



CLAIMS KIT

Thank you for choosing U.S. Specialty Insurance (USSIC) as your Primary Employer's Indemnity carrier. Attached is your Claims Kit containing the necessary documents to report a claim. The Claims Kit is a critical component of your insurance program. By completing the reporting forms correctly, USSIC will be able to handle your claims in the most efficient manner.

The attached Claims Kit includes the following reporting forms:

- First Report of Injury - This document is required to begin the claims handling process. The *First Report of Injury* provides USSIC notice that a workplace injury has occurred. It is critical that this document be completed and faxed or emailed to USSIC within 24 hours of the loss.
- Employee Statement – to be completed by the employee
- Supervisor's Report – to be completed by the supervisor
- Witness Statement – to be completed by the witness, if any
- Medical Authorization – to be signed by the employee
- Declined Medical – to be signed by the employee if he/she declines treatment
- Wage Statement – If an employee is anticipated to be off of work for more than **seven** days, this document needs to be completed to determine the employee's *average weekly salary*. Wage replacement will be 75% of the employee's average weekly salary, up to a maximum of \$600 per week.
- ERISA Verification – When your company installed the ERISA Plan, employees were given the opportunity to either except or reject the benefits offered under the ERISA Plan. A copy of the signed Arbitration Agreement is needed to verify that the injured employee is entitled to receive benefits.

Please use the above contact information to email or fax the above referenced reporting forms. Feel free to contact the Claims Department with any questions, comments, or concerns. U.S. Specialty Insurance looks forward to developing a long and pleasant working relationship with you.

Thank you,
U.S. Specialty Insurance
Claims Department

U.S. SPECIALTY INSURANCE COMPANY



FIRST REPORT OF INJURY

Please print or type form

EMPLOYEE INFORMATION

Name		Gender		Social Security No.	
Address		City	State	Zip Code	Phone
Date of Birth	Occupation	Department	Shift <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd		Date of Hire

INJURY DETAILS

Date of Injury	Time of Injury	Date Reported	Time Reported
Address Where Injury Occurred			
Was Employee Doing Regular Job?		Supervisor Name	
Description of Accident			
Description of Injuries/Part of Body			
Cause of Injury (Tool, Fall, Machine, etc.)			
Name of Medical Provider	Address		Phone
Name of Witness	Address		Phone
Name of Witness	Address		Phone
Date Disability Began	Date Return to Work	Rate of Pay Hourly \$ Weekly \$	
Average Gross Weekly Wage (At least 12 weeks prior to accident, or number of weeks worked.)			

DOCUMENT ATTACHMENT (Required):

- 1) Signed Employee Acknowledgement of Summary Plan Description
- 2) Signed Authorization of Medical Treatment Document

POLICY INFORMATION

Employer Name	Policy #	Federal Tax Identification Number
Employer Address		Phone
Person Completing This Report	Date Completed	

The employer agrees to make modified duty available for partially disabled employees able to return to some form of work as agreed to by their treating physician.

Employer Signature _____

Position _____

Fax complete form to (713) 744-9675 or Call (888) 688-0775

U.S. SPECIALTY INSURANCE COMPANY



EMPLOYEE STATEMENT

Employer: _____

Department/Division: _____

Employee name:: _____
Last First Middle Initial

Telephone () _____

Address: _____
Street Apt

_____ City State Zip Code

Employee D.O.B. _____ Social Security Number _____

Date of Injury _____ Time _____ a.m. _____ p.m. _____

ACCIDENT INFORMATION

Where did Injury Occur? _____

Describe Injury: _____

Area of body injured: _____

Witnesses: _____ Yes _____ No

Name(s) _____

Employee Job Titla: _____

Date reported to Supervisor _____ Supervisor's Name _____

Job being performed at time of Injury _____

I certify this is a true and accurate report of the circumstances which occurred on the date of my injury stated above:

Signautre of Injured Employee: _____
Witness

Date Signed: _____ : _____



DECLARACIÓN DEL EMPLEADO

Empleador: _____

Departamento/División: _____

Nombre del Empleado: _____
Apellido Primer Inicial 2^{do} Nombre

Telefono () _____

Dirección: _____
Calle Apto.

Ciudad Estado Codigo Postal

Fecha de Nacimiento del Empleado: _____ No. de Seguro Social: _____

Fecha de Herida: _____ Hora: _____ a.m. _____ p.m. _____

INFORMACION DEL ACCIDENTE

Donde ocurrio la herida? _____

Describe la herida: _____

Parte del cuerpo herida: _____

Testigos? _____ Si _____ No

Nombre(s): _____

Titulo/Ocupación del Empleado: _____

Fecha reportada al Supervisor: _____ Nombre del Supervisor: _____

Trabajo que estaba haciendo al tiempo que ocurrio la herida: _____

Yo certifico que este es un reporte exacto y verdadero de las circunstancias que ocurrieron la fecha de mi herida declaradas arriba.

