KENTUCKY SCHOOL BOARDS INSURANCE TRUST KSBIT
KSBA's Insurance and Safety Solution

Contact List

CLAIMS REPORTING

Contact Debbie Frick with KSBIT Marketing to report claims	Phone for reporting:	(toll-free) **888-696-9620**
	Fax reporting:	**859-296-4583**
	E-mail reporting:	Debbie.frick@ksba.org
	After hours/weekends	
	Phone for reporting:	(toll-free) 866-545-7800
	Internet reporting:	www.klcis.org
	Fax reporting:	(toll-free) 866-545-7801
	E-mail reporting:	claims@collinsandco.com

CLAIMS ADMINISTRATORS

Collins and Company, Inc., Third Party Claims Administrators for Kentucky School Boards Association		
Collins and Company, Inc. Bldg 4, Suite A 204 Bevins Lane Georgetown, KY 40324	Sherman Cothran Regional Manager (Management Contact) E-Mail: scothran@collinsandco.com	Georgetown Local Numbers Office: 502-863-4177 Fax: 502-863-4476
Collins and Company, Inc. 112 West Court Street, Suite 203 Prestonsburg, KY 41653	Toll Free Phone: 866-545-7800	Prestonsburg Local Numbers Office: 606-886-1967 Fax: 606-886-1334
Collins and Company, Inc. 516 South 6th Street Mayfield, KY 42066	Toll Free Fax: 866-545-7801	Mayfield Local Numbers Office: 270-251-9074 Fax: 270-251-0956
Collins and Company, Inc. 9000 Wessex Place, Ste 301 Louisville, KY 40222		Louisville Local Numbers Office: 502-423-9711 Fax: 502-423-9715

KENTUCKY SCHOOL BOARDS INSURANCE TRUST KSBIT KSBA's Insurance and Safety Solution

Workers' Compensation Incident / Claim Reporting

All claims should be reported immediately or as soon as possible following the incident. The employee may decline to receive medical treatment; however, if minor first-aid treatment is all that is required, the incident must still be reported to claims. The following procedures apply to incidents that involve a **job-related injury or illness sustained by an employee**..

Step 1:	Get the injured worker immediate medical treatment and make sure that any unsafe condition is immediately corrected to prevent any further injuries.
Step 2:	Coordinate the documentation of the incident with the employee and employee's supervisor. A **Kentucky First Report of Injury or Illness** form and a **Supervisor's Incident Investigation Report** must be completed for all incidents where an employee sustains a job-related injury or illness, including incidents where medical treatment is waived.
Step 3:	Report the incident to Claims as soon as possible via telephone, fax, or e-mail. Claims submitted after hours or on the weekend should be emailed. a. **Phone** 1-888-696-9620**:** Debbie Frick with KSBIT Marketing will take the claim information from the **Kentucky First Report of Injury or Illness** form. b. **Fax** 1-859-296-4583**:** Fax the completed **Kentucky First Report of Injury or Illness** form. c. You can also scan and **e-mail** the **Kentucky First Report of Injury or Illness** form to debbie.frick@ksba.org. If the employee was injured and waives medical attention, report the incident to Collins and Company, Inc. as a "record only". Collins and Company, Inc. will direct the injured employee to the Eckman Freeman Managed Care Organization located at **ksba.org/riskmanagement/mco** Collins and Company, Inc. will send the injured worker the claims information package including the claim number, KY Form 106 Medical Waiver and Consent, KY Form 113 Designated Choice of Physician, Employee Status Letter, and Employee Questionnaire, and an Rx pharmacy card(which the employee will use to obtain prescriptions with no out of pocket cost to the employee). The forms will need to be completed by the claimant and returned to Collins and Co, Inc., which will be made part of the claim file.
Step 4:	If medical treatment is required, Collins and Company, Inc. will provide the employee with a KY Form 106 Medical Waiver and Consent. This form includes a HIPPA release.
Step 5:	If the employee was injured and waived medical attention, assure completion of the **"Medical Treatment Disclaimer"** on the **Post-Incident Drug Test Authorization Form**.
Step 6:	Fax the completed **Supervisor's Incident Investigation Report** and the **Kentucky First Report of Injury or Illness** form (if not faxed at first report) to Debbie Frick with KSBIT Marketing at 1-859-296-4583.

