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# **Claims Manual**

***WISDOT US 41 Corridor Project***

**Owner Controlled Insurance Program  
(OCIP)**

***February 27, 2009***



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## ***I. CLAIMS ADMINISTRATION TEAM***

### **Insurance Carrier Claim Contacts**

#### **Workers Compensation**

**Victoria Marrs** – Team Leader  
ESIS Chicago WC  
PO Box 31109  
Tampa, FL 33631-3109  
Telephone: 312-775-7860  
Fax: 800-230-4866  
[Victoria.marrs@esis.com](mailto:Victoria.marrs@esis.com)

#### **General Liability**

**Maritza Castro** – Team Leader  
Chicago General Liability Claims  
PO Box 31090  
Tampa, FL 33631-3090  
Telephone: 312-775-7809  
Fax: 800-231-8506  
[Maritza.castro@esis.com](mailto:Maritza.castro@esis.com)

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#### **Builder's Risk**

**Bill Bartkowski**  
Claims Manager  
Aon Risk Services  
330 East Kilbourn Avenue  
Milwaukee, WI 53202  
Telephone: 414-225-5375  
Cell Phone: 414-336-4843  
Fax: 414-225-7413  
[Bill\\_bartkowski@ars.aon.com](mailto:Bill_bartkowski@ars.aon.com)

RSUI Group, Inc.  
Attn: Claims Department  
945 E. Paces Ferry Road  
Suite 1800  
Atlanta, GA, 30326-1160  
Fax: 404-264-7239  
[reportclaims@rsui.com](mailto:reportclaims@rsui.com)

## ***CLAIMS ADMINISTRATION TEAM - continued***

### **Aon Contacts**

#### **Workers Compensation**

**Christine Green**

Claims Manager  
Aon Risk Services  
200 East Randolph  
Chicago IL 60601  
Telephone: 312-381-2458  
Cell Phone:  
Fax: 312-381-0290  
[Christine\\_green@ars.aon.com](mailto:Christine_green@ars.aon.com)

#### **General Liability**

**Bill Bartkowski**

Claims Manager  
Aon Risk Services  
330 East Kilbourn Avenue  
Milwaukee, WI 53202  
Telephone: 414-225-5375  
Cell Phone: 414-336-4843  
Fax: 414-225-7413  
[Bill\\_bartkowski@ars.aon.com](mailto:Bill_bartkowski@ars.aon.com)

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### **OCIP Safety Contacts**

**TBD** Safety Manager  
Highway 41 Field Office  
2905 Universal Drive  
Oshkosh, WI 54904  
Telephone: **TBD**  
Cell Phone: **TBD**  
Fax: **TBD**

**Rick Barton**

Technical Services. Aon Risk Services  
330 East Kilbourn Avenue  
Milwaukee, WI 53202  
Telephone: 414-225-5377  
Cell Phone: 414-331-2938  
Fax: 414-225-7413  
[rick\\_barton@ars.aon.com](mailto:rick_barton@ars.aon.com)

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### **WISDOT OCIP Claim Contacts**

**Damien Barr**

Manager of Risk Management  
Section Chief for Risk, Safety & Facilities  
Wisconsin Department of Transportation  
Telephone: 608-267-7722  
Cell: 608-206-2634  
[Damien.Barr@dot.state.wi.us](mailto:Damien.Barr@dot.state.wi.us)

**Kevin Gehrman**

OCIP Project Manager  
Department of Transportation  
Cell Phone: 608-235-0622  
Fax: 608-267-4892  
[Kevin.gehrman@dot.state.wi.us](mailto:Kevin.gehrman@dot.state.wi.us)

## **II. WORKER'S COMPENSATION CLAIM REPORTING INSTRUCTIONS/PROCEDURES:**

1. The **EMPLOYER** of the injured worker must notify the OCIP Safety Manager:

**TBD**  
Highway 41 Field Office  
2905 Universal Drive, Oshkosh, WI 549047  
Telephone: **TBD**  
Cell: **TBD**  
Fax: **TBD**

of any on-site injury or occupation-related illness immediately following knowledge of the injury/illness. Any accidental injury and occupational illness needs to be reported regardless of how minor, including only first aid treatment cases. **Failure to report an injury/illness to the OCIP Safety Manager will be considered a violation of project safety rules and regulations, and as such, monetary penalties may be imposed on the EMPLOYER.**

- **In an emergency situation**, contact the appropriate medical personnel and OCIP Safety Manager and stay with injured worker until help arrives.
2. The injured worker and his/her **EMPLOYER** must provide the OCIP Safety Manager with the factual information required to make the required notification to the insurer. See Exhibit C for a blank example of the Wisconsin Employer's First Report of Injury or Disease and Exhibit H for a fax cover sheet. **Each EMPLOYER needs to complete the Wisconsin First Report of Injury report and provide this form to the OCIP Safety Manager on a timely basis.**
  3. **The Wisconsin Department of Transportation (WisDOT) is committed to a drug-free project. Drug testing will be performed on any accident or injury that occurs on the OCIP project.** Please refer to the separate drug policy in the Safety & Health Program Manual for specific details. A positive drug test will have adverse consequences to the involved employee. For example, if an employee has a positive drug test, for the first offense, he/she must be immediately removed from OCIP work and will be barred from any further work on this OCIP for a period of sixty (60) calendar days. Drug testing will be administered at a designated medical facility.
  4. The OCIP Safety Manager will provide notification to the insurer ACE Insurance Company and the third party administrator (ESIS, Inc.). This relieves the **EMPLOYER** of its responsibility to notify ESIS.

