Association Members

Workers' Compensation Trust

Claims Kit

CREATED AND SPONSORED BY:

NH Retail Association

NH Grocers Association

P.O. Box 859222-9222 / Braintree, MA 02185 / (781) 843-0005 / 800-790-8877

AMWCT 4/2022

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SECTION 1

Introduction

This claims guideline has been provided to reflect current requirements and procedures contained within the Workers' Compensation Law for New Hampshire.

These procedures will streamline the claims reporting process thereby allowing the timely and effective management and payment of injured workers' claims.

Since our primary function is to serve you as our trust member and employer, it is essential that you familiarize yourself with this guide so that you will be aware of the services we provide. **Feel free to call us at 1-800-790-8877 for information and guidance whenever you need it.**

Fundamentals of Effective Claim Service:

- Early and aggressive investigation to detect questionable elements.
- Prompt payment of legitimate claims.
- Thorough and cooperative effort to bring injured workers back to work.
- Medical cost management.

These services cannot be rendered without the immediate and complete cooperation of employers with our investigators and claims professionals. The time element is of the utmost importance not only because it affects the speed with which benefits may be paid or determined, but also because the law requires prompt reporting as noted later in this booklet under section 6 "Forms."

Employees should be instructed to report all work related injuries to you no matter how trivial. The direct supervisor should, in turn, report the incident to a designated individual in your company who maintains accident records. That individual will also act as a liaison between your company and Cove Risk Services, LLC.

When submitting subsequent correspondence to us, please include the following information:

- Your company's full name.
- Your trust member certificate number.
- The claimant's full name.
- The date of accident.
- The claim number, if available.

Instructions for Reporting NH Workers' Compensation Claims

Please read the following instructions entirely. Our preferred method of reporting is to **complete an injury report via our website**: Report an Injury.

For Lost Time and all other claims, please use Form 8WC.

- Have all employee demographic information and accident information handy.
- Click on the link to the form you want to complete to report your claim.
- Complete the form filling in ALL FIELDS. Missing information could result in delays in the claim being set up.
- We are a mandatory reporter to CMS (Medicare) and MUST have the full SSN for the employee.
- Press the SUBMIT button. The injury report will be submitted electronically to us.
- You will receive a confirmation of receipt by email with a copy of the FROI.
- You may email supplemental documents such as witness statements, medical reports or accident investigation forms to FROI@coverisk.com or via fax to 800-382-8891.

Cove Risk reports claims electronically on your behalf with the required state agency.

If you are unable to complete an injury report online, you can:

- Print a blank report, complete it manually, and submit it via fax to 800-382-8891 Attn: New Claims Reporting.
- Email it to FROI@coverisk.com
- Call us at 800-790-8877, option 1.

Concerned about Safety? Checkout Cove Risk's Safety Services Resources online at www.coverisk.com/safety

CoveRisk Services, LLC

P.O. Box 859222-9222 / Braintree, MA 02185 / www.coverisk.com / 800-790-8877 / FAX 800-382-8891

SECTION 2

Insured's Responsibilities After Loss

- Provide / obtain immediate medical attention for the injured employee if necessary.
- Follow your internal reporting procedures and complete an incident / accident report. This report should then be forwarded immediately to the person responsible for completing the "Workers' Compensation, Employer's First Report of Occupational Injury or Disease."
- File the first report of injury with Cove Risk Services Claims via our website www.coverisk.com; or via fax 1-800-382-8891, phone 1-800-790-8877, or mail as soon as possible!

If the injury involves a fatality, fracture, or other serious condition, call us as soon as the ambulance leaves your premises! Also keep in mind that OSHA requires you to report the loss to them directly within 8 *hours* of the injury.

