WORKERS' COMPENSATION NOTICE THAT

Employer: _____

has complied with the provisions of the Workers' Compensation Act, Title §34A-2-101, Utah Code Annotated, 1997 (as amended), and the rules of the Labor Commission, and has insured the liability to pay the compensation and other benefits provided by said Act by insuring with Insurance Carrier: _____

Policy Number: _____

Address for the above insurance carrier is _____

Telephone number is _____

WORKERS' COMPENSATION

IS INSURANCE WHICH PROTECTS YOU DURING WORK. IF YOU HAVE AN ON-THE-JOB INJURY OR OCCUPATIONAL DISEASE, IT WILL PAY FOR: HOSPITAL AND MEDICAL BILLS * TIME LOST FROM WORK * PERMANENT LOSS OF BODY FUNCTION * PROSTHETIC DEVICES * BURIAL BENEFITS IN DEATH CASES.

HOW TO REPORT AN ACCIDENT

1. Report the injury - no matter how slight - to your boss immediately. (You may lose your rights if your injury is not reported within 180 days of injury or work related illness.)

2. Ask your employer to fill out the employer's first report of injury form. A copy of this report is to be given to you and copies are to be sent to the Labor Commission and to the insurance company within seven (7) days of the accident.

3. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.

4. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a medical report form. Copies of the report are to be sent within seven (7) days of your visit to (1) the insurance company, (2) the Labor Commission and (3) you, the employee.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation for your company.

2. Ask your doctor to send a medical report to that insurance company.

3. Ask your employer to send a report of the accident to that insurance company.

4. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the doctor's report, employer's report, and may ask you to fill out a request for compensation.

REHABILITATION

IF YOU CANNOT RETURN TO WORK, YOU MAY BE ELIGIBLE FOR A REHABILITATION PROGRAM – CALL YOUR INSURANCE CARRIER AS LISTED ABOVE.

FRAUD

"For your protection, Utah Law requires the following to appear on this form, any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

STATE OF UTAH
LABOR COMMISSION
160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610 (801)530-6800 – (800)530-5090

If you want an Employee's Guide to Workers' Compensation or have questions, call the Labor Commission at the above listed numbers or go to our web page at www.laborcommission.utah.gov.

Note: This notice must be posted and kept continuously in a public and conspicuous place in the office, shop or place of business of the employer as per §34A-2-204 and §34A-2-104.5, Utah Code Annotated.

Revised 8/23/2016

COMPENSACIÓN AL TRABAJADOR
NOTE QUE

La empresa: _____

Ha cumplido con las provisiones del Acta de Compensación al Trabajador, Titulo §34A-2-101, en el libro de Código de Utah anatado en 1997, y las reglas de la Comisión de Labor (Labor Commission), y ha asegurado tener la responsabilidad de pagar compensactión y otros beneficios preve idos por el Acta ya mencionada al tener cobertura con.

Compañía de Seguros: _____

No. de Póliza: _____

Dirección de la compañía de seguros: _____

Numero de teléfono: _____

COMPENSACIÓN AL TRABAJADOR

ES EL SEGURO EL CUAL LE PROTÉGÉ DURANTE EL TRABAJO. SI TIENE UN ACCIDENTE EN EL TRABAJO O UNA ENFERMEDAD GENERADA A CAUSA DE SU TRABAJO, SU SEGURO PAGARA POR: HOSPITAL Y GASTOS MEDICOS * INCAPACIDAD * PERDIDA PERMANENTE DE UNA FUNCION DE SU CUERPO * PROTESIS * GASTOS DEL FUNERAL EN CASO DE MUERTE.

COMO REPORTAR UNACCIDENTE

1. Reporte la lesión – no importa que tan leve sea – a su supervisor immediatamente. (Pierde sus derechos si no reporta su accidente entre 180 dias después del incidente.)

2. Pida a su supervisor que llene la forma del primer reporte de accidente. Una copia de este reporte es para usted y las demás copias deben ser enviadas a La Comisión Laboral a la compania de seguro dentro De los primeros siete (7) dias del accidente.

3. Si en su trabajo hay un cuarto de primeros auxilios o un doctor de la compañía, vaya inmediatemente para obtener tratamiento, Si no, vaya al doctor de su preferencia.