## **WORKERS COMPENSATION CLAIMS – continued**

5. For informational purposes, ESIS contracts with a third party, First Notice (FNS), to provide a toll-free telephone number dedicated to this OCIP for reporting injury/illness claims. The FNS facility is operational daily, 24 hours per day. FNS electronically feeds the loss information to ESIS's claim handling system.
6. At the time of the initial report, the OCIP Safety Manager will report to FNS the location code assigned to the involved **EMPLOYER** so that loss experience may be properly tracked.
  - Aon provides each **EMPLOYER'S** location code along with the OCIP enrollment materials.
7. If an injured worker needs off-site medical care, the **EMPLOYER** will prepare the Site Treatment Authorization Form (Exhibit A) to accompany the injured worker to a designated medical facility. This form expedites the treatment process, providing pertinent information needed by the medical provider, and starts the tracking process regarding the worker's return to work. The treating doctor will complete this Site Treatment Authorization Form and advise the treated worker to return the form to the OCIP Safety Manager, along with pertinent comments.
8. WisDOT has **MANDATORY RETURN TO WORK** provisions for each enrolled **EMPLOYER**. Please refer to the separate Safety & Health Program Manual for specific details. Each **EMPLOYER** must provide an injured worker the opportunity to maximize rehabilitation and enable his/her early return to work by accommodating temporary alternate work assignments in compliance with medical restrictions. **Monetary penalties may be imposed upon an EMPLOYER for each violation of mandatory return to work provisions.**
9. Upon receipt of the claim-intake information from FNS, ESIS's Workers' Compensation team leader reviews the claim and assigns it to the Claim Representative. ESIS will further generate the first report of injury to the Wisconsin Department of Workforce Development, providing copies to the involved **EMPLOYER**, Aon and WisDOT.
10. On all lost time claims, ESIS's Claim Representative will attempt to make four-point contacts within 24 hours from date of claim receipt, involving the injured worker, the OCIP Safety Manager, off-site treating medical provider(s) and the **EMPLOYER**. The designated ESIS Claims Representative will manage the claim.

11. In the event of serious accident/injury, contact the OCIP Safety Manager. OCIP Safety Manager will contact ESIS's Workers' Compensation Team Leader to report the matter, along with WISDOT and the Wisconsin Department of Workforce Development.  
Examples of a serious injury include:
  - Fatalities
  - Catastrophic, disabling injuries to back or limbs
  - Serious fractures—compound fractures
  - Serious lacerations (dismemberment, amputation or disfiguring injuries)
  - Neck and/or spinal cord injuries with known, suspected or possible paralysis
  - Loss of consciousness or head trauma with possible brain damage
  - Serious burns
  - Major bleeding due to lacerations
  - Any injury for which an ambulance is called
12. On a monthly basis, the OCIP Administrator will make available copies of loss summaries to the prime contractors that have claim activity. Each prime contractor will be responsible for distribution of the claim activity of their sub-contractors. This information will enable each enrolled **EMPLOYER** to review losses associated with their work.
  - The claim summaries allow each enrolled **EMPLOYER** to timely review their claims and advise of any coding or other changes need to be made to avoid inaccurate reporting of claims to the National Council on Compensation Insurance (NCCI) impacting future Workers' Compensation experience ratings. Any coding or other data errors should be promptly reported to the on-site OCIP Administrator.
  - ACE Insurance Company will report all Workers' Compensation claims to NCCI in accordance with regulatory guidelines.
13. Like any insurance program, each **EMPLOYER** needs to cooperate with ESIS by providing information, documents and investigative files deemed necessary by ESIS to resolve a claim.
14. Any suspicious or questionable claim should immediately be brought to the attention of ESIS's designated Claim Representative, along with supporting facts and documentation. Take the time to provide the ESIS investigator with as much information as possible.

15. Medical providers should be instructed to directly bill ESIS for treatment:

**ESIS Chicago WC  
P.O. Box 31109  
Tampa, FL 33631-3109**

If a medical billing relating to a covered injury is directed to either the EMPLOYER or injured worker, the original medical bill including the Claim Number should be sent to the Highway 41 OCIP Administrator:

**Highway 41 Field Office  
2905 Universal Drive  
Oshkosh, WI 54904  
Telephone: TBD  
Fax: TBD**

**Note:** The following information should be put on every medical bill for prompt processing:

- WisDOT US 41 Corridor OCIP
- Claim Number & Policy Number
- Name & Social Security Number of INJURED WORKER (e.g., John Smith)
- Name of EMPLOYER (e.g. Concrete Inc.)



### **III. GENERAL LIABILITY CLAIM REPORTING INSTRUCTIONS/PROCEDURES:**

1. The enrolled Party (**CONTRACTOR OR SUBCONTRACTOR**) who causes damage to a third-party or is aware of or suspects that a claim will be forthcoming as a result of activity on the project, must immediately notify the OCIP Safety Manager:

**TBD**

**Highway 41 Field Office**

**2905 Universal Drive, Oshkosh WI 54904**

**Telephone: TBD**

**Cell: TBD**

**Fax: TBD**

2. The **CONTRACTOR OR SUBCONTRACTOR** aware of, causes or is alleged to have caused any third-party damage or injury must assemble the necessary information for a General Liability claim **within 24 Hours following notice of any incident/accident.** Please complete the General Liability Acord form (Exhibit G) and provide this form to the OCIP Safety Manager.
3. The **CONTRACTOR OR SUBCONTRACTOR** must communicate the required information to both ESIS and the OCIP Safety Manager within the above time frame. **Telephonic notices are strongly recommended to avoid delays in claim processing / investigation.**
4. WisDOT is committed to a drug-free project. Drug testing will be performed on all employees of enrolled **CONTRACTOR OR SUBCONTRACTOR** involved in an accident/incident that produces or may produce a general liability claim. Post Accident drug screening will take place at a designated medical facility.
5. To the extent payments are made under the General Liability coverage of this OCIP, including court costs, attorney's fees, and costs of defense, which are attributable to a **CONTRACTOR'S OR SUBCONTRACTOR'S** work, acts or omissions, including any other entity for whom **CONTRACTOR OR SUBCONTRACTOR** may be responsible, WisDOT is due the sum of up to \$10,000 per occurrence.
6. For informational purposes, ESIS contracts with a third party, First Notice (FNS), to provide a toll-free telephone number dedicated to this OCIP for reporting General Liability claims. The FNS facility is operational daily, 24 hours per day. FNS electronically feeds the loss information to ESIS's claim handling system.
7. Upon receipt of the claim-intake information from FNS, ESIS's General Liability Team Leader reviews the claim and then assigns it to the Claims Representative.