- Fully cooperate with the adjuster assigned to handle your losses.
- As soon as possible identify any witnesses and determine the cause of the accident. Then take corrective action so that future occurrences can be avoided.
- Notify this office as soon as the injured employee returns to work, or goes out of work on a subsequent occasion due to the injury. An "Employer's Supplemental Report of Injury" must also be filed.
- Advise us of any other employment or work the injured employee is involved in, whether with your company, or not, as well as any prior injuries they may have sustained to your knowledge.
- Follow-up with the employee. Make it clear to them that they are missed and are needed back at work as soon as possible.
- Inform your employees of their obligations once injured. Be sensitive and responsive to their needs. Allow employees who return to work to take the needed time off to seek follow-up medical attention.
- Instill in your employees that the relationship between them, Cove Risk Services, LLC, and you is not an adversarial one.
- In the event we deny a claim, the injured worker may be entitled to Disability Benefits. Notify your disability insurance carrier and send a copy of the disability report to us. That will enable us to provide that carrier with any information they need to expedite their administration of benefits.
- Communicate with us. Advise whenever there is a change in the employee's status, you have a situation which may warrant additional investigation, or whenever you have concerns or questions.
- Upon receipt of a notice of hearing from the Department of Labor, call your adjuster immediately to determine if you are required to attend. If your testimony is needed, please make every effort to be present. Your absence could severely compromise our defense.
- Identify and implement temporary, alternative duty whenever and wherever possible. Promote full duty return to work of all injured employees.
- Eliminate risk by identifying problem areas and taking swift corrective action.

By following these guidelines, you will find that the "soft" costs along with direct costs of claims can be minimized

Soft costs of claims include:

- Lost productivity
- Lost man-hours resulting in increased overtime expenditures.
- Departmental goals and budgets missed.
- Staffing issues such as shift coverage scheduling, and reallocation.
- Low morale for those "left behind" to pick up the slack.
- Increased similar claim volume.

SECTION 3

Return to Work Program

In the majority of cases, return to work is accomplished in a timely fashion. As a Self-Insured employer you have accepted a greater amount of responsibility and have shown a desire to better control the Workers' Compensation exposure to your company.

One way to control these costs is to participate in return to work programs for full and light duty capacities and to participate as a member of the recommended workers' compensation managed care program.

As your claims administrator, we will be working with you and other team members to accomplish this goal. The other team members consist of your adjuster, vocational and rehabilitational specialists, physicians, defense counsel, and risk management associates.

A return to work program is designed to minimize the loss dollars spent by the trust by returning the employee back to work as soon as possible.

Only as a coordinated team can we maintain a successful return to work program.

SECTION 4

Rehabilitation

The purpose of medical and vocational rehabilitation is to restore injured employees to suitable employment. To achieve this objective, it is the responsibility of all parties involved to cooperate in developing a rehabilitation process designed to promote re-employment at a level of earnings commensurate with the employee's ability.

We will employ a managed care network which includes the services of registered nurses, or vocational counselors when applicable to facilitate the effort to return the injured worker to employment. Your full cooperation will help accomplish that result.

SECTION 5

Posting Notice

Pursuant to section 281-A:4, the Workers' Compensation Law, you are required to post a notice (provided separately from this booklet) in a conspicuous place upon the premises advising that you are working under the provisions of the New Hampshire Workers' Compensation Law, RSA 281-A. The notice will contain the name and address of the claims administrator, the policy number and effective date of coverage. Cove Risk Services, LLC will provide these notices to you. In the event you have not received a copy of this notice of compliance by the time you receive this packet please call one of our policy services representatives at 1-800-790-8877.

SECTION 6

Forms to Be Filed By the Insured

Copies of the following forms are enclosed for your review and use. Please retain the originals and copy as needed. Further copies may be downloaded and printed directly from the NH Dept. of Labor's website at: **www.labor.state.nh.us in the left hand "Documents" option and then in the "Forms" sub-option. Then click on the "Workers' Compensation" option and choose the desired form.**

Incident Report - As part of our continuing commitment to our customers' needs, we have developed a standard Incident Report to assist your initial investigation and information gathering effort. The claimant will complete the majority of the form, thereby freeing the supervisor to complete his/her section to verify the circumstances and to determine if any follow-up action will be necessary. Accompanying the incident report is a medical authorization form that the claimant must sign. This authorization enables us to obtain pertinent medical information on the individual which will expedite our management of the claim.

Employer's First Report of Occupational Injury or Disease (form 8WC) - In the event you decide to call in your claims we will complete the first report for you. The time required for this call can be minimized by your prior completion of the "Incident Form"noted above since it contains all the information necessary to convey to us for the first report. NH Workers' Compensation Law (Section 281-A:53) states: The Employer's First Report of Occupational Injury or Disease (Form 8WC), must be filed as soon as possible, but not later than 5 days after the employer learns of the occurrence of such an injury.