When to Notify OSHA

OSHA standards require that the deceased's **employer** contact OSHA if a **fatality** occurs onsite as a result of a work-related incident **within eight (8) hours**. In the event that the cause of the fatality is not known, but occurs at the workplace, OSHA must still be contacted within the specified timeframe, as "cause of death" can only be determined by a medical examiner, doctor, or coroner.

Also, when three (3) or more workers are hospitalized as a result of one incident, the injureds' **employers** must contact OSHA within eight (8) hours.

If you do not have a local number for OSHA, contact them at: 800-321-674

Kentucky First Report of Injury or Illness Form (page 1 of 2)

IA-1 WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)	Carrier/Administrator Claim Number	Report Purpose Code
Bath County Board of Education 405 West Main Street Owingsville, KY 40360	Jurisdiction / Jurisdiction Claim Number	
	Insured Report Number	
	Employer's Location Address (if different): same	Location No.
Sic Code / Employer FEIN: 61-6001341		Phone No.: 606-674-6314

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)	Policy Period	Claims Admin (Name, Address & Phone Number)
Collins and Company, Inc. Bldg. 4, Suite A, 204 Bevins Lane Georgetown, KY 40324	To ☐ Check if self insured	
Carrier FEIN / Policy Number or Self-Insured Number		Administrator FEIN
Agent Name & Code Number		

Employee/Wage

Legal Name (Last, First, Middle)	Date of Birth	Social Security Number	Date Hired	State of Hire
Address (Incl. Zip)	Sex: ☐ Male ☐ Female ☐ Unknown	Marital Status: ☐ Unmarried/Single/Div. ☐ Married ☐ Separated ☐ Unknown	Occupation/Job Title	
			Employment Status	
Phone	No. of Dependents		NCCI Class Code	
Wage Rate $ ☐ Day ☐ Week	☐ Month ☐ Other	# Days Worked/WK # Hrs Worked per Day	Full Pay for Date of Injury? ☐ Yes ☐ No	Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM	Date of Injury or Illness	Time Occurred ☐ AM ☐ PM	Last Work Date	Date Employer Notified	Date Disability Began
Employer Contact Name/Phone Number		Type of Illness/Injury		Part of Body Affected	
Did Injury/Illness Exposure Occur on Employer's Premises? Yes ☐ No ☐		Type of Illness/Injury 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 Returned to Work	If Fatal, Date of Death		Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No Were they used? ☐ Yes ☐ No		

Treatment

Physician/Health Care Provider (Name & Address)	Hospital (Name & Address)	Initial Treatment
		0 ☐ No Medical Treatment 1 ☐ Minor: By Employer 2 ☐ Minor Clinic/Hosp 3 ☐ Emergency Care 4 ☐ Hospitalized > 24 hr. 5 ☐ Future Major Medical/Lost Time Anticipated

Other

Witness to Accident (Name & Phone Number)			
Date Administrator Notified	Date Prepared	Preparer's Name & Title	Preparer's Phone Number
IA-1 (2/95)	SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE		

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Kentucky First Report of Injury or Illness Form (page 2 of 2)

Applicable in Alaska
A person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception.

Applicable in Arkansas
Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding worker's compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

Applicable in California
Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Applicable in Connecticut
This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Applicable in Delaware and Oklahoma
Any person who, knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. *Delaware Statutes Regulation: Del #C Section 913(B)

Applicable in Florida
Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Applicable in Idaho
Any person who Knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company, Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

Applicable in Indiana
A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kentucky and New York
Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Michigan
Any person who knowingly and with intent to injure or defraud any insurer submits a claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to $5,000.00.

Applicable in Minnesota
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada
Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire
Any person who, with 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.

Applicable in New Jersey
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Ohio
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Pennsylvania
Any person who knowingly and with intent to injure or defraud any insurer files a claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years or payment of a fine of up to $50,000.

