Workers' Compensation

Claims Packet

And

Posting Notices

Report All Claims To:

Debbie Moore
Director of HR
I Love Vacations
deb@ilovevacations.com

Please note this does not confirm that the injury or condition is covered by Workers' Compensation insurance. That determination will be made when a claims representative completes a review/investigation.
Please submit all medical records, bills (including post accident drug test charges) and documentation within the time frame required by applicable state law. **Send directly to CNA by Fax 800.953.7389 or email lossreport@cnaasap.com or by phone 877.262.2727**

Important!

Workers' Compensation Claims Information

EMPLOYEE:

- ☐ Immediately notify the supervisor that a work-related injury or illness has occurred.

- ☐ Complete the "Injured Employee Accident Report" and give to supervisor.

SUPERVISOR:

- ☐ Assess the incident and assist the employee in seeking appropriate medical care or necessary treatment.

- ☐ Request a post-accident drug screening from the medical provider.

- ☐ Report the work-related injury, accident or illness within 24 hours to Propel HR by completing the "Supervisor's Incident Report."

EMPLOYEES TO REPORT ALL CLAIMS TO:

Debbie Moore
Director of HR
I Love Vacations
deb@ilovevacations.com

HR TO REPORT ALL CLAIMS TO:

Susan Kain
Workers' Compensation Manager
skain@propelhr.com
Direct Line: (864) 679-6067
Direct Fax: (864) 335-4769

IMPORTANT! If an employee seeks medical treatment prior to reporting a work related injury or illness to employer, medical expense reimbursement may be denied.

Supervisor's Incident Investigation Report

Employer Data

Company Name: _____

Company Address: _____

Phone: _____ FEIN #: _____

Employee Data

Employee Name: _____

Last *First* *M.I.*

Street Address: _____ City/State: _____

Zipcode: _____ Phone Number: _____

Job Title: _____ Social Security #: _____

☐ Part Time ☐ Exempt Rate of Pay: _____

☐ Full Time ☐ Hourly Pay Frequency: _____

Date of Hire (xx/xx/xxxx): _____ Date of Birth (xx/xx/xxxx): _____

Department: _____ Shift Hours: _____

What days does employee work? _____

Was employee paid in full for the date of injury? _____

Incident Data

Incident Date: _____ Time of incident: _____

Exact location of incident (including address): _____

Reported to whom

Date reported to Company: _____ (name, title, phone): _____

Did employee return to work? _____ Return date: _____

Brief description of injury/illness (burn, fracture, strain, cut, etc.):

Body part affected:

Did employee visit the doctor? Date of doctor visit

Doctor's Name and/or Facility

List any witnesses:

Incident Details

Job or activity at time of incident _____

Describe clearly what occurred (How, when, where). Include diagram and pictures if needed.

Supervisor Information

Report Completed By: _____

Job Title: _____ Signature: _____

INJURED EMPLOYEE - ACCIDENT INVESTIGATION REPORT

This form is for reporting to management and may be submitted to the Insurance Company if petitioned to do so.

WHO WAS INJURED?	NAME_____ OCCUPATION_____ DEPARTMENT_____
TIME AND PLACE	DATE_____ TIME_____ EXACT LOCATION_____
DESCRIBE INJURY	
A DETAIL ACTIONS PRIOR AND UP TO INJURY. WHAT HAPPENED? USE REVERSE SIDE TO EXTEND COMMENTS	
B WHAT UNSAFE CONDITION (S) OR ACT (S) CAUSED THIS ACCIDENT?	
HOW CAN SIMILAR ACCIDENTS BE AVOIDED?	
WHAT ACTION HAVE YOU TAKEN TO PREVENT SIMILAR ACCIDENTS?	

_____ EMPLOYEE NAME-POSITION _____ DATE

_____ EMPLOYER NAME-POSITION _____ DATE

EMPLOYER'S FIRST REPORT OF INJURY SUBMITTED _____ DATE

Employee Refusal of Medical Treatment Form

I have been advised by my supervisor/safety specialist that I may seek medical treatment for the injury that may have occurred on the job per the below listed information. I do not think medical treatment is needed at this time, but I will inform my supervisor or safety specialist immediately should the need arise.

_____ _____

(Employee printed name) (Date of injury per employee)

_____

(Time of injury per employee)

_____

(Employee list specific body part(s): Example: Right hand, index finger)

_____

(Employee list specific injury type: Example: Scratch, burn, cut)

_____ _____

(Employee Signature) (Today's Date)

_____ _____

(Supervisor/Safety Specialist Signature) (Today's Date)

Manager/Safety Specialist Comments:

_____

_____

_____

Manager/Safety Specialist note: Use this form if an employee has a minor injury and they do not feel that they need medical treatment. If the employee's injury is obvious, get medical attention and/or call 911, if necessary.