Firma del Empleado Herido: _____

Fecha de Firma: _____ Testigo: _____



SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Work related or on the job incident/injury

Send this form to your company's main office, Manager, Risk Manager or designee within 24 hours

Employee name: _____

Date of incident: _____ Exact time of incident: _____

Where did it happen? _____
(Incl. street address or department/location the employee was in at the time.)

List witnesses, addresses and phone numbers, including any persons that may have knowledge of the injury or incident, if known.

Name: _____ Address: _____ Phone #: _____

Name: _____ Address: _____ Phone #: _____

Did you take the employee to the doctor? _____ Yes _____ No

Did the employee go to a doctor on own? _____ Yes _____ No

Please state the date and time of the injury: Date: _____ Time: _____

Did you actually see this injury happen? _____ Yes _____ No

Did the employee lose any work time due to the alleged injury i.e. unable to report to work for the next regular shift?
_____ Yes _____ No

List attending physician and or Hospital, if known.

Doctor Name: _____ Address: _____ Phone #: _____

Hospital Name: _____ Address: _____ Phone #: _____

How long is the employee expected to be off work, if any?

Has the employee returned to work? _____ Yes _____ No (as of date of this report)

What happened? (Describe fully what took place or what caused you to make this investigation.)

Exact date and time employee reported incident to manager/supervisor: _____

If not reported by injured employee, how did you learn of incident? _____

Name of the injured employee's immediate supervisor: _____ Phone #: _____

Investigated by: _____ Title: _____ Date: _____ Phone #: _____

Date this report was completed: _____

Date this report was forwarded to company Management : _____

Signature of Employee

Person Completing Report



INVESTIGACIÓN DE ACCIDENTE REPORTADO POR EL SUPERVISOR

Incidente/herida relacionado por ú ocurrido en el trabajo

Mande esta forma a la oficina central, al Gerente, Gerente de Riesgo o designado entre 24 horas.

Nombre del Empleado: _____

Fecha del Incidente: _____ Hora exacta del Incidente: _____

Donde ocurrió? _____
(Incl. direccion de calle o departamento/localidad del empleado durante ese tiempo.)

Nombre testigos, direcciones y numeros de telefonos, incluyendo nombre de cualquier persona que pudiera tener conocimiento del incidente, si usted sabe.

Nombre: _____ Dirección: _____ Telefono: _____

Nombre: _____ Dirección: _____ Telefono: _____

Fue usted quien llevo a el empleado al doctor? _____ Sí _____ No

Fue el empleado al doctor por su propia cuenta? _____ Sí _____ No

Por favor indique la fecha y la hora de la herida: Fecha: _____ Hora: _____

Vio usted cuando la herida actualmente ocurrió? _____ Sí _____ No

Perdio tiempo de trabajo el empleado a causa de la presunta herida, por ejemplo, no pude reportarse al trabajo el siguiente turno?

_____ Sí _____ No

Nombre el doctor que lo atendio y/o el hospital, si usted sabe.

Doctor: _____ Dirección: _____ Telefono: _____

Hospital: _____ Dirección: _____ Telefono: _____

Cuanto tiempo se espera que el empleado este fuera del trabajo, si esta fuera?

Ha regresado a trabajar el empleado? _____ Sí _____ No (hasta el dia de este reporte)

Que paso? (Describa con detalle que ocurrió o que causo que usted inicie esta investigación.)

Fecha y hora exacta cuando el empleado reporto el incidente al gerente/supervisor: _____

Si no lo reoportó el empleado herido, como se dio cuenta usted del incidente? _____

Nombre del supervisor inmediato del empleado: _____ Telefono: _____

Investigado por: _____ Titulo: _____ Fecha: _____ Telefono: _____

Fecha este reporte fue completado: _____

Fecha este reporte fue enviado a la oficina central de la compañía : _____

Firma del Empleado

Persona que completo este reporte



WITNESS STATEMENT

Name of Company: _____ Date of Incident: _____

Name of Injured Employee: _____

Name of Witness: _____

Address: _____ Phone #: _____

Same Employer as injured employee? _____ Yes _____ No

If not, employed by: _____ Employer's Phone #: _____

Are you related to the injured employee? _____ Yes _____ No

If "yes", how? _____

How long have you known this employee? _____

Please state the date and time of the injury: Date: _____ Time: _____

Did you actually see this injury happen? _____ Yes _____ No

If "no", how do you know about it? _____

How near to the injured employee were you at the time of the injury? _____

Please explain in detail what you know about this incident: _____

Did this employee ever talk with you about getting hurt on the job? _____ Yes _____ No

If "yes", when did this conversation take place? Date: _____ Time: _____

What did the employee say? _____

Do you know of any other injury, accident or illness this employee has had? _____ Yes _____ No

If "yes", please explain: _____

Give the names of any other persons who might know about this accident/injury: _____

Additional comments: _____

To the best of my knowledge, this statement is true and correct.