## **GENERAL LIABILITY CLAIM REPORTING – *continued***

8. ESIS's Claim Representative will attempt contact with the claimant within 24 hours from date of claim receipt. The ESIS Claims Representative will manage the claim.
9. No OCIP coverage is provided for Automobile Liability insurance and Automobile Physical Damage insurance. It is the sole responsibility of each **CONTRACTOR OR SUBCONTRACTOR** to report accidents/claims involving their own vehicles to their own insurers. However, all motor vehicle accidents within the footprint of the OCIP project must be immediately reported to the OCIP Safety Manager. Accident investigations will occur and focus upon liability issues arising out of ongoing construction activities that could result in claims being asserted (i.e., due to conditions of the roads, barricading, flagging, etc.). Each **CONTRACTOR OR SUBCONTRACTOR** must cooperate in the investigation of each such accident.
10. Never admit liability or responsibility to any third party in the accident investigation process.
11. In the event of serious damage and/or injury, immediately contact the OCIP Safety Manager.

Examples of a serious injury and damage include:

- Serious Bodily injury — same as the Workers' Compensation claim reporting instructions.
  - Water damage — flooding due to broken water/sprinkler lines, connections and pipes.
  - Structural damage to buildings or infrastructure caused by work means & methods of **CONTRACTOR'S OR SUBCONTRACTOR'S** operations.
  - Claims causing an exposure for business interruption or an unscheduled disruption of any public/private utility services.
12. Like any insurance program, each enrolled **CONTRACTOR OR SUBCONTRACTOR** needs to fully cooperate with ESIS in providing whatever information, documents and investigative files are deemed necessary by ESIS to resolve a claim.
  13. Any suspicious or questionable claim should immediately be brought to the attention of ESIS's designated claim representative, along with supporting facts and documentation.

#### **IV. BUILDER'S RISK CLAIM REPORTING/PROCEDURES:**

*(Note: The Builder's Risk coverage is not a part of the OCIP program; it is a separate insurance coverage.)*

1. All risk of direct physical loss or damage to OCIP property, including flood and earthquake but excluding mold and defective workmanship, is generally covered by the Builder's Risk policy. There is a \$25,000 per occurrence obligation (deductible) that applies to all Builder's Risk claims.
2. Any insured party having knowledge of such loss must immediately notify the OCIP Safety Manager:

**TBD**  
**Highway 41 Field Office**  
**2905 Universal Drive, Oshkosh WI 54904**  
**Telephone: TBD**  
**Cell: TBD**  
**Fax: TBD**

within 24 hours following knowledge of such loss. The initial report of such loss should include the following information:

- The date of the loss?
  - How did insured first obtain knowledge/ information regarding the loss?
  - At what specific location or segment did the loss occur?
  - What event or accident may have caused or contributed to the loss?
  - Explain how the Incident occurred?
  - Provide the names, addresses, telephone numbers and other contact information for all persons who have firsthand knowledge of the loss. Loss investigators will need this information to further investigate the loss.
3. As soon as practicable, the involved party should complete the Acord form for property damage and fax such information to 404-264-7239. The attachment section below has the Acord Property Loss Notice form.
  4. WisDOT is committed to a drug-free project. Drug testing will be performed on all employees of enrolled **CONTRACTORS OR SUBCONTRACTORS** involved in such loss. Drug testing will be administered at all designated medical facilities.
  5. The carrier will use the provided information to notify the insurance carrier, RSUI, of the loss. Bill Bartkowski will be the primary contact person for the builder's risk carrier, RSUI.

## V. CLAIM INVESTIGATION:

It is important to promptly conduct each investigation while the information is readily available. Memories will be fresh and pertinent facts will be readily visible and available. These efforts are critical to avoid or minimize potential liability. Litigation or claims may arise many years after an accident/injury.

Because accidents/injuries can occur for a variety of reasons, it is important to investigate occurrences and to use such efforts to prevent future occurrences. This allows needed revisions to be made to construction procedures and remedial actions to be taken. If the investigation is haphazard or incomplete, the future effects may be serious injury or death, not to mention economic losses.

Investigations should not be one-dimensional. A successful investigation is accomplished by utilizing several different tools simultaneously. As examples, one may wish to consider the following:

1. Secure the accident scene for serious injury/accident for possible investigation by outside investigators, including insurer personnel. The notice requirements necessitate such investigations.
2. Obtain the names and secure written statements from any witnesses who have firsthand information regarding an accident/injury. Any written report should be as thorough and descriptive as possible. Memories fade, people forget and recollections change. If you cannot obtain names, note who was present at the accident scene in written documentation.
3. Background facts and general information:
  - Who, what, where, when, how and why? Answer these questions regarding an accident/injury and its cause. Do not speculate - advise known facts only.
  - Involvement of **CONTRACTOR'S OR SUBCONTRACTOR'S** personnel before or during the accident/injury.

## ***CLAIM INVESTIGATION – continued***

4. What happened to cause the accident/injury?
  - Describe the event, not just the damage.
  - If the event is complicated, explain the specific steps that lead to the event. When explaining, assume that the people to you are communicating to are ignorant of the event and knows nothing about the location of the accident/injury.
  - A diagram/field sketch can aid in showing what happened after a complex incident. The diagram can show the approximate location of the Project's facilities from the accident site; damage to the Project's facilities; geographic orientation; other facilities that may have contributed to accident/injury; approximate locations of witnesses; and identification of photographs. **The diagram/field sketch should be dated and signed by its preparer.**
  - Photographs are very useful to document conditions, evidence locations, spatial arrangements and many other aspects related to investigations. Pictures should be taken from different angles. The photographer needs to record: (1) what each photograph is intended to show; (2) the direction from which each photograph was taken; and (3) numbering or coding system identifying the various photographs. **The photographs should be dated and signed by the photographer.**

