Workers' Compensation Handbook & Guide

United Business Insurance Company
400 Franklin Road, Suite 240
Marietta, GA 30067
Phone 678-766-8242 X204
www.united-business.us

Dear Valued Client:

Welcome! United Business Insurance Company recognizes the vital importance of responsive and aggressive claims management. Our claims staff is experienced in every area of workers' compensation and provides the very best claims service available. Some of these services include areas often overlooked in workers' compensation, such as subrogation and second injury fund recovery. United Business Insurance Company ensures these issues are addressed and noted during the initial file review. If there is an opportunity for us to recover and mitigate case exposure, it will be identified and acted upon.

With the rise of fraudulent cases, the only true means to reduce one's exposure is aggressive and well-structured case management. United Business Insurance Company takes every possible step to provide this assertive management. This philosophy is applied to every claim, beginning with prompt contact with the employer, employee, and doctor. It continues throughout the claim process, including litigation management, medical treatment supervision, timely and accurate reserving, as well as subrogation.

In summary, we take the claims management role very seriously. Workers' compensation in any state is one of the most challenging lines of insurance to manage from a claims standpoint. Successfully handling a claim requires a strong emphasis on aggressive and timely claims management. The enclosed requirements are one way United Business Insurance Company helps your company reduce its workers' compensation costs. Please take the time to review and complete the enclosed steps. United Business Insurance Company has done the majority of the work for you to ensure your company complies with state regulations.

Sincerely,

Debbie L. Siler
Claims Supervisor
678-766-8242 X204
dsiler@united-business.us

REPORTING AN INJURY

FOLLOW THE PROCEDURES LISTED BELOW WHEN AN INJURY OCCURS:

Render first aid to the injured employee. If the injury is life threatening in nature seek immediate qualified medical attention from the nearest hospital emergency room.

If **NOT** a life-threatening injury the claimant has the right to pick an urgent care facility or doctor's office off the panel of physicians to be treated at.

Please send the next two forms with the claimant to the doctor! The first form is authorization for treatment which the employer needs to fill out. The second is the pharmacy drug information.

Report the injury immediately or within 24 hours by visiting our website at www.united-business.us or following this link: Report a Claim.
Complete the electronic WC1 First Notice of Injury Report under the "Report an Injury" tab near the bottom of the screen.

OR

Complete the paper copy of the WC1 Employers First Notice of Injury Report and fax it to 678-766-8243.

If you need assistance call: United Business Insurance Company
Claims Department, 678-766-8242, ext. 204

400 Franklin Gateway SE Suite 240
Marietta, GA 30067
(678)766-8242
www.united-business.us

Date: _____

Dear Medical Provider:

In compliance with the Georgia Workers' Compensation Law our employee has chosen you as their authorized treating physician. Please provide medical treatment to the following employee.

Injured Employee's Name:_____
Date of Injury:_____

Description of Injury:_____
_____

Employee's Title:_____
Employers Name:_____

Phone#:_____ **Fax #:**_____

Contact Person:_____

In compliance with Georgia Law please invoice our insurance company.

BILLING ADDRESS:	**CONTACT**
United Business Insurance Company	Phone #: 678-766-8242 X204
400 Franklin Gateway, Ste. 240	Fax #: 678-766-8243
Marietta, GA 30067	Email: dsiler@united-business.us

PERFORM DRUG AND ALCOHOL SCREEN? Yes [ ] No [ ]

Our company would like to work closely with you to get our employee back to their position as soon as they are physically able. If our injured employee has some physical limitations that may prohibit them from returning to their regular job we will attempt to create a transitional position that will accommodate their physical limitations:

Signed:_____
Employer

Signed:_____
Employee

We have partnered with Preferred Medical Network in order to save cost on drugs.

Please give a copy of this page to your injured employees before they go to the doctor or emergency room.

FOR YOUR PRESCRIPTION DRUGS

Have your pharmacy call Preferred Medical Network (Group #PMN2012) at 1-888-586-4650

OR

Call United Business Insurance Company at

678-766-8242 X204

Remember there should be no out of pocket expense for medical treatment or prescription drugs on an approved worker's compensation claim.

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PANEL OF PHYSICIANS

United Business Insurance Company has developed five (3) easy steps which will reduce the cost of your workers' compensation claims. This process will also allow your company and United Business Insurance Company to properly handle your claims in a timely and effective manner.

