Service American
Indemnity Company

CLAIMS KIT

P.O. Box 26850 Austin, Texas 78755 1 800 299-6977 www.serviceamerican.com

CLAIMS REPORTING

You may report your claims by telephone, fax or through the mail.

Telephone: (800)-299-6977

In Austin: (512)-343-0600

Fax: Complete the loss report and fax to 512-231-8248

Mail: Send the completed loss report to:

P O Box 26850
Austin, Texas 78755

CLAIM REPORTING INSTRUCTIONS

Workers' Compensation Claims
Every accident involving lost time or medical treatment should be reported promptly using the **Employer's First Report of Injury**. Report death claims immediately by telephone.

Employee Returns to Work
Complete the Employer's Supplemental Report of Injury, in duplicate, on the same day employee returns to work and mail promptly. Once weekly compensation benefits are started, payments continue until notice is received that the employee has resumed work.

Weekly Benefits
There is a one-week waiting period for weekly compensation. Compensation is paid for the second week of lost time, beginning with the eighth day of disability, including weekends. If disability continues for 14 calendar days, the employee will then get compensation for the first week.

Medical Expenses
Medical expenses are paid in accordance with statutory provisions. The attending doctor will be requested to send their report and bill directly to Service American Indemnity Company. Payments are made directly to the doctor.

Correspondence on Claims
Each claim is assigned a claim number; please refer to this number when corresponding.

Reordering Supplies or Forms
Request supplies by calling (800)-299-6977

Service American
Indemnity Company

CHECK LIST

WHEN AN ON-THE-JOB INJURY OCCURS:

1. Immediately fill out Employers First Report of Injury in its entirety and send in. **DO IT TODAY!**

2. If an injury has previously been reported as no lost time and the employee starts losing time from work, immediately fill out a Supplementary Report of Injury and send it in. **DO IT TODAY!**

3. If an injury has been reported as a lost time injury and the employee returns to work, immediately fill out a Supplementary Report of Injury, and send it in**. DO IT TODAY!**

4. Should medical bills be sent to you, please send them on to the insurance company. **DON'T HOLD THEM!!**

5. Fill in all applicable blanks.

P.O. Box 26850 Austin, Texas 78755 1 800 299-6977 www.serviceamerican.com

Service American
Indemnity Company

SUPERVISOR'S ACCIDENT/INCIDENT INVESTIGATION

(Should be completed within 24 hours of accident)

1. NAME OF EMPLOYEE:____________________
2. DEPARTMENT: __________________________
3. DATE/LOCATION OF ACCIDENT:_________________
   TIME:__________A.M. P.M. (circle one)
4. WITNESSES: a. _____________________
   b. _____________________
5. BRIEFLY DESCRIBE ACCIDENT AND NATURE OF INJURY:

____

____

6. ACCIDENT CAUSES (check all factors)

PHYSICAL CAUSES

___Defective/improper tools or equipment
___Poor housekeeping (trash, slippery floor, etc.)
___Unguarded/improperly guarded equipment
___Congested area
___Unstable/Improper piling or acreage
___Improper apparel
___Improper light, ventilation, temp, etc.
___External security doors, window, alarms, etc.
___Other

PERSONAL CAUSES

___Not Properly Trained/Instructed
___Failure to use personal protective equipment
Failure to follow rules or instructions
Using improper/defective tools or equipment
___Horseplay
___Using improper methods/procedures
___Operating without authority
___Physical limitations of work
___Other (describe) ____________________

7. SIGNATURES: Prepared By: __________________________
   (Supervisor)
   Reviewed By: __________________________
   (Person Responsible for Safety)

   ____
   (Manager)

8. FOLLOW UP: What HAS been done to prevent recurrence of this type accident?
   (Follow up within 30 days of accident, check progress at 30 day intervals until complete.)

____

____

SIGNATURES: ______________________________
(Person Responsible for Safety)

____
(Manager)

Date: ______________________________

NOTE: Record any additional information, diagrams, photos, etc. on reverse side.
(Form furnished by Service American Indemnity Company)

Service American
Indemnity Company

SUPERVISOR'S ACCIDENT/INCIDENT INVESTIGATION

(Should be completed within 24 hours of accident)

1. NAME OF EMPLOYEE:____________________
2. DEPARTMENT: __________________________
3. DATE/LOCATION OF ACCIDENT:__________________
   TIME:__________A.M. P.M. (circle one)
4. WITNESSES: a. ______________________
   b. ______________________
5. BRIEFLY DESCRIBE ACCIDENT AND NATURE OF INJURY:

____

____

6. ACCIDENT CAUSES (check all factors)

PHYSICAL CAUSES

___Defective/improper tools or equipment
___Poor housekeeping (trash, slippery floor, etc)
___Unguarded/improperly guarded equipment
___Congested area
___Unstable/Improper piling or acreage
___Improper apparel
___Improper light, ventilation, temp, etc.
___External security doors, window, alarms, etc.
___Other

PERSONAL CAUSES

___Not Properly Trained/Instructed
___Failure to use personal protective equipment
Failure to follow rules or instructions
Using improper/defective tools or equipment
___Horseplay
___Using improper methods/procedures
___Operating without authority
___Physical limitations of work
___Other (describe) ____________________

7. SIGNATURES: Prepared By: __________________________
   (Supervisor)
   Reviewed By:__________________________
   (Person Responsible for Safety)

   ____
   (Manager)

8. FOLLOW UP: What HAS been done to prevent recurrence of this type accident?
   (Follow up within 30 days of accident, check progress at 30-day intervals until complete.)

____

____

SIGNATURES: ______________________________
(Person Responsible for Safety)

____
(Manager)

Date: ______________________________

NOTE: Record any additional information, diagrams, photos, etc. on reverse side.
(Form furnished by Service American Indemnity Company)

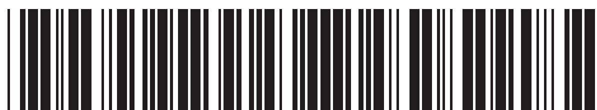
DWC FORM-1
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM -1 (Rev. 10/05)] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

[Workers' Compensation Rule 120.2]



INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-1)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM - 1 (Rev. 10/05) to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed $500.00. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Article 8308 -5.04. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Article 8308 - 7.03 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8: Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.

Item 4: If no home phone, please provide a phone number where the employee can be reached.

Items 5,15,17, 26,29,30: Enter data in month, day, year format. Example: 08-13-54.

Item 18: List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.

Item 19: List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.

Item 20: Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.

Item 22: State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.

Item 24: List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.

Items 32,33: Enter date in month-year format. Example: 02-56.

Item 37: Enter the number of days or hours that make up a full work week for your employees.

Item 45: Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.

Item 46: For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # ______________________________

CARRIER'S CLAIM # ______________________________

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☐ M ☐

3. Social Security Number - -

4. Home Phone ( )

5. Date of Birth (m-d-y) - -

6. Does the Employee Speak English? If No, Specify Language
YES ☐ NO ☐

7. Race White ☐ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box
City State Zip Code County

10. Marital Status
Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)
City State Zip Code

15. Date of Injury (m-d-y) - -

16. Time of Injury : am ☐ pm ☐

17. Date Lost Time Began (m-d-y) - -

18. Nature of Injury*

19. Part of Body Injured or Exposed*

20. How and Why Injury/Illness Occurred*

21. Was employee doing his regular job? YES ☐ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.) *

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
Street or P.O. Box County
City State Zip Code

24. Cause of Injury (fall, tool, machine, etc.)*

25. List Witnesses

26. Return to work date/or expected (m-d-y) - -

27. Did employee die? YES ☐ NO ☐

28. Supervisor's Name

29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -

31. Was employee hired or recruited in Texas? YES ☐ NO ☐

32. Length of Service in Current Position Months______Years ______

33. Length of Service in Occupation Months______Years ______

34. Employee Payroll Classification Code

35. Occupation of Injured Worker

36. Rate of Pay at this Job $______Hourly $______Weekly

37. Full Work Week is: _____ Hours _____Days

38. Last Paycheck was: $_____for____Hours or______Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form

41. Name of Business

42. Business Mailing Address and Telephone Number
Street or P.O. Box Telephone ( )
City State Zip Code

43. Business Location (If different from mailing address)
Number and Street
City State Zip Code

44. Federal Tax Identification Number

45. Primary North American Industry Classification System Code:(6 digit)

46. Specific NAICS Code (6 digit)

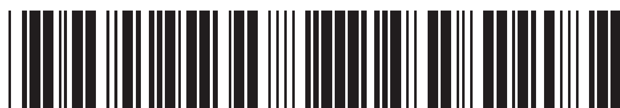
47. Texas Comptroller Taxpayer No.