## VI. MEDICAL

**THE BELOW INFORMATION WILL BE OCIP PROJECT SPECIFIC**

1. **Occupational Medicine:**

Aurora BayCare Health Center  
2253 W. Mason  
Green Bay, WI 54303  
Main Telephone Number: 920-327-7300

Aurora BayCare Center  
1881 Chicago Street  
De Pere, WI 54115  
Main Telephone Number: 920-403-8000

Aurora BayCare Medical  
2845 GreenBrier Rd  
Green Bay, WI 54311  
Main Telephone Number: 920-288-8100

Aurora Health Center  
855 N. Westhaven  
Oshkosh, WI 54904  
Main Telephone Number: 920-303-8750

**2. Hospitals:**

Aurora Medical Center  
855 N. Westhaven  
Oshkosh, WI  
Main Telephone Number: 920-456-6000

Aurora BayCare Medical Center (Level Two Trauma)  
2945 Greenbrier  
Green Bay WI 54311  
Main Telephone Number: 920-288-8000

**3. Level One Trauma:**

Froedtert Hospital  
9200 West Wisconsin Ave.  
Milwaukee WI 53226-3596  
Main Telephone Number: 414-805-3000  
Admissions: 414-805-5100

## VII. LITIGATION

**CONTRACTORS OR SUBCONTRACTORS** should immediately forward all summons, notice of hearings, and complaints to the proper insurer. Copies of such materials should also be faxed to the Aon contact identified in the CLAIMS ADMINISTRATION TEAM.

Contact information by line of coverage (insurer) is as follows:

1. **Workers' Compensation:**

ESIS Chicago WC  
Attn: Victoria Marrs  
Workers Compensation Team Leader  
P. O. Box 31109  
Tampa, FL 33631-3109  
Direct Telephone Number: 312-775-7860  
Fax Number: 800-230-4866

2. **General Liability:**

ESIS Chicago APL  
Attn: Maritza Castro  
General Liability Team Leader  
P.O. Box 31090  
Tampa, FL 33631-3090  
Direct Telephone Number: 312-775-7809  
Fax Number: 800-231-8506

3. **Builder's Risk:**

Bill Bartkowski  
AON Risk Services  
330 East Kilbourn Avenue  
Milwaukee, WI 53202  
Direct Telephone Number: 414-225-5375  
Fax Number: 414-225-7413  
Cell: 414-336-4843



## ***VIII. APPENDIX***

Exhibit A – Site Treatment Form

Exhibit B – Workers' Compensation Claim Form - ACE

Exhibit C – Work Comp: Employer's First Report of Injury - WI

Exhibit D – Medical Facilities

Exhibit E – Workers Comp Incident Investigation

Exhibit F – Flow Chart

Exhibit G – General Liability First Report of Injury

Exhibit H – Acord Property Loss Form

Exhibit I – Fax Cover Sheet



## WisDOT US 41 Corridor Site Treatment Authorization

Contractor Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Project Contact Name & Phone #: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

Type of Injury/Illness Sustained: \_\_\_\_\_

***THIS COMPLETED FORM MUST BE RETURNED TO THE PROJECT BY THE  
EMPLOYEE SO HE/SHE CAN RETURN TO WORK***

This certifies that the above named individual is employed on an Owner Controlled Insurance Program Project. Workers Compensation coverage is provided by **ACE USA**. Please provide appropriate evaluation and treatment, and bill to the address below. **Post-accident drug screening is required for all covered workers seeking medical evaluation/treatment. Return To Work Program in-place; employers expected to provide light/restricted duty work.**

Site Approval (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Site Approval Signature: \_\_\_\_\_

### THIS SECTION MUST BE COMPLETED BY THE ATTENDING PHYSICIAN

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

1. Is the Employee able to return to work?  
Full Duty \_\_\_\_\_ Restricted Duty \_\_\_\_\_ Total Disability \_\_\_\_\_  
If restricted duty was selected, briefly describe restrictions: \_\_\_\_\_  
\_\_\_\_\_
2. Will employee require any follow up treatment? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes was selected, when is the next scheduled visit?  
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_ Est. # of follow up visits \_\_\_\_\_
3. I am aware of the restrictions placed on me by the treating Physician:

Employees Name (Please print): \_\_\_\_\_

Employees' Signature: \_\_\_\_\_

Physicians' Name (Please print): \_\_\_\_\_

### Bills should be sent to:

ACE USA  
RE: US 41 Corridor OCIP  
P.O. Box 31109  
Tampa, FL 33631-3109

### Questions should be referred to:

312.775.7860  
Victoria Marrs, Team Leader



# WORKER'S COMPENSATION CLAIM FORM

Please fax to 866-300-8206 or email to [esis\\_FNOL@firstnotice.com](mailto:esis_FNOL@firstnotice.com)

**WisDOT US 41 Corridor**

**Dedicated 800-Number -TBA**

Date of Loss:	Time of Loss:	am <input type="checkbox"/>	pm <input type="checkbox"/>
Type: (select one)	Claim <input type="checkbox"/>	Record Only <input type="checkbox"/>	
Employers Policy #:	Location/Site Code:		
Employers (Contractor) Name:			
Carrier Name: ACE USA	Policy Eff:	Exp:	

## Caller Information:

Name:		
Address:		
City/St/Zip:		
Work Phone#:	Cell Phone #:	
Fax #:	E-Mail:	
Job Title:	Department:	
<input type="checkbox"/> Insured	<input type="checkbox"/> Employee/Claimant	<input type="checkbox"/> Agent
<input type="checkbox"/> Attorney	<input type="checkbox"/> 3 <sup>rd</sup> Party Representative of Claimant	
<input type="checkbox"/> First Script Referral	<input type="checkbox"/> Clinic Referral	<input type="checkbox"/> Other
Special Type of Claim:	<input type="checkbox"/> None	<input type="checkbox"/> Longshore
<input type="checkbox"/> <b>OCIP</b>	<input type="checkbox"/> Defense Based	<input type="checkbox"/> Continental Shelf
<input type="checkbox"/> Non-Appropriated Funds		<input type="checkbox"/> Foreign

## Corporate Information:

Entity Name:	
Address:	
City/St/Zip:	
Work Phone#:	Fax #:

## Employer Information: (injured workers direct employer)

Name:		
Address:		
City/St/Zip:		
Phone#:	Ext:	Fax #:
E-Mail :		
FEIN #:	State Unemployment ID #:	
SIC (Standard Industry Code):		

## Loss Location:

<b>Benefit State Applicable:</b>
Project Name:
Address:
City/St/Zip:



# WORKER'S COMPENSATION CLAIM FORM

Please fax to 866-300-8206 or email to [esis\\_FNOL@firstnotice.com](mailto:esis_FNOL@firstnotice.com)

**WisDOT US 41 Corridor**

**Dedicated 800-Number -TBA**

## Employee Information:

First Name:		Last Name:	
Home Address:			
City/St/Zip:			
Home Phone #:		Work Phone#:	Ext:
Cell Phone #:		E-Mail Address:	
Social Security #:		Employee ID #:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown			
Total Dependents:		Date of Birth: / / Age:	
Height:		Weight:	
Job Class Code:		Job Title:	Department:
Supervisor First Name:		Last Name:	
Supervisor Phone #:		Cell #:	
Supervisor E-Mail:			
<b>Pre-Existing Conditions:</b>			
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Obesity			
<b>Do You Question the Validity of this Claim?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			

## Employment Information:

Hire Date: / /		Hire State:	State Hire Date: / /	
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Apprenticeship Part Time <input type="checkbox"/> Apprenticeship Full Time				
<input type="checkbox"/> Disabled <input type="checkbox"/> Laid Off <input type="checkbox"/> Not Employed or Unemployed <input type="checkbox"/> On Strike				
<input type="checkbox"/> Other/Unknown <input type="checkbox"/> Piece Worker <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal				
<input type="checkbox"/> Volunteer <input type="checkbox"/> Terminated				
<input type="checkbox"/> Hourly Wage \$ _____/hour <input type="checkbox"/> Salary \$ _____/year				
<input type="checkbox"/> Variable Wage \$ _____ Type of Variable: _____				
Hours worked per day:		Days worked per week:		
Other Payments not reported as wages/salary:				
Was employee Drug Tested After Incident? <input type="checkbox"/> No <input type="checkbox"/> Yes				

## Lost Time & Return to Work Information:

Did the Employee Miss Work Beyond Their Normal Shift:	
<b>If Yes to LT answer these Questions:</b>	
Last Date Worked: / / Disability Date: / /	
Paid in Full for the Day of Injury: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Did the Salary Continue After the Injury: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Last Date Employee Paid Through: / /	
Did the Employee Return to Work: <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>If Yes to RTW answer these Questions:</b>	



# WORKER'S COMPENSATION CLAIM FORM

Please fax to 866-300-8206 or email to [esis\\_FNOL@firstnotice.com](mailto:esis_FNOL@firstnotice.com)

**WisDOT US 41 Corridor**

**Dedicated 800-Number -TBA**

Number of Lost Days:	
Does EE have Release to Return to Work:	<input type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, Release Date:     /     /	
Return to Work Date:     /     /	Return to duty at: <input type="checkbox"/> Full <input type="checkbox"/> Light
If Light Duty, Paid Full Wages:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Return to Work at Regular Occupation:	<input type="checkbox"/> No <input type="checkbox"/> Yes
If No, Return to Work Occupation: _____	
Return to Work at Same Wage:	<input type="checkbox"/> No <input type="checkbox"/> Yes
If no, Return to Work Wage: \$ _____ Per: _____	
Wage Period: _____	

## Incident Information:

Time Employee Began Work:     :     :	<input type="checkbox"/> am <input type="checkbox"/> pm
Scheduled Quit Time:     :     :	<input type="checkbox"/> am <input type="checkbox"/> pm
Employer Notified Date:     /     /	
Date Employer Knowledge of Disability:     /     /	
Department Where Injury Occurred:	
Activity Engaged in:	
Work Process:	
Accident/Injury Description:	
Were there any Witnesses: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Objects or Material Causing the Injury:	
Was Injury Caused by a Product:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Material Secured:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Safeguards/Safety Equipment:	
Provided <input type="checkbox"/> No <input type="checkbox"/> Yes     Used <input type="checkbox"/> No <input type="checkbox"/> Yes     Modified <input type="checkbox"/> No <input type="checkbox"/> Yes	

## Medical Treatment:

Medical Treatment: <input type="checkbox"/> None <input type="checkbox"/> Minor by Employer <input type="checkbox"/> Minor by Clinic/Hospital
<input type="checkbox"/> Medical Services other than First Aid <input type="checkbox"/> Injuries Beyond First Aid
<input type="checkbox"/> Emergency Care Hospitalized > 24 hours <input type="checkbox"/> Future Major Med/Lost Time
Admitted to Hospital: <input type="checkbox"/> No <input type="checkbox"/> Yes     Still in Hospital: <input type="checkbox"/> No <input type="checkbox"/> Yes
Transported Via Airlift or Emergency Vehicle: <input type="checkbox"/> No <input type="checkbox"/> Yes
History Work Related Injuries: <input type="checkbox"/> No <input type="checkbox"/> Yes     Attorney Involved: <input type="checkbox"/> No <input type="checkbox"/> Yes
Additional Treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, What Specialty: _____
More than two visits with Primary Care Physician: <input type="checkbox"/> No <input type="checkbox"/> Yes



# WisDOT US 41 Corridor

# EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

An employer subject to the provisions of ch. 102, Wis. Stats., shall, within one day after the death of an employee due to a compensable injury, report the death to the Department of Workforce Development (DWD) and to the employer's insurance carrier, if insured. In cases of permanent disability or where temporary disability results beyond the 3-day waiting period, an insured employer shall also notify its insurance carrier of a compensable injury or illness within 7 days after the injury or beginning of a disability from occupational disease related to the employee's compensable injury.

Insurance carriers and self-insured employers must report all compensable claims to DWD on this form, the EDI system, or the internet format within 14 days of the date of injury.