Please complete the steps listed below and return a signed copy of this form.

[] Step One

I have posted a completed PANEL OF PHYSICIANS in a prominent place upon the business premises.

[] Step Two

I have posted the BILL OF RIGHTS in the same location as the PANEL OF PHYSICIANS.

[] Step Three

A copy of the EMPLOYEE ACKNOWLEDGEMENT STATEMENT has been reviewed and signed by each employee. I have retained a copy of the form and sent the original to United Business Insurance Company.

_____

Employer/Insured

_____

Employer Representative Signature

_____

Employer/Insured Company Name

_____

Date

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Marietta, GA 30067
(678)766-8242
www.united-business.us

PHYSICIANS PANEL
(Step one)

POST YOUR PANEL OF PHYSICIANS IMMEDIATELY!

Please make sure all your employees know where the panel is located and have read the Bill of Rights. Complete the employee acknowledgement form for all employees.

Not following the above guidelines is the foremost cause of legal issues and losing control of the medical side of the claim.

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BILL OF RIGHTS
(Step two)

Pursuant to the Georgia Workers' Compensation Act, every employer is required to:

- Educate all employees so they are aware of their rights and responsibilities when they are involved in an on-the-job injury (see step 3)

- Post a summary of the employee's rights, benefits, and responsibilities pursuant to the Georgia Workers' Compensation Act in the same location as the Posted Panel of Physicians.

- Any employer who fails to comply with these requirements shall be subject to an Administrative fine not to exceed **$1,000.00**.

United Business Insurance Company has provided you with a copy of the Bill of Rights for each of your locations (see attached). Properly explaining and posting the Bill of Rights will ensure that injured workers understand their rights and responsibilities when they are involved in an on-the-job injury and your organization complies with the Georgia's Workers' Compensation Act.

The Bill of Rights MUST be placed in the same location as the Posted Panel of Physicians (see step one).

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EMPLOYEE'S ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITIES PURSUANT TO GEORGIA'S WORKERS' COMPENSATION ACT
(Step Three)

Please have the employee's initial each line and sign the bottom of the form

_____ I understand that if I am hurt on the job while working for _____ ("the company"). I may receive medical, rehabilitation and income benefits in accordance with the Georgia Workers' Compensation Act.

_____ If I am hurt on the job, I will IMMEDIATELY report my injury to my supervisor or the highest ranking person at the company at the time of my injury. I understand that if I do not timely report a work related injury to management as required by Georgia law, I may be denied benefits under certain circumstances.

_____ I understand that the company keeps a list of company approved doctors known as the POSTED PANEL OF PHYSICIANS in prominent places upon the business premises.

_____ I also acknowledge that the company has explained that I MUST see one of the physicians on the POSTED PANEL OF PHYSICIANS for treatment of a condition resulting from an on-the-job injury (unless it is an actual emergency, in which case I may go to the emergency room). I understand that I can make ONE change of physician from the POSTED PANEL OF PHYSICIANS without authorization from the company. I also understand that the company will give appropriate assistance in contacting a panel physician to schedule an appointment, if requested.

If I do not go to one of the company doctors listed on the Posted Panel of Physicians, I understand that the company will not pay medical bills from unauthorized medical providers, and I will be responsible for the payment of those bills myself.

_____ I understand that I have certain rights and responsibilities after I am involved in an on-the-job injury while working for the company. I understand that the company keeps a list of my rights and responsibilities known as the BILL OF RIGHTS in the same location as the POSTED PANEL OF PHYSICIANS, discussed above. I acknowledge that I have read and reviewed my rights and responsibilities listed on the BILL OF RIGHTS.

_____
Employee Signature

_____
Employer Company Name

_____
Date

WORKERS' COMPENSATION FORMS

Employee Statement

This should be filled out immediately after the incident or accident while it is still fresh in the employees and supervisors mind. Please submit this to United Business Insurance Company when you file the WC1 First Notice of Claim.

WC1 – First Report of Notice

This is the same form and information requested on our website **www.claims@united-business.us** for the first report of notice. Only use this form if you do not have accessibility to a computer.