Employer's Supplemental Report of Injury (form 13WCA) - If an injury results in a disability extending beyond three days, the employer shall file with the commissioner a supplemental report (Form 13WCA) giving notice of such disability as soon as possible after such waiting period, but no later than seven days after the accidental injury if the first report of injury did not already indicate that lost time was occurring. The supplemental report must also be filed immediately when an employee returns to work following a work related disability, or when subsequent periods of related disability occur.

Wage Schedule (form 76 WCA) - The wage schedule is completed by the employer to outline wages earned during the 26 weeks prior to a work related injury. It is this schedule from which the Average Weekly Wage is established and which determines the compensation wage rate for the duration of the claim. It must be filed no later than the injured worker's fifteenth day of disability resulting from a work related injury.

Job Analysis Form - This is a Cove Risk Services, LLC form used to capture a description of the employee's actual job duties. You will receive this form from us whenever an employee is, or is expected to be on an extended period of disability. We will use the form to obtain an early return to work release from the employee's attending physician. Once you have completed it, we will forward it to the doctor at the appropriate time and request that (s)he review the job description and comment on whether the employee may return to work in the capacity outlined. If the doctor agrees, then (s)he simply signs the bottom and releases the employee back to work.

The form should be completed either by Human Resources, or ideally by the direct supervisor. After you become familiar with the form it should only take about ten minutes to complete. It also has a legend on the back that defines the terms utilized to describe the employee's activities at work.

Similarly, we use this form when the attending physician has already indicated that the employee is ready to return to work, but with physical restrictions. The job analysis can then be used to tell the doctor what job you have available for the employee. Rather than completing the form with the employee's regular duties, fill it out with the parameters of a light duty job according to the doctor's restrictions. Once we receive the form we will forward it on to the doctor. Since (s)he has already indicated the employee has a partial disability and can do some form of work with restrictions, if you describe a job that mirrors those restrictions then we stand a much better chance to obtain a return to work release from the doctor.

If your organization already has a light duty program in place this form may be a good supplement to that program. If you are already utilizing a form similar to this one on a regular basis, please contact us when you plan on using your own so that efforts are not duplicated. Finally, if you do not have a light duty program but wish to implement one, please contact us and we will assist you in developing one.

Should you have any questions, or concerns during the course of completing any of these forms, please call us and speak directly with your dedicated claims professional at ***1-800-790-8877****.*

SECTION 7

First Aid/Record Only Claims

In some circumstances the injury that has been sustained by an employee will be minor with no lost time attributed to the injury. When this occurs, you may have the option to pay the bills yourself, or submit them to us to pay under a "Medical Only", claim file.

New Hampshire Lab rule 502.09 defines a "first aid" case as one that requires only a "…one-time treatment that generates a bill less than $750." You as the employer may choose to take advantage of the option to pay the medical bills yourself for work related injuries which meet the definition of a "first aid" claim. If you choose this option, you may still report the claim to Cove Risk Services, LLC as a "Record Only" claim. A "Record Only" claim at Cove Risk Services, LLC is exactly that. A claim number is assigned to it, but it stands as an unreserved, closed case.

Reporting qualified claims as "Record Only" affords employers several benefits:

- Once a claim has been reported and created by Cove Risk Services, LLC as a "Record Only" case, you may then forward any medical bills received from treatment of that injury to Cove Risk Services, LLC to review for proper billing practices to ensure any workers' PPO network discounts are applied to the fee prior to your payment of those fees.
- Once the medical fee has been reviewed, the bill and the "Explanation of Review" are returned to you to then pay the recommended allowance to the medical provider.
- Any questions, or issues medical providers have in relation to the reduction of their fees are directed to the medical bill review service for response, thereby removing you from billing issues.
- Reporting all minor injuries as "Record Only" claims and collecting information regarding that group of claims can be an effective risk management tool by assisting in loss trend analysis. Locations and causes of groups of claims can be more readily identified and prevented, thus, working to avoid the possibility of a major loss caused by the same circumstances.

Once you have decided to submit a claim as "Record Only," the process is simple. Complete and forward the first report as you would normally, but clearly indicate "Record Only" in the injury description. If there is any question on your part as to whether an injury should, or shouldn't qualify as a "Record Only" claim, we encourage you to call and discuss the case with your claims professional at Cove Risk Services, LLC prior to reporting it.

SECTION 8

Claims Review Meetings

As your claim administrator, Cove Risk Services, LLC will provide claims and risk management liaisons to review cases, or special circumstances which occur due to a loss.

Many such discussions can be handled over the phone, but when a more-in-depth meeting is needed, appointments can be scheduled for you.

