

# 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](http://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, Título §34A-2-101, en el libro de Código de Utah anadado en 1997, y las reglas de la Comisión de Labor (Labor Commission), y ha asegurado tener la responsabilidad de pagar compensación y otros beneficios previstos 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 UN ACCIDENTE

1. Reporte la lesión – no importa que tan leve sea – a su supervisor inmediatamente. (Pierde sus derechos si no reporta su accidente entre 180 días 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 compañía de seguro dentro de los primeros siete (7) días del accidente.
3. Si en su trabajo hay un cuarto de primeros auxilios o un doctor de la compañía, vaya inmediatamente 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 ser enviadas dentro de siete (7) días de su visita a (1) la compañía 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 requiere lo siguiente que aparezca en esta forma, cualquier persona que intencionalmente presente información false o fraudulenta, que abara o cause que sea abierto un caso fraudulento de discapacidad o beneficios médicos, o que entregue un reporte fraudulento de facturas de gastos médicos u otros servicios profesionales es culpable de crimen y puede ser sujeto a multas y encarcelado en la prisión del Estado.”



#### 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 Compensación 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](http://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 Artículo §34A-2-204, and §34A-2-104.5, en el libro de Código de Utah anadado.

Revisar 8/23/2016

**EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS**

TO BE COMPLETED BY EMPLOYER WITH ORIGINAL SENT TO INSURANCE CARRIER AND COPY SENT TO INJURED WORKER

**INJURED WORKER INFORMATION:**

Name:	Phone:
Address:	City: State: Zip:
Social Security Number:	Date of Birth:
Marital Status:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/>
Occupation / Job Title:	Date Hired:
Employment Status:	Number of Dependents:
Wage: Wage Period:	Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/>
Full Pay for Day of Injury: Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of Days Worked per Week:

**EMPLOYER INFORMATION:**

Business Name:	Phone:
Employer Contact:	Phone:
Mailing Address:	City: State: Zip:
Employment Address:	City: State: Zip:
Employer FEIN:	

**INSURANCE INFORMATION:**

Carrier:	Phone:
Carrier Address:	City: State: Zip:
Policy / Self-Insured Number:	Policy Period:

**OCCURRENCE/TREATMENT:**

Date of Injury / Disease:	Time of Injury:	Date Employer Notified:
Nature:	Body Part:	Cause:
Last Day Worked:	Date Disability Began:	Date Returned to Work:
Fatality: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Death:	Date Administrator Notified:
Address of Occurrence:	City:	State: Zip:
Premises: Employer's <input type="checkbox"/> Other <input type="checkbox"/> Description:		
Accident Description:		

**Provider Injured Worker Received Care From:**

Provider Address :	City:	State:	Zip:
Treating Physician:	Phone:		
Initial Treatment:	No Medical Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinic/Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized- 24 Hours <input type="checkbox"/> Future Major Medical/Lost Time Anticipated <input type="checkbox"/>		
Witnesses: Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes list their names and phone number:		

For your protection, it is required by Utah Law to give notice that workers' compensation fraud is a crime. See next page for full fraud statement.



**INSTRUCTIONS TO THE EMPLOYER****PLEASE NOTE:**

The filing of this form does not admit liability or fault. However, failure to file this report with the insurance carrier and provide a copy to the injured worker can result in a citation and civil penalty for each violation as per §34A-2-407(8), U.C.A.

The insurance carrier is to receive the original of this form. The injured worker shall then receive a copy along with their rights and obligations of the Utah's Workers' Compensation Act (Form 100). The employer should keep a copy for their records. The Labor Commission, Division of Industrial Accidents, will receive an electronic copy from the insurance carrier. The electronic copy of this form is private information and only released to parties of the claim.

In order to dispute the validity of the injured worker's claim, contact the insurance carrier or claim administrator for more information.

All fields on this form are required. Please complete this form entirely and do not leave any blank fields. This form will be returned and additional information will be requested if it is not properly completed. If you, the employer, need assistance to complete the form contact your workers' compensation insurance carrier or claims administrator.

*Rule R612-200-1(A)(2) Except for injuries treated only by first aid, an employer shall report each employee work injury within 7 days after receiving initial notice of the injury, as follows:*

- a. An employer that has obtained workers' compensation insurance shall report the injury to its insurance carrier.*
- b. An employer that has received Division authorization to self-insure shall report the injury to its claims administrator.*
- c. An employer that has failed to obtain worker's compensation coverage shall report the injury by contacting the Division directly.*

*3. An employer has notice of a work injury upon the earliest of:*

- a. Observation of the injury;*
- b. Verbal or written notice of the injury from any source; or*
- c. Receipt of any other information sufficient to warrant further inquiry by the employer.*

**FRAUD WARNING:**

Any person who knowingly presents false or fraudulent underwriting information, files, claim for disability compensation, medical benefits, health care fees, or other professional services are of guilty of a crime and may be subject to fines and confinement in state prison.



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, 3<sup>rd</sup> Floor  
P O Box 146610  
Salt Lake City, Utah 84114-6610  
(801) 530-6800 (800) 530-5090

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### **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](http://laborcommission.utah.gov)**

# 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.*

<b>PHYSICIAN</b>	1. Physician Name			2. Physician Phone Number			<u>Do Not Use This Space</u> CLAIM NO. POLICY NO. Class Code
	3. Treatment Facility			4. Registered Email			
<b>CARRIER</b>	5. Insurance Company						
	6. Mailing Address		City		State		Zip
<b>PATIENT</b>	7. Employee's First Name			Middle Initial	Last Name		8. SS # (or other)
	11. Mailing Address			City	State	Zip	
							10. Gender
							12. Employee Telephone Number
<b>EMPLOYER</b>	13. Name of Employer						
	14. Address			City	State	Zip	15. Employer Telephone Number
<b>HISTORY</b>	16. Date Injured (MM/DD/YYYY)			Hour _____	AM	17. Last Date Worked	
				_____	PM <input type="checkbox"/>		
18. Employee's Statement of Cause of Injury or Illness (In First Person)							
<b>EXAMINATION</b>	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?						
	<input type="checkbox"/> Yes <input type="checkbox"/> No    Undetermined						
21. Claimant Needs Interpreter		Yes	No	Language _____ (If Answer is Yes)			
<b>COMMENTS</b>	22. Other Comments						
	23. Date Submitted _____						