Department of Workforce Development  
**Worker's Compensation Division**  
 201 E. Washington Ave., Rm. C100  
 P.O. Box 7901  
 Madison, WI 53707-7901  
 Imaging Server Fax: (608) 260-2503  
 Telephone: (608) 266-1340  
 Fax: (608) 267-0394  
 http://www.dwd.state.wi.us/wc/  
 e-mail: DWDDWC@dwd.state.wi.us

The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay.  
 Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)]. (Please read the instructions on page 2 for completing this form)

EMPLOYEE	Employee Name (First, Middle, Last)		Social Security Number		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Employee Home Telephone No. ( ) -	
	Employee Street Address		City	State	Zip Code	Occupation	
	Birthdate	Date of Hire	County and State where accident or exposure occurred				
EMPLOYER	Employer Name UW-Milwaukee		WI Unemployment Insurance Account No. 6911180002		Self-Insured? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Nature of Business (specific product) Higher Education
	Employer Mailing Address P.O. Box 413		City Milwaukee	State WI	Zip Code 53201-0413	Employer FEIN 39 - 1805963	
	Name of Worker's Compensation Insurance Co. or Self-Insured Employer UW system OSLIP (State of WI)						Insurer FEIN 39 - 1805963
	Name and Address of Third Party Administrator (TPA) used by the Insurance Company or Self-Insured Employer N/A						TPA FEIN - N/A
WAGE INFORMATION	Wage at Time of Injury \$		Specify per hr., wk., mo., yr., etc.		In Addition to Wages, <input type="checkbox"/> Meals Check Box(es) if <input type="checkbox"/> Room		No. of Meals/wk. No. of Days/wk.
					Employee Received: <input type="checkbox"/> Tips		Avg. Weekly Amt. \$
	Is worker paid for overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, after how many hours of work per week?						
	For the 52 week period prior to the week the injury occurred, report below the number of weeks worked in the same kind of work, and the total wages, salary, commission and bonus or premium earned for such weeks.						
	No. of Weeks:	Gross Amount Excluding Tips: \$		If Piece-Work, No. of Hrs. Excluding Overtime:			
INJURY INFORMATION	Employee's Usual Work Schedule When Injured:		Start Time <input type="checkbox"/> AM <input type="checkbox"/> PM		Hours Per Day	Hours Per Week	Days Per Week
	Employer's Usual Full-Time Schedule For This Type of Work At Time of Employee's Injury:						
	Part-Time Employment Information:		Are there other part-time workers doing the same work with the same schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?			Number of full-time employees doing the same type of work:	
	Injury Date	Time of Injury AM PM	Last Day Worked	Date Employer Notified	<input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return		
	Did injury cause death? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Death	Was this a lost time or other compensable injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injury occur because of: <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Failure to Use Safety Devices <input type="checkbox"/> Failure to Obey Rules		
Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Name and Address of Treating Practitioner and Hospital:							
Case Number from the OSHA Log:							
Injury Description - Describe activities of employee when injury or illness occurred and what tools, machinery, objects, chemicals, etc. were involved.							
What happened to cause this injury or illness? (Describe how the injury occurred)							
What was the injury or illness? (State the part of body affected and how it was affected)							
Report Prepared By		Work Phone Number ( ) -		Position		Date Signed	

WKC-12-E (R. 02/2002)

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT



## EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

### MANDATORY INFORMATION

**In order to accurately administer claims, each of the following sections of this form must be completed.** The First Report of Injury will be returned to the sender if the mandatory information is not provided.

**Employee Section:** Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

**Employer Section:** Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

**Wage Information Section:** Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

**Injury Information Section:** Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.



## **MEDICAL FACILITIES:**

### 1. Occupational Medicine:

Aurora BayCare Health Center  
2253 W. Mason  
Green Bay, WI 54303  
Main Telephone Number: 920-327-7300

Aurora BayCare Center  
1881 Chicago Street  
De Pere, WI 54115  
Main Telephone Number: 920-403-8000

Aurora BayCare Medical  
2845 GreenBrier Rd  
Green Bay, WI 54311  
Main Telephone Number: 920-288-8100

Aurora Health Center  
855 N. Westhaven  
Oshkosh, WI 54904  
Main Telephone Number: 920-303-8750

### 2. Hospitals:

Aurora Medical Center  
855 N. Westhaven  
Oshkosh, WI  
Main Telephone Number: 920-456-6000

Aurora BayCare Medical Center (Level Two Trauma)  
2945 Greenbrier  
Green Bay WI 54311  
Main Telephone Number: 920-288-8000

### 3. Level One Trauma:

Froedtert Hospital  
9200 West Wisconsin Ave.  
Milwaukee WI 53226-3596  
Main Telephone Number: 414-805-3000  
Admissions: 414-805-5100

***SUPERVISOR'S WORKERS' COMPENSATION INCIDENT INVESTIGATION REPORT***

Incident Date: \_\_\_\_\_ Time: \_\_\_\_\_ Place: \_\_\_\_\_

***EMPLOYEE INFORMATION (Complete one report for each employee involved)***

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ DL#: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Occupation: \_\_\_\_\_

How long was Employee performing this operation/job? \_\_\_\_\_

Employer: \_\_\_\_\_

***INCIDENT INFORMATION***

Describe in detail how incident occurred:

\_\_\_\_\_

What was the employee doing at time of incident?