SECTION 9

Cove Risk Services, LLC Duties

- Upon receipt of the loss, we will initiate contact with you within one business day to begin the information gathering process and investigation into compensability, lost time, or any other questionable elements of the claim.
- Assignment of a dedicated nurse to initiate triage and to contact the attending physician, claimant and you when appropriate.
- On site investigations performed as required.
- Immediate contact with the employee by the adjuster to obtain a statement, review benefits and request documentation such as a medical authorization.
- Continuous contact with the employee while (s)he is out of work to review their progress and to facilitate return to work efforts.
- Regular contact with the attending physician to review treatment plans and return to work dates.
- Coordinate any related services the claim may require, such as independent medical exams, special investigators and defense counsel.
- Reduce attorney representation by educating injured employees and being available to answer their questions.
- Pay what we owe and defend against non-meritorious claims.
- Pursue all types of financial recovery that arise. Whenever an opportunity arises to collect money from another party, we will aggressively pursue it.

SECTION 10

Cost Containment

All bills that are received from medical providers are audited to make sure they are properly coded and related to the injury of record. Any workers' compensation PPO discounts are also applied.

Certain red flags are provided to us through this process. We are alerted to treatment frequency issues routinely involving chiropractors and physical therapists. We are alerted when an independent medical exam (IME) is required and also to providers who are chronic "abusers" of the set guidelines for billing practices. Watching for these red flags allows us to keep the cost of medical care to a minimum.

We also utilize a radiological service network that provides certain diagnostic tests at reduced rates. Normally CT scans, MRI's, and bone scans are covered by this service.

SECTION 11

Defense Control

As required by the Workers' Compensation Law, Cove Risk Services, LLC will appoint defense counsel to represent your interests at all workers' compensation proceedings involving the NH Department of Labor. Our expert claims professionals will always be involved in the litigation process and will coordinate any defense counsel activity.

SECTION 12

Employee Benefits

Your employees are entitled to certain statutory benefits once we have accepted liability for the claim. They include, but are not limited to:

- Medical treatment for any condition related to the injury for as long as it is necessary. The law allows medical treatment to be available to the employee for life as long as they can show it is reasonable and related to the original accident.
- Payment of their lost time up to the current, statutory maximum rate. The exact benefit is calculated using 60% of the average weekly earnings for the 26 weeks prior to the injury.
- Partial wage benefits, or reduced earning rates to compensate the employee for lost income when a return to work results in a lower paying job.
- Continued payments to the employee on a weekly or lump sum basis for permanency awards.
- Rehabilitation in the form of vocational or medical counseling.
- Death benefits to spouses and dependents and burial expenses.
- Replacement of eyeglasses, false teeth, or prosthetic devices damaged as a direct result of an injurious accident. Also, reimbursement will be made for causally related prescriptions, medical equipment, and mileage for doctor's appointments. (Benefits do not include lost wages for time lost due to medical treatment).

Waiting period: This is not a benefit, but a requirement of the law you should be aware of which affects your employees' benefits. There is a three day waiting period for lost time benefits only. However, benefits are payable retroactively to day one when the lost time exceeds 14 days. Medical treatment is payable immediately regardless of the amount of lost time.

SECTION 13

New Hampshire Dept. of Labor, Workers' Compensation Division

NH Department of Labor
Workers' Compensation Division
95 Pleasant Street
Concord, NH 03301

Division Contact Numbers

Coverage:	(603) 271-2042
Claims:	(603) 271-3174
Vocational Rehabilitation:	(603) 271-3328
Self – Insurance:	(603) 271-6172

SECTION 14

Conclusion

The Claims procedures outlined in this manual are to be viewed only as a guideline and are not to be construed as a substitute for the law or legal advice. They are not intended to reduce an employer's responsibility under applicable state and federal safety laws.

The Workers' Compensation law governs claim reporting requirements and forms to be used in the administration of claims. Our claims administration policy is to ensure correct and timely payment of employee's claims, and to satisfy the New Hampshire regulations.

The Employer's First Report of Occupational Injury or Disease (form 8WC) and the Employer's Supplemental Report form (13WCA) are the most common forms you will be submitting to us. The first report of injury must be filed with us as soon as possible after the injury occurs. We have an immediate contact policy and, therefore, it is critical that the report be in our hands promptly so that we may investigate and either pay, or deny the claim timely. Our claim professional will contact you, or the supervisor, the injured worker and the attending physician. Please do all that is possible to provide as much information as soon as possible to us. This will enable us to conclude our investigation much sooner, pay, or deny the claim more quickly and reach the most timely and acceptable resolution.