4. Digale al doctor **CÓMO, CUÁNDO Y DÓNDE** ocurrió el accidente. El doctor llenara una forma de reporte médico. Copias de ese reporte deben se enviadas dentro de siete (7) dias de su visita a (1) la compañia de seguros, (2) La Comisión Laboral (3) usted, el empleado.

COMO EMPREZAR LA COMPENSACIÓN

1. Pregunte a su supervisor cual es la compañía de seguros que paga Compensación al Trabajador de su trabajo.

2. Pida a su doctor que mande un reporte médico a esa compañía de seguros.

3. Pida a su supervisor que mande un reporte del accidente a esa compañía de seguros.

4. Llame a la compañía de seguros y pidales que empiecen sus beneficios de compensación al trabajador. La compañía de seguros requerirá el reporte del doctor, el reporte de su trabajo, y le pedirá que llene una forma para obtener compensación.

REHABILITACION

SI NO PUEDE REGRESAR A SU TRABAJO, USTED PUEDE CALIFICAR PARA UN PROGRAMA DE REHABILITACION – LLAME A LA COMPAÑIA DE SEGUROS MENCIONADA ARRIBA.

FRAUDE

"Para su protección, la ley de Utah require lo siguiente que aparezca en esta forma, cualquier persona que intensionalmente presente información false o fraudulenta, que abara o cause que sea abierto un caso fraudulento de disabilidad o beneficios médicos, o que entregue un reporte fraudulento de factusas de gastos médicos u otros servicios profesionales es calpable de crimen y puede ser sujeto a multas y encarceuado en la prisión del Estada."

ESTADO DE UTAH
COMISION LABORAL
160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610
(801)530-6800 – (800)530-5090

Si desea una Guía del Empleado para Compensacion al Trabajador o si tiene preguntas, llame a la Comisión Labor a los números mencionados arriba o visite nuestra página de web en www.laborcommission.utah.gov.

NOTA: Esta información debe ser publicada y permanecer continuamente colocada en un lugar público ya sea en la oficina, taller, o lugar de negocio de la empresa de acuerdo con el Articulo §34A-2-204, and §34A-2-104.5, en el libro de Código de Utah anatado.

Revisar 8/23/2016

Form 122

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

(Filing this form is not an admission of liability for the claim.)

GENERAL

Employer (Name & Address Include Zip)

Carrier/Administrator Claim Number | OSHA Log Number | Report Purpose Code

Jurisdiction | Jurisdiction Claim Number

Insured Report Number

Employer's Location Address (If Different) | Location Number

Industry Code | Employer FEIN | Phone Number

CARRIER

CLAIMS ADMIN

CARRIER/CLAIMS ADMINISTRATOR

Carrier (Name, Address & Phone Number)

Policy Period _____ To _____

Check If Appropriate Self-Insurance ☐

Claims Administrator (Name, Address & Phone Number)

Carrier FEIN | Policy/Self-Insured Number | Administrator FEIN

Agent Name and Code Number

EMPLOYEE

EMPLOYEE/WAGE

Name (Last, First, Middle) Address (incl. Zip)

Date of Birth | Social Security Number | Date Hired | State of Hire

Sex ☐ Male ☐ Female ☐ Unknown

Marital Status ☐ Unmarried/single/Divorced ☐ Married ☐ Separated ☐ Unknown

Occupation / Job Title

Employment Status

NCCI Class Code

Claimant may need an interpreter: Yes ☐ No ☐ Language _____

Phone | Number of Dependents

WAGE

Rate _____ Per: ☐ Day ☐ Month ☐ Week ☐ Other

Number of Days Worked/Week

Full Pay For Day of Injury ☐ Yes ☐ No

Did Salary Continue ☐ Yes ☐ No

OCCURRENCE

OCCURRENCE/TREATMENT

Time Employee Began Work _____ ☐ AM ☐ PM | Date of Injury/Illness | Time of Occurrence ☐ 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

Cause Of Injury Code

How Injury or Illness / Abnormal Health Condition Occurred, Describe the Sequence of Events and Include Objects or Substances that Directly Injured The Employee or Made The Employee Ill

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 (Name & Address)