Signature of Witness: _____ Date Signed: _____



DECLARACION DEL TESTIGO

Nombre de la Compañía: _____ Fecha del Incidente: _____

Nombre del Empleado Herido: _____

Nombre del Testigo: _____

Dirección: _____ No. Telefónico: _____

Misma Compañía que la Persona Herida? _____ Sí _____ No

Si no, para que compañía trabaja? _____ Telefono de la Compañía: _____

Es usted pariente del empleado herido? _____ Sí _____ No

Si lo es, cual es el parentesco? _____

Cuanto tiempo conoce usted al empleado herido? _____

Porfavor indique la fecha y hora en que ocurrio la herida: Fecha: _____ Hora: _____

Vio usted cuando la herida actualmente ocurrio? _____ Sí _____ No

Si "no" vio, como se dio cuenta usted? _____

Que tan cerca estaba usted del empleado al momento que ocurrio la herida? _____

Por favor explique en detalle lo usted sabe acerca de la herida: _____

Alguna vez le platico este empleado en relacion de lastimarse en el trabajo ? _____ Sí _____ No

Si la respuesta es "Sí", cuando ocurrio esta conversacion? Fecha: _____ Hora: _____

Que le dijo el empleado? _____

Sabe usted de otra herida, enfermedad, o accidente que este empleado haya tenido? _____ Sí _____ No

Si la respuesta es "Sí", por favor explique: _____

Dé los nombres de otras personas que pudieran saber algo acerca de este accidente/herida: _____

Comentario Adicional: _____

A lo mayor de mi conocimiento, esta declaracion esta correcta y verdadera.

Firma del Testigo: _____ Fecha Firmada: _____



MEDICAL AUTHORIZATION

You are hereby authorized to release to my employer any and all information, facts and particulars, which may be requested regarding my physical condition and/or treatment rendered to me and to permit my employer and any person appointed by my employer to examine all x-rays or records regarding my physical condition or treatment and to obtain copies of such records.

Date

Signature of Employee



AUTORIZACIÓN MEDICA

Usted esta autorizado a reveler a mi compañía de empleo cualquier y toda información, hechos y particulares, cual podrian ser pedidos con respecto a mi condicion fisica y/o tratamientos recibidos y permitir a mi compañía de empleo y cualquier persona designada por mi compañía de empleo a examiner todas las radiografías (rayos X) o archivos con respecto a mi condicion fisica o tratamientos y obtener copias de dichos archivos.

Fecha

Firma del Empleado



OFFER OF MEDICAL TREATMENT DECLINED

I, _____, declined medical treatment on this date
of _____ for an injury sustained on the date of _____. I am aware
that my employer, _____ will not be responsible
for any medical expenses unless specifically approved by my
employer, _____.

Date

Signature of Employee



DECLINACION DE OFERTA DE TRATAMIENTO MEDICO

Yo, _____, declino oferta de tratamiento medico esta fecha de por herida(s) sostenidas la fecha de _____. Estoy consciente que mi compañía de empleo, _____ no será responsable por ningun gasto medico a menos que sea especificamente aprobado por mi compañía de empleo, .

Fecha

Firma del Empleado

USSIC EMPLOYER REIMBURSEMENT

13403 Northwest Freeway, Houston, TX 77040, Facsimile: (713) 744-9675



WAGE STATEMENT

Employee	Date of Injury	Claim No.
Employer	Date	

I have examined the payroll records for the employee listed above. The following table shows the weeks worked and the wages earned by the employee during the 52-week period prior to the injury or the actual number of weeks worked from date of hire; whichever is greater.

WK#	WEEK ENDING			DAYS WORKED	GROSS WAGES	WK#	WEEK ENDING			DAYS WORKED	GROSS WAGES
	MO	DAY	YR				MO	DAY	YR		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					

$$\frac{\text{TOTAL GROSS BENEFITS}}{\text{NO. OF WEEKS}} = \text{AVERAGE WEEKLY WAGE} \times 75\% = \text{DISABILITY BENEFIT}$$

Preparer's Signature _____ Date _____

USSIC EMPLOYER REIMBURSEMENT

13403 Northwest Freeway, Houston, TX 77040, Facsimile: (713) 744-9675



DECLARACION DE SUELDO

Empleado	Fecha de Herida	No. de Reclamo
Empleador	Fecha	

You examiné el record de pago de sueldo del empleado nombrado arriba. Lo siguiente muestra las semanas trabajadas y el sueldo ganado por el empleado durante el periodo de 52 semanas antes de la herida o el numero actual de las semanas trabajadas desde el dia que empezo este trabajo; cual sea mayor.

WK#	WEEK ENDING			DAYS WORKED	GROSS WAGES	WK#	WEEK ENDING			DAYS WORKED	GROSS WAGES
	MO	DAY	YR				MO	DAY	YR		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
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23						49					
24						50					
25						51					
26						52					

$$\frac{\text{TOTAL GROSS BENEFITS}}{\text{NO. OF WEEKS}} = \frac{\text{AVERAGE WEEKLY WAGE}}{\text{AVERAGE WEEKLY WAGE}} \times 75\% = \text{DISABILITY BENEFIT}$$

Preparer's Signature _____ Date _____