\_\_\_\_\_

Were activities part of the job? YES/NO (If NO, describe further)

\_\_\_\_\_

Were photos taken? Yes \_\_\_\_\_ No \_\_\_\_\_ By whom? \_\_\_\_\_

Name, address and phone number of all witnesses to the incident (use separate sheet if necessary):

\_\_\_\_\_

Any contributing factors to incident, i.e., equipment/tools, unsafe acts of employee, or others:

\_\_\_\_\_

Did the incident result in an injury? Yes<sup>a</sup> \_\_\_\_\_ No \_\_\_\_\_ (If No, skip Injury Information section)

***INJURY INFORMATION***

Describe nature and extent of injury: \_\_\_\_\_

Was first aid given? Yes \_\_\_\_\_ No \_\_\_\_\_ When and by whom? \_\_\_\_\_

Was injured transported via ambulance? Yes \_\_\_\_\_ No \_\_\_\_\_ Where taken? \_\_\_\_\_

I decline medical treatment at this time: \_\_\_\_\_

(Employee's Signature)

Comments: \_\_\_\_\_

\_\_\_\_\_

Supervisor's Name (Please print.): \_\_\_\_\_

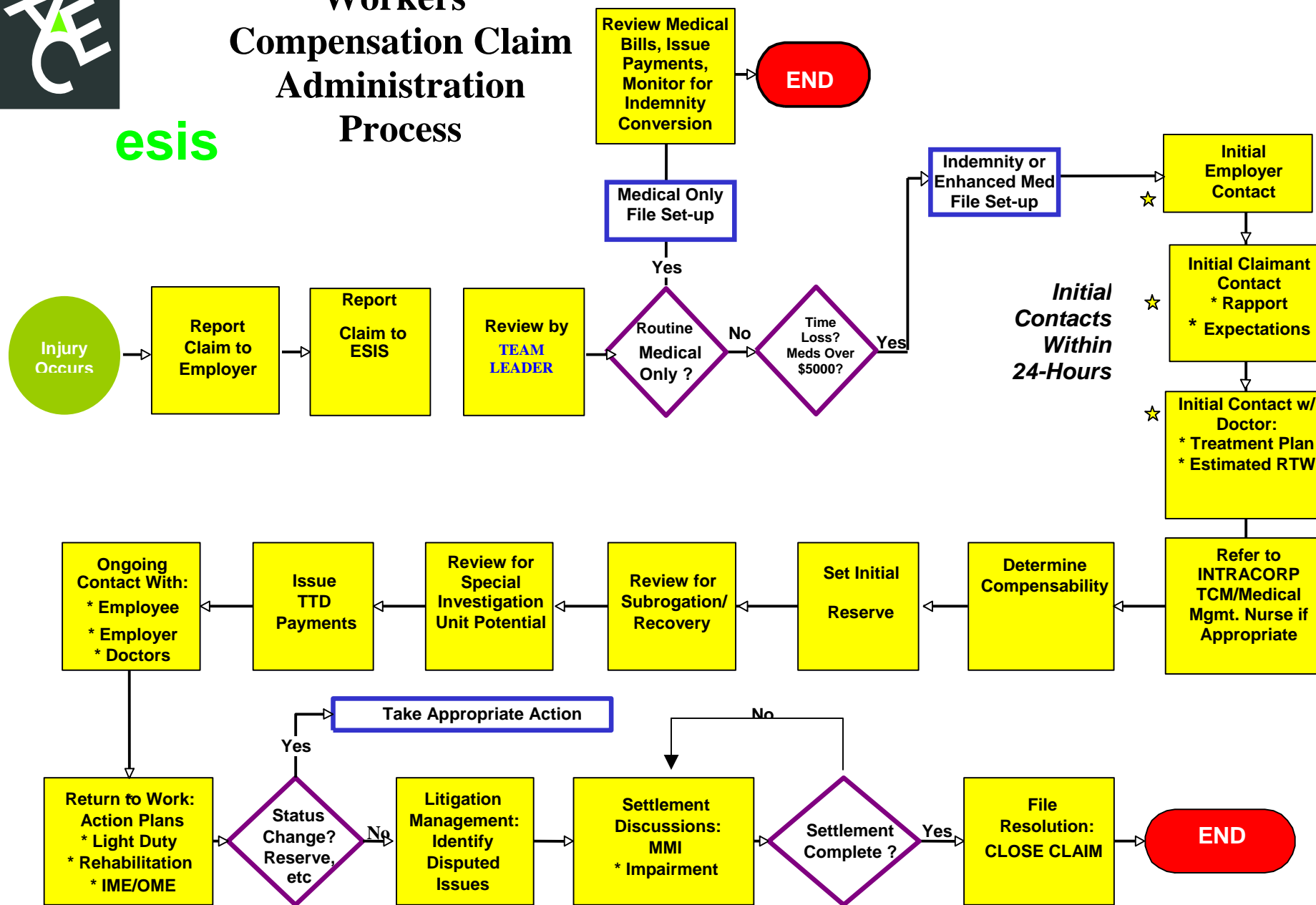
Supervisor's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