Please call us at any time to discuss any questions, or concerns you have regarding the information enclosed, or regarding specific claims issues. **Call us at 1-800-790-8877.**

CoveRisk Services, LLC

INCIDENT REPORT

1) EMPLOYEE: Complete Part A.
2) EMPLOYER: Complete Part B.
3) FAX IMMEDIATELY:
Cove Risk Services, LLC, 800-382-8891

PART A. TO BE COMPLETED BY EMPLOYEE

Questions? Call (800) 790-8877

1. EMPLOYEE INFORMATION

Name: _____

Home Address: _____

Phone #: (____) - _____ - _____ Social Security #: _____ -____ -_____ Date of Birth: _____/_____/_____

Sex: ☐ M ☐ F Martial Status: ☐ S ☐ M ☐ D ☐ W Department in which you work: _____

2. ACCIDENT INFORMATION (EMPLOYEE REPORT)

Accident Date: ____/____/____ Day of week: ☐ Su ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa Hour: _____: _____ AM/PM

Date accident was reported : ____/____/____ Witnesses' Names:_____

To whom: _____ _____

Location of accident: _____ _____

Description of accident (what you were doing, what equipment you were using, what actually caused unjury, etc.):

_____

_____

_____

Description of injury (include nature of injury and part of body):

_____

_____

Did you receive medical care on premises? ☐ Yes ☐ No If "Yes", please describe: _____

_____

If receiving medical treatment:

Name and Address of Physician: _____

_____ Phone: (_____) _____-_____

Name and Address of Hospital: _____

_____ Phone: (_____) _____-_____

3. MEDICAL AUTHORIZATION

Please complete, sign and return the attached "Authorization to Disclose Health Information" together with this Incident Report.

4. EMPLOYEE'S SIGNATURE

"Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20."

EMPLOYEE'S SIGNATURE_____ DATE: _____/_____/_____

PART B. TO BE COMPLETED BY EMPLOYER

5. EMPLOYER/EMPLOYEE INFORMATION

Employer's Name: _____

Employer's Address: _____

Phone #: (_____) _____ - _____

Employee's Name: _____

Department: _____Employee's Title_____

Date of Hire: _____/_____/_____ Annual Earnings: $ _____ Status: ☐ FT ☐ PT

Work Schedule: Hours worked daily: _____:_____AM / PM to _____:_____AM / PM Union: Yes:_____ No ☐

Scheduled days off: ☐ Su ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Varies

6. ACCIDENT INFORMATION/(EMPLOYER REPORT)

Date of first report of accident: _____/_____/_____ Was employee on duty? ☐ Yes ☐ No

Is employee being paid for lost time? ☐ Yes ☐ No

If "Yes", for what period is employee being paid?: _____/_____/_____ to _____/_____/_____

Description of accident (what was employee doing, what equipment was employee using, what actually caused injury, etc.):

_____

_____

_____

WITNESSES:

Name: _____ Phone #: (_____) _____- _____ Account of Accident: _____

_____

Name: _____ Phone #: (_____) _____- _____ Account of Accident: _____

_____

Name: _____ Phone #: (_____) _____- _____ Account of Accident: _____

_____

Did employee receive medical care on premises? ☐ Yes ☐ No If "Yes", please describe: _____

_____

_____

Questionable elements of injury, if any: _____

_____

_____

Days out of work in last two months: _____

7. EMPLOYEE HISTORY

Has the employee previously suffered a disabling accident or illness? ☐ Yes ☐ No

If "Yes", did employee make a claim for benefits of compensation? ☐ Yes ☐ No

Give details of prior injury or illness (include accident date and insurance carrier, if known):

_____

_____

_____

Completed by: _____ Title: _____

Signature: _____ Date: _____/_____/_____

Claim #: _____

Caption: _____ **v.** _____

Authorization to Disclose Health Information

Patient Name: _____

Date of Birth: ____/____/_____ Social Security Number: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below:
2. The individuals or organizations listed on page two are authorized to make the disclosure.
3. The type and amount of information to be used or disclosed is as follows:

medical records, office notes, hospital records, pharmaceutical records, x-ray films, MRI films, CAT scans, other radiological films and medical bills concerning my medical treatment arising out of or prior to the date of accident.