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

EMPLOYEE SIGNATURE: ______________________________
IA-1 (2-95)

Supervisor's WC Incident Report

Incident Date:____________________ Time:______________ Place:_____________________________

EMPLOYEE INFORMATION: (Complete one report for each employee involved)

Name:____DOB:______________________

Address:____

____Driver's License/Photo ID #:_______________

Home Telephone:___________________________________Occupation:____________________________

How long was employee performing this operation/job:____

Employer:____

INCIDENT INFORMATION:

Describe in detail how incident occurred:____

____

What was employee doing at time of incident:____

____________________________________Were activities part of the job: YES/NO (If *NO*, describe further)

____

Were weather conditions a factor? YES/NO Describe conditions:______________________________

Name, address and phone number of all witnesses to the incident (use separate sheet if necessary):

____

Did the incident result in an injury: YES/NO (If *NO*, skip Injury Information Section)

Did the incident result in property damage: YES/NO (If *YES,* complete Property Damage Information Section)

INJURY INFORMATION:

Describe nature and extent of injury:____

Was first aid given: YES/NO When and by whom:____

Give name, address, and phone number of injured person (if different than employee listed above):

____

Supervisor's WC Incident Report (continued)

Was injured transported from scene via ambulance: YES/NO Where were they taken:____________

____

SAFETY:

Contributing unsafe conditions, consider equipment/tools, materials housekeeping, etc.:__________________

____

Contributing unsafe acts; consider action(s) of employee, co-worker or others, violation of safe work rules/practices, etc:____

____

Corrective action(s) recommended by Supervisor:____

____

____

Prepared by:
Employees Supervisor:

____ Date:__________________________

Fax this form to:

1. Debbie Frick with KSBIT Marketing **859-296-4583**
2. After hours/weekends, Collins and Company...................................... **866-545-7801**

Step 6:	Fax the completed **Supervisor's Incident Investigation Report** (if not faxed at first report) to Debbie Frick at 859-296-4583.

Medical Treatment Authorization Form

Employers Name: ____________________

Employee Name: ____________________ **Driver's License/Photo ID#:** ________________

Employee Address: ____

Date of Injury: ____________________________ **Time of Injury:** ____________________

THIS COMPLETED FORM MUST BE RETURNED TO THE EMPLOYER BY THE EMPLOYEE SO HE/SHE CAN RETURN TO WORK

This certifies that the above named individual is employed by______________________________.
Please provide appropriate evaluation and treatment, and bill to the address below.

Approval (Print): ________________________________Date: __________________

Approval Signature: _________________________ Phone Number:________________

THIS SECTION MUST BE COMPLETED BY THE ATTENDING PHYSICIAN

Diagnosis: ____
____

1. Is the Employee able to return to work?
   Full Duty _____ Restricted Duty _____ Total Disability _____
   If restricted duty was selected, briefly describe restrictions: ____________________
   ____
2. Will employee require any follow up treatment? Yes _____ No _____
   If yes was selected, when is the next scheduled visit?
   Date: ____/____/____ Time __________ Est. # of follow up visits
3. I am aware of the restrictions placed on me by the treating Physician:
4. Ten panel Drug testing completed? Yes______ No_______

Employee's Name (Please print): ____________________________________

Employees' Signature: ____

Physicians' Name (Please print): ____________________________________

Please return a copy of this completed form to the Collins and Company, Inc.

Bills for treatment should be mailed to:	*Drug test results should be mailed to:*	*Questions regarding treatment should be directed to:*
Collins and Company, Inc. Bldg 4, Suite A, 204 Bevins Lane Georgetown, KY 40324 1-866-545-7800 FAX 1-866-545-7801	**Collins and Company, Inc. Bldg 4, Suite A, 204 Bevins Lane Georgetown, KY 40324 1-866-545-7800 FAX 1-866-545-7801**	**Collins and Company, Inc. Bldg 4, Suite A, 204 Bevins Lane Georgetown, KY 40324 1-866-545-7800 FAX 1-866-545-7801**

MEDICAL TREATMENT DISCLAIMER

I, ______________________________, ELECT NOT TO GO FOR MEDICAL TREATMENT AT THIS TIME FOR

THE FOLLOWING INJURY: ____

WHICH OCCURRED ON _______________ AT ____________________________________

SIGNED: ________________________
(EMPLOYEE)

WITNESS: _______________________ WITNESS: _______________________

Patient's Employer: ____

Address: ____

Phone Number: ____________________ Fax Number: ____________________

Approved by: ____
Signature

____
Print Name Title

____
Phone Number Fax Number

Bills for drug tests should be mailed to:	*Drug test results should be mailed to:*	*Questions regarding drug testing should be directed to:*
Collins and Company, Inc. Bldg 4, Suite A, 204 Bevins Lane Georgetown, KY 40324 1-866-545-7800 FAX 1-866-545-7801	**Collins and Company, Inc. Bldg 4, Suite A, 204 Bevins Lane Georgetown, KY 40324 1-866-545-7800 FAX 1-866-545-7801**	**Collins and Company, Inc. Bldg 4, Suite A, 204 Bevins Lane Georgetown, KY 40324 1-866-545-7800 FAX 1-866-545-7801**

