worker's street address, town, state, zip code, and telephone number**.
2. **In the "EMPLOYER" box** at the lower left side of the form, **type or neatly print the name of the employer** ("Name of employer" means the name of the organization for which you work, NOT your boss or supervisor.) **and its street address, town, state, zip code, and telephone number**. **Next indicate** (YES or NO) **whether the injured worker's injury occurred at the employer's location just listed; *if the injury took place at a location other than that listed*, fill in the location, street address, town, state, zip code, and telephone number where the injury actually occurred**.
3. **In the "INJURY" box** at the upper right side of the form, **type or neatly print the date of the injured worker's injury and the town in which the injury occurred** (Note the city or town in which the injury actually occurred. This will not necessarily be the same location as the employer's business address!). I**ndicate the part(s) of the worker's body injured and how the injury occurred** (In the blank space describe your injury in simple terms, specifying the part(s) of your body affected and the type(s) of injury. For example: "sprain to the right shoulder", "amputation of the left thumb", "fracture of the right ankle", "severe strain to lower back", etc.). **Next check the first box**, *if the injury is an occupational disease or a repetitive trauma*, **check the second box** *if you have more than one employer*, **and check the third box** *if you are a police officer, parole officer, or firefighter claiming benefits for PTSD pursuant to Public Act 19-17*.
4. **In the "SIGNATURE OF INJURED WORKER OR REPRESENTATIVE" box** at the lower right side of the form, **sign your name and fill in the date of your signature, if you are the injured worker. *If you are NOT the injured worker*, then sign your name, fill in the date of your signature, and then type or neatly print your name, the name** (if any) **of your firm, your street address, town, state, zip code, and your telephone number**.
5. **In the "WCC File #" box** at the upper right side of the form (just below the "30C" number in the upper right corner), **type or neatly print the WCC File Number, ONLY IF YOU KNOW IT**. In most instances, this number will be assigned to your claim by the Workers' Compensation Commission only after you send the 30C Form in, so **it is okay to leave this one area of the form blank, if you are not absolutely sure of the number**.

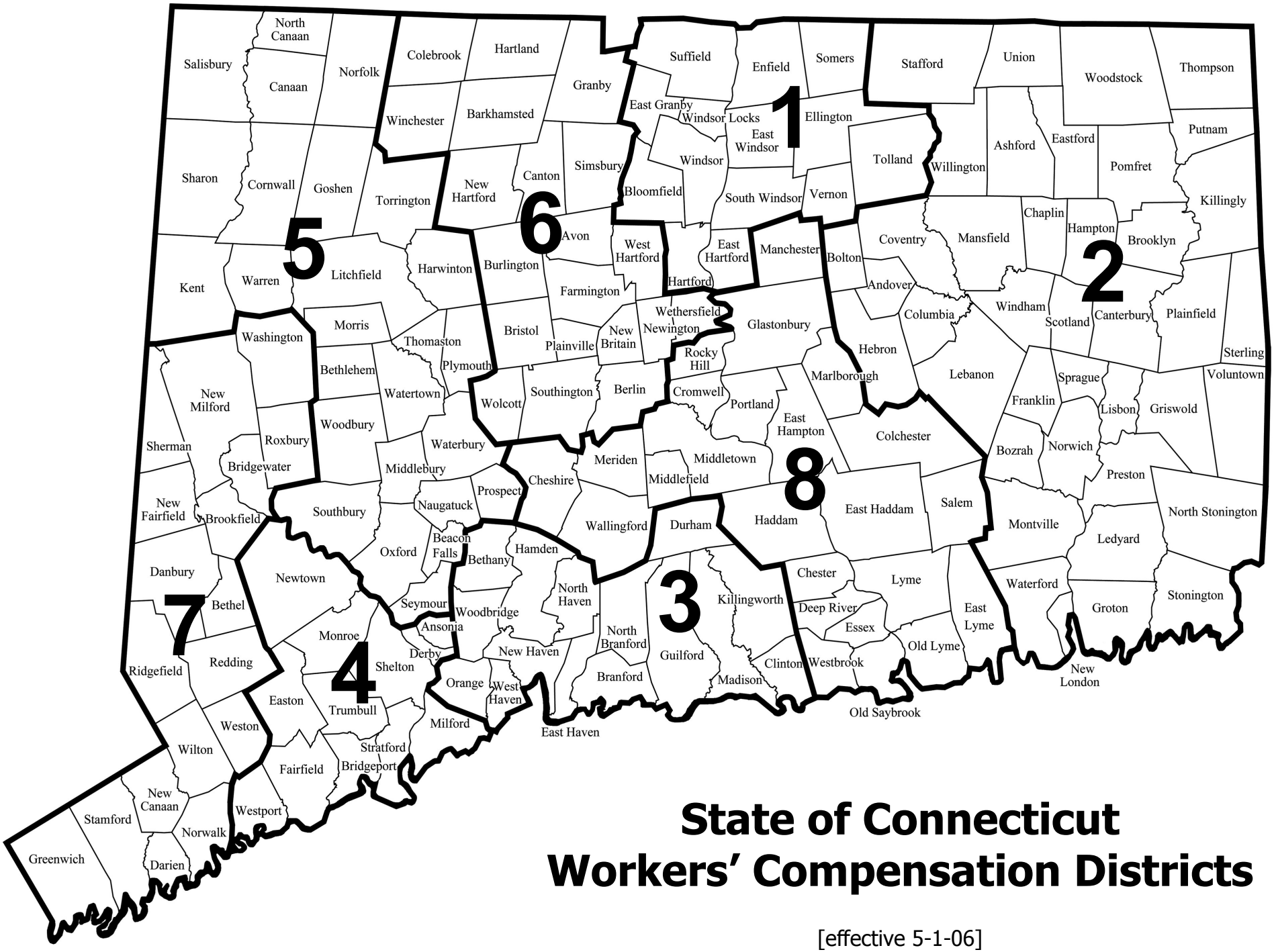
Once you have completed the 30C Form, follow these procedures:

6. **Make two (2) extra copies of your completed 30C Form** (this can be done at many quick-copy printers).
7. **Send the original 30C to your employer* by Certified or Registered mail, return receipt requested. The claim may also be delivered in person but if so, have the employer acknowledge in writing the receipt of the claim.**

   **** State employees**' work-related injuries and illnesses are reported on Form PER-WC 207, entitled "Report of Occupational Injury or Disease to an Employee". If a State employee elects to file a 30C Form, then he or she must send the 30C Form to the Commissioner of Administrative Services, 450 Columbus Boulevard, Hartford, CT 06103, NOT to the particular office where employed. (The Form PER-WC 207 is ONLY an accident report and is NOT the official claim form for workers' compensation benefits — State employees, like any other employees, must file a 30C Form in order to file an official workers' compensation claim.)*

   **** Municipal employees**, like any other employees, must file a 30C Form in order to file an official workers' compensation claim; if a municipal employee elects to file a 30C Form, then he or she must send the 30C Form to the town clerk of the municipality in which he or she is employed.*

   **** Employees (other than State or municipal employees):** if your employer pursuant to statute has posted the location where you must file a 30C Form, it is your obligation to file it at that location, using certified mail.*
8. **Send a copy of the 30C to the appropriate Workers' Compensation Commission District Office by Certified or Registered mail, return receipt requested, or deliver by personal presentation.** Addresses for all Workers' Compensation Commission District Offices may be found in this packet of material. **The "District Office"refers to the number given to the District Workers' Compensation Commission Office for the town in which you were injured**. Refer to the Connecticut map provided with the Form 30C for the number of the Compensation District for the town in which you were injured.
9. **Keep the remaining copy of the 30C for your own file.**



State of Connecticut
Workers' Compensation Districts

[effective 5-1-06]

Workers' Compensation Commission District Offices

District 1 — Hartford

999 Asylum Avenue
Hartford, CT 06105

Phone: (860) 566-4154
Fax: (860) 566-6137

District 2 — Norwich

55 Main Street
Norwich, CT 06360

Phone: (860) 823-3900
Fax: (860) 823-1725

District 3 — New Haven

700 State Street
New Haven, CT 06511-6500

Phone: (203) 789-7512
Fax: (203) 789-7168

District 4 — Bridgeport

350 Fairfield Avenue
Bridgeport, CT 06604

Phone: (203) 382-5600
Fax: (203) 335-8760

District 5 — Waterbury

55 West Main Street
Waterbury, CT 06702

Phone: (203) 596-4207
Fax: (203) 805-6501

District 6 — New Britain

24 Washington Street
New Britain, CT 06051

Phone: (860) 827-7180
Fax: (860) 827-7913

District 7 — Stamford

111 High Ridge Road
Stamford, CT 06905

Phone: (203) 325-3881
Fax: (203) 967-7264

District 8 — Middletown

90 Court Street
Middletown, CT 06457

Phone: (860) 344-7453
Fax: (860) 344-7487

Mileage Worksheet for Medical Treatment — Examination — Physical Therapy — Laboratory Test

[Section 31-312 C.G.S.]

Rev. 3-17-2006

Employee Name _____ Date of Injury _____ Claim # _____

(Please TYPE or PRINT IN INK)

Employer Name _____

DATE: Month / Day / Year	FROM: City / Town , State	TO: City / Town , State	REASON FOR VISIT — NAME OF PHYSICIAN or Other Health Care Provider	ROUND-TRIP MILEAGE:
____/____/____				
____/____/____				
____/____/____				
____/____/____				
____/____/____				

DATE SUBMITTED _____

TOTAL MILEAGE = _____

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 formulario 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
Dominicks
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
Pathmark
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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