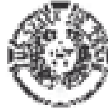
48. Workers' Compensation Insurance Company

49. Policy Number

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X______________________________ Date ______________________





CLAIM #	
Carrier #	

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name
2. Employer phone #
3. Employer mailing address
4. Insurance carrier name
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes ☐ no ☐
   If so, identify contact person and phone # ______________________ ______________________
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes ☐ Date__________ no ☐
7. Has the employer requested RTW training from DWC or the insurance carrier? yes ☐ no ☐
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes ☐ Date__________ no ☐
9. Has the employer requested accident prevention services from the insurance carrier? yes ☐ no ☐

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. ☐ a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
    ☐ b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
    ☐ c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
    ☐ d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name
12. SSN (last 4 digits) XXX-XX-
13. DOI
14. Injured worker mailing address and phone #
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)
16. First day of additional lost time or reduced wages (mm/dd/yyyy)
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes ☐ no ☐
    If yes, the date of the 8th day (mm/dd/yyyy) ______________
18. Date of most recent RTW ________
    ☐ Full duty, full pay
    ☐ Limited duty, full pay
    ☐ Limited duty, reduced pay
19. Has the injured worker resigned, been terminated or died? yes ☐ no ☐
    date of resignation __________ date of termination __________ date of death __________
    19a. Reason for resignation/termination ______________________
    19b. Was the injured worker on limited duty when terminated? yes ☐ no ☐
20. Hours the injured worker was working during the pay period of __________ to __________ : __________ hours per week
    Indicated hours are:
    ☐ Increase from pre-injury
    ☐ Same as pre-injury
    ☐ Decrease from pre-injury
21. Weekly/hourly earnings for the pay period of __________ to __________ : $ __________ weekly or $ __________
    Indicated wages are:
    ☐ Increase from pre-injury wage
    ☐ Same a pre-injury wage
    ☐ Decrease from pre-injury wage

This form to be filed with: ***The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.***

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: ☐ Employer ☐ Injured Worker *(If no longer working for the employer where injury occurred.)*

______________________________ ______________
Signature and Title of person completing this form Date

DWC FORM-6
Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker is entitled to temporary income benefits if he/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

By EMPLOYER	By INJURED WORKER
The **EMPLOYER** means the employer for whom the injured worker was working when the injury occurred. If the employer is the current employer, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-21, sign and date.	If you (the **INJURED WORKER**) are no longer employed by the employer where the injury/illness occurred, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. This form may be used to do so. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date.
The EMPLOYER must file this form: • **For** a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1, Employer's First Report of Injury; and • **During** the time the injured worker is entitled to temporary income benefits (TIBs); and • **Until** the injured worker: ➢ Reaches maximum medical improvement (MMI), or ➢ Is no longer employed by the employer.	If you are employed by a new employer after the injury; and • You are receiving benefits, you must tell the insurance carrier if your wages change, regardless of whether your income went up or down; or • You are *not* receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income.

This report must be filed in the following situations within the timeframes indicated:

- 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury;
- 3 days after the injured worker returns to work;
- 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury;
- 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury;
- 10 days after the injured worker resigns or is terminated.

While most of the sections on this form are self-explanatory, please note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:

- If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time.
- If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is beginning.

This form is to be filed by first class mail or personal delivery with: • The insurance carrier, and • The injured worker. This report is considered filed when personally delivered or postmarked. **Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed $500.**	**This form is to be filed** by first class mail or personal delivery with: • The insurance carrier. This report is considered filed when personally delivered or postmarked. **If you return to work** for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted. **Failure to report earned wages and/or offers of employment to the insurance carrier who is paying benefits to you is a crime that may result in fines and/or imprisonment.**

TLC§ 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC website at: www.tdi.state.tx.us

Send to workers' compensation carrier:

____
(Name and fax number of carrier)

CLAIM # ______________________

CARRIER'S CLAIM # ______________________

☐ Initial ☐ Amended

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed $500.00 for an initial offense and not to exceed $10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

(A) the employee's eighth day of disability;
(B) the date the employer is notified that the employee is entitled to income benefits;
(C) the date of the employee's death as a result of a compensable injury.

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at www.tdi.state.tx.us

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, M.I.):	Employer's Business Name:
Employee's Mailing Address (Street or P.O. Box):	Employer's Mailing Address (Street or P.O. Box):
City: State: ZIP Code:	City: State: ZIP Code:
Social Security Number:	Federal Tax I.D. Number:
Date of Hire: Date of Injury:	Name and Phone # of Person Providing Wage Information:

☐ As of today's date, the employee is not back at work. **OR**
☐ The employee returned to work on____________and is working:
☐ without restriction. **OR**
☐ with restrictions and is earning wages of $____________per week/month (circle one).

NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings.

I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature:______________________________Date: ____________

EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply)

☐ **Full-time:** employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time.

☐ **Seasonal:** employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.

☐ **Part-time: Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period.

☐ **Part-time: Not Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows part-time and full-time work during that period.

☐ **Apprentice:** employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.

☐ **Minor:** employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student.

☐ **Student:** employee enrolled in a course of study in high school, college or other institute of higher education or technical training.