FORM 106
ADOPTED JULY 2003

COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS' CLAIMS
CLAIM NO:__________________

MEDICAL WAIVER AND CONSENT

I, ____ having filed a claim for workers' compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize any health care provider to furnish to myself, my attorney, my employer, its workers' compensation carrier or its agent, the Division of Workers' Compensation Funds, the Uninsured Employers' Fund, or Administrative Law Judge any information or written material reasonably related to my work-related injury occurring on or about ______________ any medical information relevant to the claim including past history of complaints of, or treatment of, a condition similar to that presented in this claim or other conditions related to the same body part.

Such information is being disclosed to the purpose of facilitating my claim for Kentucky workers' compensation benefits.

I understand I have the right to revoke this authorization in writing at any time, by sending written notification to each individual health care provider, but such revocation will not have any affect on actions taken prior to revocation. Moreover, inasmuch as KRS 342.020(8) requires a medical waiver to be executed, revocation may result in suspension or delay of the workers' compensation claim.

I understand that no medical provider may condition treatment or payment on whether I sign this medical waiver; however, I further understand that failure to sign this medical waiver may result in suspension or delay of the workers' compensation claim.

I understand that the information used or disclosed pursuant to this medical waiver may be subject to re-disclosure by the recipient.

This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

The authorization includes, but is not restricted to, a right to review and obtain all copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

Signed at ____________________________________, Kentucky, this ________ day of __________________, 20______.

____

Signature of Patient Or Personal Representative

Social Security Number: ____________________

____

Witness Signature

____

Description Of Personal Representative's Authority

KENTUCKY WORKERS' COMPENSATION AND HIPAA

On April 14, 2003, the federal Health Insurance Portability and Accountability Act [HIPAA] privacy regulation will take effect. This regulation limits the situations in which medical providers may release patient information, unless the information is necessary for the purpose of treatment, payment, or health care operations. Moreover, it is important to note that disclosures for workers' compensation are in most instances exempt from HIPAA privacy requirements. The exact wording is as follows: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation…"

Since HIPAA defers to state law regarding disclosures relating to workers' compensation, it is important for claimants and medical providers to know what Kentucky law requires for disclosure of patient information. An employee who reports a work injury or who files for workers compensation benefits must "execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation." KRS 342.020 (8). Kentucky law further states that once this Form 106 is signed, any health care provider "shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer [or its agent or assignee], special fund, uninsured employers' fund, or the administrative law judge, provide the **requesting party** with any information or written material reasonably related to any injury or disease for which the employee claims compensation."

Once the Form 106 is signed, health care providers may disclose information as set out in Kentucky law. Another section of the regulation allows release of information pursuant to an administrative or judicial order or subpoena, provided that there has been a reasonable effort to notify the injured worker [or his attorney] that such a request has been made. Should there be questions regarding disclosures pursuant to this form, appropriate legal counsel should be consulted or you can contact the Office of Workers' Claims at 1-800 554-8601.

Two-Sided Form

Form 113
Revised 03-12-03

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
Claim No. ________________

NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: ______________________________
Name
____
Street Address
______________________________ ( ) ____
City, State, Zip — Telephone Number

______________________ ______________________
Date of Birth — Social Security Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

____
Name
____
Street Address
____
City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: ______________________________

DATE OF INJURY OR LAST EXPOSURE: ______________________________

FIRST DESIGNATED PHYSICIAN:

____
Name
____
Street Address
______________________________ ( ) ____
City, State, Zip — Telephone Number

Accepted by: ______________________________

MEDICAL INFORMATION RELEASE: I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

______________________ ______________________
Date — Employee Signature

MEDICAL PAYMENT OBLIGOR:

____
Name Of Obligor
____
Representative
____
Street Address
______________________________ ( ) ____
City, State, Zip — Telephone Number

This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.

Notice: The Workers' Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as "designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for medical services.