WC6 – Wage Information Form

The wage from is used when an employee is going to be out of work more than seven days. This form requests the **PRIOR** 13 weeks of gross wages not to include the week of the injury. One week per line. This is what determines the amount of indemnity or lost time the employee will receive. It is important to have the correct wage information so please pay careful attention to this form and send accounting backup or copies of checks.

Post-Employment Health Questionnaire

A completed post-offer health questionnaire can help us maintain a possible intentional misrepresentation defense under Georgia's Workers' Compensation Act. Under certain circumstances, an employee may be barred from recovery of workers' compensation benefits if they intentionally misrepresent a preexisting condition on the post offer health questionnaire.

Please do not require applicants to complete the health questionnaire prior to an offer of employment because your company may violate the Americans with Disabilities Act ("ADA"). The purpose of this health questionnaire is to gather information and should not be utilized to make any employment decisions your company should seek the advice of corporate counsel or outside counsel. United Business Insurance assumes no responsibility for use of provided information.

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Employee Statement

Company Name:_____

Description of accident: _____
_____
_____
_____

Cause of accident: _____
_____
_____
_____

Action needed to prevent reoccurrence: _____
_____
_____
_____

I understand that the employer may recommend a doctor from the panel of physicians but that it is my right to choose any physician from the panel. In the event of an emergency I may have to go to the emergency room, but once the emergency is over I am required to seek treatment from a physician from the panel. I understand my rights. **Yes [ ] No [ ]**

Signature: _____

Date:_____

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to$10,000 and one year in prison.

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Supervisor Statement

Description of Accident: _____
_____
_____
_____

When were you first notified by the employee about the injury? _____
_____
_____
_____

Action needed to prevent reoccurrence: _____
_____
_____
_____

Did you explain to the employee their right to select a Panel Physician? **Yes [ ] No [ ]**
Did you give the employee a physician's authorization form? **Yes [ ] No [ ]**
Did you or anyone accompany the employee to the physician's office? **Yes [ ] No [ ]**

Signature: _____

Date: _____

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Witness Statement

Witness Statement 1: Did you witness accident or do you have any information that may assist in the investigation of the claim? Please describe below:

_____
_____
_____
_____
_____
_____

Witness Statement 2: Did you witness the accident or do you have any information that may assist in the investigation of the claim? Please describe below:

_____
_____
_____
_____
_____
_____

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to$10,000 and one year in prison.

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WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	☐ Male ☐ Female	Birthdate	Phone Number	Employee E-mail
Address		City	State	Zip Code
EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)	
Address		Phone Number	Employer FEIN	
City	State	Zip Code	Employer E-mail	
INSURER / SELF-INSURER	Name: United Business Insurance Company	Insurer/Self-Insurer FEIN: 020608690	Insurer/ Self-Insurer File #	
CLAIMS OFFICE	Name: UBIC	Claims Office FEIN #: 020608690	Claims Office Phone: 678-766-8242	Claims Office E-mail: claims@united-business.us
SBWC ID# (five digit no.): 40015	Address: 400 Franklin Road, Ste. 240	City: Marietta	State: GA	Zip Code: 30067

EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: ☐ per Hour ☐ per Day ☐ per Week ☐ per Month
Insurer Type Code: ☒ I – Insurer ☐ S-Self-insurer ☐ Group Fund	List Normally Scheduled Days Off			

INJURY/ILLNESS & MEDICAL	Time of Injury ☐ am ☐ pm	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
Did Employee Receive Full Pay on Date of Injury? ☐ Yes ☐ No	Did Injury/Illness Occur on Employer's premises? ☐ Yes ☐ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				
Treating Physician (Name and Address)	Initial Treatment Given: ☐ None ☐ Minor: By Employer ☐ Minor: Clinical/Hospital ☐ Emergency Room ☐ Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: / Returned at what wage per Week / If Fatal, Enter Complete Date of Death	

Report Prepared By (Print or Type)	Telephone Number	Date of Report

☐ B. INCOME BENEFITS **Form WC-6 must be filed if weekly benefit is less than maximum**

Previously Medical Only ☐ Yes ☐ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability:

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

☐ Temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of _____ % to _____ for _____ weeks.

UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

☐ C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

☐ D. MEDICAL ONLY ☐ **No disability paid or controverted**

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Phone and Ext.	E-mail	

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.

2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY**.
   Do not send this form to the State Board of Workers' Compensation.