esis

# Workers' Compensation Claim Administration Process



<b>ACORD™ GENERAL LIABILITY NOTICE OF OCCURRENCE/CLAIM</b>										DATE (MM/DD/YYYY)					
PRODUCER		PHONE (A/C, No, Ext):		NOTICE OF OCCURRENCE NOTICE OF CLAIM		DATE OF OCCURRENCE AND TIME		AM PM		DATE OF CLAIM		PREVIOUSLY REPORTED YES NO			
				EFFECTIVE DATE		EXPIRATION DATE		POLICY TYPE		RETROACTIVE DATE					
				OCCURRENCE		CLAIMS MADE									
				COMPANY		NAIC CODE:		MISCELLANEOUS INFO (Site & location code)							
CODE:		SUB CODE:		POLICY NUMBER				REFERENCE NUMBER							
AGENCY CUSTOMER ID:															
<b>INSURED</b>										<b>CONTACT</b>				CONTACT INSURED	
NAME AND ADDRESS				SOC SEC # OR FEIN:		NAME AND ADDRESS						WHERE TO CONTACT			
												WHEN TO CONTACT			
RESIDENCE PHONE (A/C, No)				BUSINESS PHONE (A/C, No, Ext)		RESIDENCE PHONE (A/C, No)				BUSINESS PHONE (A/C, No, Ext)					
<b>OCCURRENCE</b>															
LOCATION OF OCCURRENCE (Include city & state)										AUTHORITY CONTACTED					
DESCRIPTION OF OCCURRENCE (Use separate sheet, if necessary)															
<b>POLICY INFORMATION</b>															
COVERAGE PART OR FORMS (Insert form #s and edition dates)															
GENERAL AGGREGATE		PROD/COMP OP AGG		PERS & ADV INJ		EACH OCCURRENCE		FIRE DAMAGE		MEDICAL EXPENSE		DEDUCTIBLE		PD BI	
UMBRELLA/ EXCESS		UMBRELLA		EXCESS		CARRIER:		LIMITS:		AGGR		PER CLAIM/OCC		SIR/ DED	
<b>TYPE OF LIABILITY</b>															
PREMISES: INSURED IS		OWNER		TENANT		OTHER:		TYPE OF PREMISES							
OWNER'S NAME & ADDRESS (If not insured)								OWNERS PHONE (A/C, No, Ext):							
PRODUCTS: INSURED IS		MANUFACTURER		VENDOR		OTHER:		TYPE OF PRODUCT							
MANUFACTURER'S NAME & ADDRESS (If not insured)								MANUFACT PHONE (A/C, No, Ext):							
WHERE CAN PRODUCT BE SEEN?															
OTHER LIABILITY INCLUDING COMPLETED OPERATIONS (Explain)															
<b>INJURED/PROPERTY DAMAGED</b>															
NAME & ADDRESS (Injured/Owner)										PHONE (A/C, No, Ext)					
AGE		SEX		OCCUPATION		EMPLOYER'S NAME & ADDRESS				PHONE (A/C, No, Ext)					
DESCRIBE INJURY						WHERE TAKEN		WHAT WAS INJURED DOING?							
FATALITY						WHERE CAN PROPERTY BE SEEN?		WHEN CAN PROPERTY BE SEEN?							
DESCRIBE PROPERTY (Type, model, etc)				ESTIMATE AMOUNT											
<b>WITNESSES</b>															
NAME & ADDRESS								BUSINESS PHONE (A/C, No, Ext)				RESIDENCE PHONE (A/C, No)			
REMARKS															
REPORTED BY		REPORTED TO		SIGNATURE OF INSURED				SIGNATURE OF PRODUCER							



## PROPERTY LOSS NOTICE

AGENCY		PHONE (A/C, No, Ext):	MISCELLANEOUS INFO (Site & location code)		DATE OF LOSS AND TIME		DATE (MM/DD/YYYY)		PREVIOUSLY REPORTED		
POLICY TYPE		COMPANY AND POLICY NUMBER			NAIC CODE		POLICY DATES		AM		
PROP/ HOME		CO:					EFF:		PM		
FLOOD		CO:					EXP:		YES		
WIND		CO:					EXP:		NO		
FAX (A/C, No):		E-MAIL ADDRESS:		FLOOD		POL:		EXP:			
CODE:		SUB CODE:		WIND		POL:		EXP:			
AGENCY CUSTOMER ID											
<b>INSURED</b>						<b>CONTACT</b>		<b>CONTACT INSURED</b>			
NAME AND ADDRESS OF INSURED				DATE OF BIRTH		NAME AND ADDRESS OF INSURED					
				SOC SEC # OR FEIN:							
RESIDENCE PHONE (A/C, No)				BUSINESS PHONE (A/C, No, Ext)							
NAME AND ADDRESS OF SPOUSE (IF APPLICABLE)				DATE OF BIRTH		RESIDENCE PHONE (A/C, No)		BUSINESS PHONE (A/C, No, Ext)			
				SOC SEC # OR FEIN:		WHERE TO CONTACT		WHEN TO CONTACT			
<b>LOSS</b>											
LOCATION OF LOSS						POLICE OR FIRE DEPT TO WHICH REPORTED					
KIND OF LOSS						PROBABLE AMOUNT ENTIRE LOSS					
FIRE											
THEFT											
LIGHTNING											
FLOOD											
OTHER (explain)											
HAIL											
WIND											
DESCRIPTION OF LOSS & DAMAGE (Use separate sheet, if necessary)											
<b>POLICY INFORMATION</b>											
MORTGAGEE											
NO MORTGAGEE											
HOMEOWNER POLICIES SECTION 1 ONLY (Complete for coverages A, B, C, D & additional coverages. For Homeowners Section II Liability Losses, use ACORD 3.)											
A. DWELLING		B. OTHER STRUCTURES		C. PERSONAL PROPERTY		D. LOSS OF USE		DEDUCTIBLES		DESCRIBE ADDITIONAL COVERAGES PROVIDED	
										ON	
COVERAGE A. EXCLUDES WIND											
SUBJECT TO FORMS (Insert form numbers and edition dates, special deductibles)											
FIRE, ALLIED LINES & MULTI-PERIL POLICIES (Complete only those items involved in loss)											
ITEM		SUBJECT OF INSURANCE		AMOUNT		% COINS		DEDUCTIBLE		COVERAGE AND/OR DESCRIPTION OF PROPERTY INSURED	
		BLDG <input type="checkbox"/> CNTS									
		BLDG <input type="checkbox"/> CNTS									
		BLDG <input type="checkbox"/> CNTS									
SUBJECT TO FORMS (Insert form numbers and edition dates, special deductibles)											
FLOOD POLICY		BUILDING		DEDUCTIBLE:		ZONE		PRE FIRM		DIFF IN ELEV	
		CONTENTS:		DEDUCTIBLE:				POST FIRM		FORM TYPE	
WIND POLICY		BUILDING		DEDUCTIBLE		CONTENTS		ZONE		GENERAL DWELLING	
								FORM TYPE		CONDO	
REMARKS/OTHER INSURANCE (List companies, policy numbers, coverages & policy amounts)/NY ONLY: PREVIOUS ADDRESS OF INSURED & WIFE'S MAIDEN NAME											
CAT #		FICO #		ADJUSTER ASSIGNED		ADJUSTER #		DATE ASSIGNED			
REPORTED BY		REPORTED TO		SIGNATURE OF INSURED		SIGNATURE OF PRODUCER					

## ***FACIMILE TRANSMITTAL***

**Number of pages:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**To:** TBD – OCIP SAFETY MANAGER

**Fax #:** TBD

**From:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

**RE:** (Circle One) Workers Compensation Notification

General Liability Notification

Other \_\_\_\_\_

\_\_\_\_\_