This request is strictly limited to medical information relevant to the occupational injury or illness that underlies the patient's workers' compensation claim, including any past history of complaints of, or treatment of, a condition similar to that presented in the claim.

Your signature must appear on the line next to the below listed items for the following types of health information to be released. Your initials and signature must also appear at the bottom of both pages respectively.

HIV/AIDS related information and/or records _____

Mental health information and/or records _____

Drug-Alcohol diagnosis and treatment information _____

Pregnancy/Family Planning related information _____

Physical/Sexual abuse relt4ed information and/or records _____

Sexually transmitted disease related information and/or records _____

4. This information may be disclosed to and used by the following individual or organization:

Cove Risk Services, LLC
PO Box 859222-9222
Braintree, MA 02185
(800) 790-8877 Fax: (800) 382-8891

for the purpose of a legal claim or workers' compensation claim.

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the person or entity I authorized to release my information. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the closure of my pending Workers' Compensation Claim or one year from the date signed, whichever is later.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

7. I authorize Cove Risk Services, LLC, its agents or assigns to communicate or correspond with my treating doctors for purposes of medical history, diagnosis, treatment, degree of disability, ability to return to work or permanency.

8. A photocopy of this authorization shall be considered as effective and valid as the original.

Claimant's signature: _____

Date: _____

Claim #: _____

Caption: _____ **v.** _____

Authorization to Disclose Health Information (CONTINUED from page 1)

Name and Address of
Current Medical Provider: _____

_____

_____

Name and Address of
Current Medical Provider: _____

_____

_____

Name and Address of your
Primary Care Medical Provider: _____

_____

_____

Names and Addresses of
Medical Provider who treated for
Pre-Existing or Prior Injuries and
Medical Conditions: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Patient: _____

Date: _____

Cove Risk will file this form with the NH Department of Labor on your behalf.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE (Form 8WC)

Return to: **The State of New Hampshire, Department of Labor**
P.O. Box 2077, Concord, NH 03302-2077
(603) 271-3176 FAX: (603) 271-6149

NH DOL USE ONLY

IMPORTANT; *Every employer shall file this report as soon as possible after knowledge of any occupational injury or disease to an employee, but no later than five days thereafter. Notice of disability of four or more days shall be filed no later than seven days after date of injury on Supplemental Report Form No. 13WCA. Failure to comply with any or all of the above carries a civil penalty of up to $2,500.00. RSA 281A:53.*

PLEASE TYPE OR PRINT. ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED.

EMPLOYEE INFORMATION

1. Name of injured: First / Middle Initial / Last		2. DOB:	3. Age:	4. Male ____ Female ____	5. SS No.:
6. Address: No. & St. / City/Town		7. State:	8. Zip Code:	9. Tel. No.:	
10. Is there on file a N.H. Youth Employment Certificate?:	11. Occupation when injured:	12. Was this his/her regular occupation? If not, state regular occupation:	13. Wages per hr.:	14. No. hrs. worked per day:	
15. No. days worked per week:	16. Average Weekly Earnings:	17. Was injured hired in N.H.?	18. Date employment began:	19. Date & Time of Injury:	
20. Date disability began:	21. Was injured paid in full for this day?	22. Date supervisor/employer was first notified:	23. Name of Person notified:	24. Location/Jobsite where accident occured:	

25. Describe fully how accident occurred and describe what employee was doing when injured:

26. Name of witness(es):	27. Part(s) of body injured:	28. Estimated length of disability:	
29. Has injured returned to work?	30. If so, what date?	31. At what occupation or job?	32. Returned at: Full Duty: _____ Alternative/Light Duty: _____
33. Equipment causing injury:	34. Were safeguards in place?	35. Was accident caused by injured's failure to use safeguards or follow regulations?	