3. If you need additional help, call your insurance company or self-insurer claims office.

4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
   This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be sent to the claimant(s) and all counsel of record. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

   If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

   If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682
In Atlanta: (404) 656-3818

http://www.sbwc.georgia.ga

WC-6 WAGE STATEMENT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

WAGE STATEMENT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address		
E-mail Address		City	State	Zip Code
EMPLOYER	Name	Address		
E-mail Address		City	State	Zip Code
INSURER/ SELF-INSURER	Name: United Business Insurance Company	SBWC ID# (five digit number): 40015		
CLAIMS OFFICE	Name: UBIC	Claims Office Address: 400 Franklin Road, Ste. 240		
E-mail Address: claims@united-business.us	Insurer/Self-Insurer File #	City: Marietta	State: GA	Zip Code: 30067

B. COMPUTATION OF AVERAGE WEEKLY WAGE

If the weekly benefit is less than the maximum, complete the schedule below for thirteen (13) weeks immediately preceding the accident. If the employee has not been in your employ for the thirteen (13) weeks, complete this schedule showing gross weekly earnings of a similar employee in the same employment.

☐ 13 Weeks of Employee's Wages ☐ 13 Weeks of a Similar Employee's Wages ☐ Full time weekly wage of injured employees

Wage at date of injury per week:

SCHEDULE OF WEEKLY EARNINGS

Week	From Date MM/DD/YYYY	To Date MM/DD/YYYY	No. of Days Worked	Gross Amount Paid Including Overtime or Extra Work	Value of Additional Compensation					Total Earnings
					Meals	Lodging	Rent	Tips	Other	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
			Total							
			Average Weekly Earnings							

C.	REMARKS:	REQUIRED TO COMPLETE:	OFF DAYS ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

Type or Print Name	Signature	Date
E-mail Address		Phone Number

HEALTH QUESTIONNAIRE (QUESTIONARIO DE SALUD)

Please Print
Por favor Impresión

Name
Nombre _____ Social Security Number
Numero de Suguro Social _____

Last *Apellido* | First *1st Nombre* | Middle Initial *Inicial*

Address *Domicilio*_____ City *Ciudad*_____ State *Estado*_____ Zip Code *Zip Code*_____

Medical History (Historia Medica)

Do you have or have you ever had any of the following? (Please check EACH of the following Yes or No. Any Yes answer must be fully explained below.) Answer ALL questions.
Tiene o ha tenido las siguientes? (Conteste Si o No. Las respuestas Si deben ser explicidas completamente abajo.) Conteste a TODAS las preguntas.

	Yes Si	No No		Yes Si	No No
Epilepsy *Epilepsia*	☐	☐	Psychiatric or Psychological Treatment or Evaluation *Tratamiento o Evaluación Siguiatrica o Sicológica*	☐	☐
Diabetes (Sugar problems) *Diabetis (Problemas de Azúcar)*	☐	☐	Hemophilia or other blood disease *Hemofilia o Otra Enfermedad de la Sangre*	☐	☐
Cardiac (Heart) Disease *Enfermedad Cardiaca (Corazón)*	☐	☐	Osteomylitis *Osteomelitis*	☐	☐
Marie Strumpell Disease *Mál de Marie Strumpell*	☐	☐	Stiff Joints *Problemas en las Articulaciones*	☐	☐
Any Loss of Vision *Perdida de Vista*	☐	☐	Hypoglycemia (Sugar Problems) *Hipoglicemia (Problemas de Azúcar)*	☐	☐
Polio *Polio*	☐	☐	Muscular Dystrophy *Distrofia Muscular*	☐	☐
Any Amputation *Aiguna Amputación*	☐	☐	Thrombophebitis *Tromboflebitis*	☐	☐
Cerebral Palsy *Paralisis Cerebral*	☐	☐	Herniated Intervertebral Disc *Hernia en los Discos Vertebrales*	☐	☐
Multiple Sclerosis *Esclerosis Múltiple*	☐	☐	Back Surgery *Cirugla de la Espalda*	☐	☐
Parkinson's Disease *Mál de Parkinson*	☐	☐	Allergies *Alergias*	☐	☐
Vascular (Circulation) Disorder *Problemas Circulatorios*	☐	☐	Arthritis *Arthritis*	☐	☐
Height *Estatura*	Ft. *Pies* ___	In. *Plgs.* ___	Weight *Peso*		Lbs. *Lbs.* _____