Initial Treatment
- ☐ No Medical Treatment
- ☐ Minor: By Employer
- ☐ Minor: Clinic/Hospital
- ☐ Emergency Care
- ☐ Hospitalized – 24 hrs
- ☐ Future Major Medical/Lost Time Anticipated

OTHER

OTHER

Witnesses (Name & Phone Number)

Date Administrator Notified | Date Prepared | Preparer's Name & Title | Phone Number

Official Form 122 *Revised 10/14*

State of Utah • Labor Commission • Division of Industrial Accidents

160 East 300 South • P O. Box 146610 • Salt Lake City, UT 84114-6610 • Telephone: (801) 530-6800

FAX: (801) 530-6804 • Toll Free: (800) 530-5090 • www.laborcommission.utah.gov

FRAUD – "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

INSTRUCTIONS TO EMPLOYER

The Employer's First Report of Injury or Illness must be submitted to the insurance carrier, per Sections §34A-2-407 and §34A-3-10B, R612-200-1 Utah Code Annotated (U.C.A.). 1997. Each employer shall file the report within seven days after the occurrence, or the employee's notification of the same, which results in medical treatment by a physician except first-aid R612-100-2, loss of consciousness, loss of work, restriction of work, or transfer to another job. Each employer shall file a subsequent report with the commission of any previously reported injury; or occupational disease that later resulted in death. Also, for your information, Section §34A-6-301(3)(b)(ii) states that each employer shall, within 8 hours of occurrence, notify the Division of Occupational Safety and Health, at (801) 530-6901 or (800) 530-5090, of any; work related fatality; disabling, serious, or significant injury; or occupational disease incident.

* All information requested on this form is of vital importance. Please answer **all** items in detail in order to avoid additional correspondence or the return of this report for completion**. Do not enter data in the shaded areas.**

* The box titled "OSHA Log Number" must be filled in with the employer assigned Case Number from OSHA's new 300 Injury Log. The Case Number needs to reflect the year of the injury – for example, your first injury in 2002 should reflect the first injury and the year 00/02 with the next injury being 00202, etc.

* Please provide **WAGE** information. This information is needed by the insurance company for paying the correct amount on a claim.

* The electronic injury report on file with the Labor Commission, Division of Industrial Accidents, is private information and is only released to parties to the claim.

* Please make sure the **EMPLOYER NAME** is correct, as well as your **FEIN #** (Federal Tax ID Number). The employer's name should be the same as reported to The Department of Workforce Services and as it appears on your WORKERS' COMPENSATION insurance policy.

* The **Worker's Compensation Insurance Carrier** gets an original copy, the **employee** gets a **second** copy, and the employer gets a **third** copy and should maintain a copy of this report. The insurance carrier will send the Labor Commission an electronic copy of the injury report.

*Failure to file this report with the insurance carrier or failure to provide the employee with a copy of the report, is a Class C misdemeanor and can also result in a citation and a civil penalty for each violation as per §34A-2-407(7), R612-200-1, §34-a-30108(7), §34A-6-302, and §34A-6-307, U.C.A.

*If you dispute the validity of this claim you need to contact your insurance carrier, and you must still file the "Employer's First Report of Injury or Illness" form with them. They will then submit it to the Labor Commission electronically. If the employer has no workers' compensation insurance this form must be submitted to the Labor Commission directly.

* **Reminder:** Inform your injured employee of his/her rights and obligations (as outlined on the back of the employee's copy) of Utah's Workers' Compensation Act.

For Additional Information please contact:
State of Utah – Labor Commission
Division of Industrial Accidents
160 East 300 South, 3rd Floor
P O Box 146610
Salt Lake City, Utah 84114-6610
(801) 530-6800 (800) 530-5090

FRAUD – "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

EMPLOYEE INFORMATION

- **INJURY/ILLNESS REPORT**: A report of your injury/occupational illness must be made with your employer. If a report of injury is not filed with your employer or the Labor Commission, Division of Industrial Accidents, within 180 days of the date of your injury/illness, you may lose the right to ever file a claim for workers' compensation benefits for that injury or illness.

- **EMPLOYER'S PHYSICIAN**: If your employer has a company physician or designated clinic for industrial accidents, you MUST see the company physician first, or you may not be eligible for workers' compensation benefits. After you have been seen by your employer's physician, you have the right to choose one treating physician.