☐ **Trainee:** employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it.

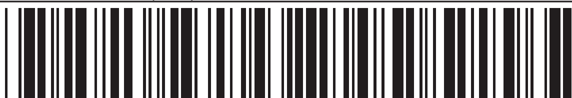
SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☐ **The Injured Employee OR** ☐ **A Similar Employee** (NOTE - If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. **If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.**

NOTE TO INJURED EMPLOYEE - If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.



WAGE INFORMATION INSTRUCTIONS

Employee Name: | Social Security #: | Date of Injury:

- The employer shall report all wages **earned in the 13 weeks immediately preceding the date of injury.** If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer shall not report wages earned on or after the date of injury.**
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

PECUNIARY WAGE INFORMATION

Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	
FROM DATE:														
TO DATE:														TOTALS
# HOURS WORKED:														
GROSS WAGES EARNED:														

NONPECUNIARY WAGE INFORMATION

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the benefits listed below but do not include monetary allowances or stipends paid **to allow the employee to purchase the benefits**.

Nonpecuniary Wage Type	Employer Provided Prior To Injury?		Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above)													Will Employer Continue To Provide?		Date Benefit Suspended (if suspended)
	YES	NO	1	2	3	4	5	6	7	8	9	10	11	12	13	YES	NO	
Health Insurance																		
Laundry/ Cleaning																		
Clothing/ Uniforms																		
Lodging/ Housing/																		
Food/ Meals																		
Vehicle/ Fuel																		
Other																		

To the Employer:

An offer of modified duty must be made in writing; it must be presented with a copy of the corresponding Work Status Report (DWC-73), and must clearly state the following even if it is the same as the employee's regular position:

1. The location at which the employee will be working;
2. The schedule the employee will be working;
3. The wages the employee will be paid;
4. A description of the physical and time requirements that the position will entail; and
5. A statement that the employer will only assign tasks consistent with the employee's physical abilities, knowledge, and skills; and **will provide training if necessary**.

The following items must be considered when evaluating whether an offer of employment is bona fide:

1. The work location is geographically accessible given physical limitations, distance, and availability of transportation;
2. The offered schedule is similar to the preinjury work schedule
3. The physical and time requirements are consistent with the doctor's certification of the employee's work abilities; and
4. The manner in which the offer was made to the employee.

Employment is "geographically accessible" to the injured employee if it is within a reasonable distance from the employee residence unless the employee proves with medical evidence that their physical condition precludes traveling that distance.

If the employee is released to work with restrictions by a doctor, but refuses to accept the work, income benefits may be suspended based on offered wages.

It also is important that Service American receive copies of all correspondence dealing with a bona fide offer of employment. Therefore, always send the adjuster a copy of the letter when the letter is mailed and when an employee's response is received.

The following two pages contain a sample letter for a Bona Fide Offer of Employment and the sample instructions that should be sent along with the letter.

Bona Fide Offer of Employment
Sample Instructions to the Employee

PLEASE FOLLOW THE INSTRUCTIONS BELOW:

1. Read the attached letter carefully. If this letter is not clear please contact our office immediately for clarification.
2. Please check the appropriate space below indicating acceptance or denial of the offer of employment.
3. Sign and date the form.
4. Return the letter immediately. A phone call may be made to accept or not accept the position. Refusal to accept the bona fide job offer may affect your temporary income benefits.

SAMPLE LETTER
MAKING A BONA FIDE OFFER OF EMPLOYMENT

Date:

Re: Bona Fide Offer of Employment

Dear **(Employee name)**:

After reviewing the information provided by your doctor, we are offering you the following temporary work assignment.

This assignment is within your capabilities as described by your doctor on the attached Work Status Report (DWC-73). You will only be assigned tasks consistent with your physical abilities, skills and knowledge. If any training is required to do this assignment, it will be provided.

Position title: ____

Description of physical requirements of this position: ______________________________

____

Location: ____

Duration of assignment: From: (_______) To: (_______)

Work Hours: From: (_______) To: (_______)

Wages:________(Hour, Week, Month)

Department:____________________________ Supervisor: ___________________________

This job offer will remain open for seven (7) calendar days from your receipt of this letter. If you do not respond within seven (7) calendar days, we will presume you have refused this offer. Refusing this offer may impact your income benefits. It is against company policy for you to work outside the restrictions provided by your doctor.

We look forward to your return. If you have any questions, please do not hesitate to contact me **(include phone number or email address).**

Sincerely,

(Signature)

(Typed name and title)

EMPLOYEE:

______ I have read and understand the requirements of the position and accept the position.

______ I have read and understand the requirements of the position but do NOT accept the position.

____________________________ ____________________

Employee's Signature Date Signed