Have you ever received treatment for a back, neck, or knee condition or head injury?
*Ha recibido usted tratamiento por algún problema en las espalda, cuello o rodilla o golpe a la cabeza?*_____

_____

Do you now or have you ever suffered from aches or pains of the back?
*Padece usted o ha padecido de dolores en la espalda?*_____

_____

Have you ever had any surgery?
*Ha tenido algúna vez cualquier tipo de cirugia?*_____

_____

Do you now or have you ever had any physical disabilities impairments or handicaps?
*Tiene usted o ha tenido impedimentos fisicos o mentales?*_____

_____

Have you ever had a workers' compensation injury?
Ha tenido usted algúna vez accidentes de trabajo? _____

_____

Have you ever received a disability rating for any reason?
Ha sido usted alg*úna vez clasificado como desabilitado?*_____

_____

Have you ever received compensation or medical benefits under workers' compensation?
Ha reibido usted compensación o beneficios médicos por accidentes de trabajo? _____

_____

Explain fully any Yes answer.
Explique completamente cualquier respuesta de Si. _____

_____
_____
_____
_____
_____
_____
_____

Do you have any questions about the completion of this form.
Usted tiene cualquier pregunta sobre la terminación de esta forma.

_____
_____
_____
_____
_____
_____
_____
_____
_____

I have been fully advised that if I am injured on the job, regardless of how minor the injury may seem, I am to report that injury immediately to my supervisor.
Yo he sido totalmente instruido que si yo sufro algún accidente in el trabajo debo reportario inmediatamente a mi supervisor, aún cuando al accidente aparezca ser pequeno. **Yes** *(Si)* ☐ **No** *(No)* ☐

I certify the above answers to be true and correct. I understand that any false or misleading answers to these questions may be sufficient reason for the denial of workers' compensation benefits and a basis for termination. Also, making false or misleading statements for the purpose of obtaining workers' compensation benefits can be punishable by fines and or a prison sentence.

Certifico las respuestas antedichas para estar verdad y correcto. Entiendo que cualquier respuesta falsa o de engaño a estas preguntas puede ser suficiente razón de la negación de las ventajas de la remuneración de los trabajadores y de una base para la terminación. También, la fabricación de declaraciones falsas o engañosas con el fin de obtener las ventajas de la remuneración de los trabjadores puede ser castigable por multas y o una oración de la prisión.

Applicant's Signature
Firma del Aplicante _____ Date
Fecha _____

Witness
Testigo _____ Date
Fecha _____

NOTE: If applicant is unable to read and write, he is to make his mark in the place for his signature. The witness is to certify that he has read the above requested information to the applicant and that the answers are those of the applicant. Sign in the space for witness to certify.
Si el aplicante no sabe leer y escribir, debe pones su marca en el espacio de la firma. El téstigo debe certificar que ha leido la información del documento al aplicante y que las preguntas han sido contestades poreste. Firme en el espacio del testigo.

Current employment practices should be reviewed by employers and/or their corporate attorneys, for compliance with the American with Disabilities Act (ADA), and other state and federal laws governing employment rules and regulations.

KEY SERVICE TEAM MEMBERS

United Business Insurance Company
400 Franklin Road, Ste. 240
Marietta, GA 30067

Phone: 678-766-8242
Fax: 678-766-8243

Joe Capers	*Executive Manager*	Ext. 201	jcapers@united-business.us
Brenda Anderson	*Policy Services*	Ext. 202	banderson@united-business.us
Matthew Harpin	*Underwriting*	Ext. 203	mharpin@united-business.us
Stacey Scott	*Marketing*	Ext. 210	stacey@united-business.us
Brad Longmire	*Underwriting*	Ext. 209	blongmire@united-business.us
Scott Hardin	*Marketing*	Ext. 212	scott@united-business.us
Debbie Siler	*Claims Supervisor*	Ext. 204	dsiler@united-business.us
Terry Jackson	*Administration*	Ext. 207	tjackson@united-business.us
Denise Phillips	*Accounting*	Ext. 213	dphillips@united-business.us
Taylor Hightower	*Claims Specialist*	Ext. 214	taylor@united-business.us