- **MEDICAL COOPERATION**: You must cooperate with your employer or the insurance carrier in following prescribed medical treatment in order to return to work as quickly as possible.

- **TRAVEL REIMBURSEMENT**: You may be eligible for travel reimbursement to and from approved medical care. You will need to keep records. Contact your insurance carrier regarding travel expenses.

- **REEMPLOYMENT ASSISTANCE**: You may be eligible for reemployment assistance if you are unable to return to work due to an industrial injury. Contact your insurance carrier or the Labor Commission, Division of Industrial Accidents, for further information.

- **MEDICAL EXPENSES**: You are entitled to have all reasonable medical expenses paid that are a result of the injury or illness.

- **COMPENSATION BENEFITS**: You are entitled to 66-2/3 of your wages up to 100% of the state average weekly wage (as of the date of your injury) after 3 days from the date of your injury, if a physician states you are totally unable to work.

    - □ If you have sustained a permanent impairment due to the industrial injury or disease, you are entitled to compensation based on the impairment rating as determined by a physician.

    - □ If you are permanently totally disabled from working due to the industrial injury, you may need to apply at the Labor Commission, Division of Industrial Accidents, for a hearing to determine if benefits are due.

- **ADDITIONAL ASSISTANCE**: If you are unable to work due to an industrial injury and meet the program's requirements, you may be eligible for other assistance. Agencies you may wish to contact:

    - □ Department of Workforce Services for food stamps, cash assistance, medical assistance, or employment assistance.
    - □ Social Security for total disability benefits.

- **UNEMPLOYMENT BENEFITS**: If you are able to work, but have been terminated from your job, you need to apply at the nearest Department of Workforce Services employment office within 90 calendar days after you are released from full-time work by your doctor.

Contact your insurance carrier if problems occur during your injury regarding payment of medical bills or compensation benefits. If you need to know who your employer's insurance carrier is, you may ask your employer or contact the Labor Commission, Division of Industrial Accidents.

More information is found on our Website laborcommission.utah.gov

Form 123

Physician's Initial Report of Work Injury or Occupational Disease

INSTRUCTIONS: 1) form to be completed by physician; 2) copy of completed form to be sent to insurance carrier with bill and progress reports; 3) copy of form only sent to injured employee, employee's employer, and Utah Labor Commission.

This report must be filled pursuant to rule R612-100-3 (A), Utah Administrative Code. For your protection Utah law requires notification that any workers' compensation fraudulent claim for disability compensation on medical benefits is a crime and may be subject to fines and prison confinement.

PLEASE PRINT OR TYPE

PHYSICIAN

1. Physician Name
2. Physician Phone Number
3. Treatment Facility
4. Registered Email

Do Not Use This Space
CLAIM NO.
POLICY NO.
Class Code

CARRIER

5. Insurance Company
6. Mailing Address City State Zip

PATIENT

7. Employee's First Name Middle Initial Last Name
8. SS # (or other) Other #
9. DOB (MM/DD/YYYY)
10. Gender
11. Mailing Address City State Zip
12. Employee Telephone Number

EMPLOYER

13. Name of Employer
14. Address City State Zip
15. Employer Telephone Number

HISTORY

16. Date Injured (MM/DD/YYYY) _____ Hour _____ AM ☐ PM ☐
17. Last Date Worked
18. Employee's Statement of Cause of Injury or Illness (In First Person)

EXAMINATION

19. Diagnosis (Written Description as Related to Industrial Claim) w/ ICD Code
20. Is the Condition Requiring Treatment the Result of the Industrial Injury or Exposure Described?
☐ Yes ☐ No Undetermined
21. Claimant Needs Interpreter ☐ Yes ☐ No Language _____ (If Answer is Yes)

COMMENTS

22. Other Comments
23. Date Submitted _____

Official Form 123 **Revised 10/14**
State of Utah * Labor Commission * Division of Industrial Accidents
160 East 300 South * P O Box 146610 * Salt Lake City, UT 84114-6610 * Telephone: (801) 530-6800
FAX: 801-530-6804 * Toll Free: (800) 530-5090 * www.laborcommission.utah.gov