36. Initial Treatment: (check those that apply) No medical treatment: ____ Care provide by Employer only (on-site): ____ Emergency care: ____ Hospitalized: ____

Other: (Outpatient): ____ (Clinic): ____ (Office Visit): ____ (Other-explain): _____

37. Name of treating physician: Name of treating hospital:	38. Has injured died? If so, what date?

EMPLOYER INFORMATION

39. Legal Business Name and/or D/B/A or Leasing Company Name:	40. Employers Federal ID:	41. If leased or temporary worker, client's business name:	
42. Business Address of No. 39 above:	43. City/State:	44. Zip:	
45. Telephone Number:	46. Insurance Co. (**not agent**) or Self Insured Group:	47. Managed Care Program? Y or N. If yes, name Provider:	
48. No. of Employees: Full-time: Part-time:	49. Is there a Written Safety Program **in force**?	50. Is there an **active** Safety Committee?	
51. Business SIC Code	52. Type or Nature of Business in N.H.:	53. If report sent by Insurance Agency, state name:	
54. Employer Signature:		55. Printed/Typed Name and Official Title:	
56. Employee Signature (**whenever** possible):		57. Date of this report:	

Form 8WC (7-95)

THE STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

Employer's Supplemental Report of Injury

This report, indicating disability of an employee of four or more days, shall be filed as soon as possible after date of knowledge of an occupational injury or disease, but no later than ten days thereafter. Consistent failure to make this report available to the labor commissioner and the nearest claims office of your insurance carrier carries an automatic civil penalty of up to $100.00. (RSA 281-A:53) This report shall also be submitted upon employee's return to work.

1. Name of Employer _____ Employer's Identification No. _____
(9 digit number assigned by proper Federal Agency)

2. Address _____
(No. and St.) (City and State) (Zip Code)

3. Insured by _____

4. Name of Employee _____
(First Name) (Middle Initial) (Last Name) (S.S. Number)

5. Address _____
(No. and St.) (City and State) (Zip Code)

6. Date of injury _____ 20____

7. Date Disability began _____ 20____ A.M. _____ P.M. _____

8. _____
(Specific dates of disability)

_____
(Specific dates of disability)

9. Has injured returned to work? _____ if so, date and hour _____ A.M. _____ P.M. _____

10. Is injured person earning same wages as before injury? _____ If not, explain _____

_____

Date of Report _____

Signed by _____

Official Title _____

Tel. No. _____

Form No. 13 WCA (7-89)

THE STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

CONCORD, N.H. 03301

WAGE SCHEDULE

Employee _____
(NAME)

Date of hire _____ **Wages per hour** _____ **Avg. wkly. earnings** _____

Employer _____
(NAME)

Address _____
(NO.) (STREET) (CITY-STATE)

EMPLOYER MUST FORWARD TO INSURANCE CARRIER BOTH COPIES OF THIS SCHEDULE AND CARRIER'S COPY OF THE SUPPLEMENTAL REPORT FORM NO. 13 WCA NO LATER THAN EMPOYEE'S FIFTEENTH DAY OF DISABILITY RESULTING FROM INDUSTRIAL ACCIDENT.

THIS WAGE SCHEDULE IS FOR 26 WEEKS PRIOR TO DATE OF INJURY AND MUST BE FILED WITH DEPARTMENT OF LABOR BY INSURANCE CARRIER TOGETHER WITH 9 WCA

WEEK ENDING		1 GROSS EARNINGS	2 OTHER ADVANTAGES (See Wages Definition)	3 TOTAL Columns 1 & 2
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				
26.				

WAGES

In addition to money payments, means reasonable value of board, rent, housing, lodging, fuel or similar advantage received from the employer, and gratuities received in the course of employment from others, but not including any sum paid by the employer to cover any special expenses entailed on the employee by the nature of his employment.

Please provide a brief explanation for weeks with no wages.

RSA 281-A:2, Par. XV.

Carrier Name _____

Address _____

_____
(EMPLOYER'S SIGNATURE)

_____
(TITLE)

Dept. Approval

Date _____

76 WCA (12-90)
P&P WHSE STOCK #4640

CoveRisk Services, LLC

Job Analysis

To Be Completed by Employer/Rehabilitation Specialist:

Claimant Name: _____ Claim No.: _____

Job Title: _____ D.O.T. No.: _____

Firm Name & Address: _____

Union: _____

Supervisor Contact: _____ Phone No: _____

Work Schedule (hours, days/week): _____ Seasonal? ☐Yes ☐ No Wage: _____

Job Summary/Description of Tasks: _____

Education/Training: _____

Modifications Available: _____

Physical Demands: (See back for instructions.)

■ In an 8-hour day, employee is required to:
(Please circle appropriate number of hours.)

