



ASSOCIATED  
CLAIMS  
ADMINISTRATORS

## **Dear Employer:**

Associated Claims Administrators (ACA) will be administering your Worker's Compensation claims on behalf of National Liability & Fire Insurance Company and in partnership with North American Risk Services (NARS).

ACA and NARS professionals are experienced in Worker's Compensation Law. Please feel free to call our office with any questions you may have regarding your Worker's Compensation concerns.

Early involvement in a claim is important. It is not only cost effective for you, but it also can help the injured employee get proper medical care and return to work as soon as possible. We look forward to working with to accomplish these goals.

You, the employer, are a vital part of making this happen. Listed below are some things you can do:

1. Report all work-related injuries as soon as you are aware of them.
2. You may report all work-related injuries by email at [claims@acaworkcomp.com](mailto:claims@acaworkcomp.com), fax to **1-800-988-4722**, or call **1-800-388-6268** for assistance reporting a claim.

After reporting your claim, you can contact NARS at **1-800-315-6090** for further assistance with your claim including:

1. Refer all medical authorization requests to NARS.
2. Communicate with your employee and NARS throughout the claim.
3. Have some light duty work available for restricted duty.
4. Advise NARS when the employee returns to work.

**Please keep copies of the attached forms to have on hand if needed. Fillable forms can also be downloaded at <https://aiamga.com/workers-compensation/states-covered/>.**

We look forward to a long and pleasant working relationship with you and your employees.

Please call anytime between 8:00am and 5:00pm Central Time, Monday through Friday if you have any questions regarding Worker's Compensation claims procedures.

**Best regards,**

**Associated Claims Administrators**

## WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE	
		JURISDICTION		JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER			
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)			LOCATION #
INDUSTRY CODE	EMPLOYER FEIN			PHONE #	
<b>CARRIER/CLAIMS ADMINISTRATOR</b>					
CARRIER (NAME, ADDRESS, & PHONE #)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)		
		TO			
		CHECK IF APPROPRIATE			
		SELF INSURANCE			
CARRIER FEIN	POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN		
AGENT NAME & CODE NUMBER					
<b>EMPLOYEE/WAGE</b>					
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX	MARITAL STATUS	OCCUPATION/JOB TITLE	
		<input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN	<input type="checkbox"/> U UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN	EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS				NCCI CLASS CODE
RATE PER:	<input type="checkbox"/> DAY WEEK	<input type="checkbox"/> MONTH OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>OCCURRENCE/TREATMENT</b>					
TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED	<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE DATE EMPLOYER NOTIFIED DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED	
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE	
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL					CAUSE OF INJURY CODE
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)		INITIAL TREATMENT	
				<input type="checkbox"/> 0 NO MEDICAL TREATMENT <input type="checkbox"/> 1 MINOR: BY EMPLOYER <input type="checkbox"/> 2 MINOR CLINIC/HOSP <input type="checkbox"/> 3 EMERGENCY CARE <input type="checkbox"/> 4 HOSPITALIZED > 24 HOURS <input type="checkbox"/> 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
<b>OTHER</b>					
WITNESSES (NAME & PHONE #)					
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE		PHONE NUMBER	

## EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

### DATES:

Enter all dates in MM/DD/YY format.

### INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

### CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

### CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

### AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

### OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

### EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

### DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

### CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

### TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

### PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

### DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg.

Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

## EMPLOYER'S INSTRUCTIONS – cont'd

### ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

### SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

### WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

### HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

### DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.



## COMMONWEALTH OF KENTUCKY WORKERS' COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers' Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Workers Compensation Carrier  
(or third party administrator): \_\_\_\_\_  
Policy #: \_\_\_\_\_, effective \_\_\_\_\_ to \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_, Contact Person \_\_\_\_\_

**EMPLOYEES: IF INJURED – NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.**

This employer IS  IS NOT  participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is \_\_\_\_\_, its representative is \_\_\_\_\_, phone number \_\_\_\_\_.

**DISABILITY BENEFITS** to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) day of disability. A CLAIM MUST BE filed with the Department of Workers' Claim WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.

**NEED ASSISTANCE?** Contact your employer's claim representative. If your questions about workers' compensation rights are not promptly answered call THE KENTUCKY DEPARTMENT OF WORKERS CLAIMS at 1-800-554-8601 to speak to an Ombudsman or Workers' Compensation Specialist.

**EMPLOYER SUPERVISORS – NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.**

04/09/09

**RE: WAGE STATEMENT**

Employee:	
Employer:	
Date of Injury:	
File Number:	

Dear Insured:

In order to calculate this employee's Workers' Compensation Benefits, we must have the gross weekly wages for the 52 weeks immediately preceding this accident. Include the value of any fringe benefits that will not be paid in behalf of the claimant during the disability period.

Please complete the form and return it to this office as soon as possible. If this employee has not been in your employment for longer than two months, submit the wages of a similar employee doing the same type of work over a one-year period of time.

Your immediate response will help speed the processing of this claim. If you have any questions, please contact us at the number above.

Sincerely,

Associated Claims Administrators

**ASSOCIATED CLAIMS ADMINISTRATORS**  
**P.O. Box 230848**  
**Montgomery, AL 36123-0848**  
 334-271-6767 (main)  
 1-800-388-6268 (toll free)  
 1-800-988-4722 (fax)

**WAGE STATEMENT**

CLAIMANT: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

A. The following table shows the wages earned by \_\_\_\_\_ employed as a \_\_\_\_\_ during the period stated.

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

I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT STATEMENT.

\_\_\_\_\_, TITLE \_\_\_\_\_

DATE: \_\_\_\_\_