									Indicate if activity is: Intermittent	Continuous
Sit	1	2	3	4	5	6	7	8	Sit ☐	☐
Stand	1	2	3	4	5	6	7	8	Stand ☐	☐
Walk	1	2	3	4	5	6	7	8	Walk ☐	☐
Drive	1	2	3	4	5	6	7	8	Drive ☐	☐

■ Employee is required to lift/carry: (Please check as appropriate.)

	Never		Occasionally		Frequently		Continuously	
	Lift	Carry	Lift	Carry	Lift	Carry	Lift	Carry
0-10 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
11-25 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
26-50 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
51-100 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
100+ lbs.	☐	☐	☐	☐	☐	☐	☐	☐

■ **Repetitive Motion:** Employee is required to use upper extremities for repetitive: (Please check as appropriate.)

	Simple Grasping	Firm Grasping	Fine Manipulation	Pushing and Pulling
Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Employee is required to use lower extremities for movement such as foot controls: (Please check as appropriate.)

Right ☐ Yes ☐ No Left ☐ Yes ☐ No

Employee is required to: (Please check as appropriate.)

	Never (0%)	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)
Balance	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Climb (Height: ____)	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Crouch/Squat	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Reach (Overhead? Y/N)	☐	☐	☐	☐
Twist	☐	☐	☐	☐

Body Part: _____ Degrees: _____

■ **Environmental Conditions:** Inside: _____ % Outside: _____ %

☐Temp. Extremes ☐ Fumes ☐Odors ☐Dust ☐Mist ☐Ventilation ☐ Fans

Noise/Vibration: _____

Hazards: _____

Machines, Tools, Equipment, & Work Aids Used: _____

■ Analysis Performed By: _____ Date: _____

Reviewed By: (Manager) _____ Date: _____

Comments: _____

■ **To Be Completed By Physician:** Job Approved Job Disapproved

State Reasons _____

Signature: _____ Date _____

(see back for Instructions)

INSTRUCTIONS

Definitions of Terms

The physical demands (PD) reflect both the physical requirements of the occupation and the physical capacities a worker must have to meet those requirements. When completing the form, identify all physical demand factors considered critical or important for average, successful work performance. The absence of a factor indicates that the activity is not critical or important for the successful job performance. When completing the job analysis form, please use the definitions provided below as reference.

BALANCE – work activities require a state of equilibrium to ensure safety. This factor is important if the amount and type of balancing exceed that needed for the ordinary locomotion and maintenance of body equilibrium.

BEND – work activities requiring the body or a part of the body to assume a curved or crooked position.

CARRY – transporting an object, usually holding it in the hands or arms or on a shoulder.

CLIMB – work activities requiring the physical ascent or descent of ladders, stairs, scaffoldings, ramps, poles, and the like, using feet and legs and/or hands and arms.

CRAWL – work activities requiring movement on hands and knees or hands and feet.

CROUCH/SQUAT – work activities requiring the body to bend downward and forward by bending legs and spine.

DRIVE – operate controls on machinery or equipment entailing the use of one or both arms or hands and/or one or both feet or legs.

ENVIRONMENTAL CONDITIONS – the physical surroundings of a worker for a specific job.

KNEEL – work activities requiring the body to bend legs at knees to come to rest on knee or knees.

LIFT – raising or lowering an object from one level to another (includes upward pulling).

REACH – work activities requiring the extension of hand(s) and arm(s) in any direction.

REPETITIVE MOTION – movement of the body or a body part in a repeating manner.

SIT – remain in the normal seated position.

STAND – remain on one's feet in an upright position at a workstation without moving about.

TWIST/ROTATE – work activities requiring the turning of a body part changing the direction of the body part to perform the job.

WALK – moving about on foot.

CATEGORIES

NEVER – not a requirement for this position.

OCCASIONALLY – required routine activity performed 0 to 3 hours of the 8-hour workday.

FREQUENTLY – required routine activity performed 3 to 6 hours of the 8-hour workday.

CONTINUOUSLY – required routine activity performed 6 to 8 hours of the 8-hour workday.

REPETITIVE MOTION

SIMPLE GRASP – light gentle holding motion of the hand with minimal force.

FIRM GRASP – steady, secure holding motion of the hand-exerting medium to maximum force

FINE MANIPULATION/FINGERING – picking, pinching, delicate, dexterous movement of the fingers

PULLING – exerting force upon an object so that the object moves toward the force (includes jerking).

PUSHING – exerting force upon an object so that the object moves away from the force (includes slapping, striking, kicking, and treadle actions).

Proudly Administered by

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AMWCT 4/2022