TASB RISK MANAGEMENT FUND

12007 Research Blvd. • Austin, Texas 78759-2439 • P.O. Box 2010 • Austin, Texas 78768-2010
Tel 512.467.3699 • 800.482.7276 • Fax 800.580.6720 • tasbrmf.org

Administered by the Texas Association of School Boards, Inc.

WHAT TO DO WHEN THERE IS AN INJURY ON THE JOB

For Emergencies please direct employee to nearest Emergency Room or Clinic. If possible ensure Employee leaves with ***Medical Notice of Reported WC Claim*** *(Page 3)* ***Helios Medical First Fill Card*** *(Page 4 & 5)*

- ❑ Go to www.tasbrmf.org and complete FROI and file with TASB Risk Management Fund & Employee (Instructions Pages 16-23)
- ❑ Give Employee **Notice of Rights and Responsibilities** English, Spanish, Chinese, Vietnamese, Korean (English & Spanish Pages 6-10)
- ❑ Have Employee sign **Acknowledgement of Medical Alliance** English, Spanish (Pages 11 & 12)
- ❑ Give Employee **Medical Notice of Reported WC Claim** (Page 3) and **Helios First Fill®** Program (Page 4 & 5)
- ❑ Have Employee advise whether he/she wishes to use available leave for any possible lost time due to the on the job injury by completing and signing an **Election of Leave** English, Spanish form. If Employee elects to use available leave you must indicate how many leave days will be used and complete the "from" and "through" dates. (Pages 13 -15)

❑ If employee is losing time, elected leave is exhausted or there is a loss of wages file the D6 Supplemental Report of Injury

To search for primary care physicians in your area go to Find a Doctor the provider search at the Medical Alliance website (www.pswca.org.)

State law requires Employers to create a First Report of Injury (FROI) on all on the job incidents, injuries or diseases they are aware of or is reported by an employee or someone acting on the employee's behalf. Creation of a FROI is not admission by an Employer that said incident, injury or illness occurred or that the facts are true.

Important Information to Remember:

The FROI must be completed on ALL incidents reported to management (Human Resources, Benefits, principals, secretaries, supervisors, nurses, etc.). When any of these people know of an incident, a FROI must be filed and kept with the Employer for 5 years from the last day of the year in which the injury occurred.

- FROI must be filed with the TASB Risk Management Fund **within 8 days** on the following claims:
  - Employee loses more than 1 day of time due to the injury on the job
  - Injury reported is an Occupational Disease. Occupational disease means a disease arising out of and in the course of employment that

causes damage or harm to the physical structure of the body, including a repetitive trauma injury. These must be filed regardless of whether there is lost time.
    - Death of an employee from a work related injury or illness
    - Employee seeks medical treatment for an injury on the job
- *Please notify the TASB Risk Management Fund anytime an employee collapses while at work*.

Once the First Report of Injury is filed the following documentation is also required:

Supplemental Report of Injury: DWC-6 *(Requires Member to log in at www.tasbrmf.org.)*
Multi-purpose form completed when work or earnings status changes from the FROI. *(Please note boxes 6-9 should be checked YES and date is Ongoing.)*

- Employee has returned to work – **Due by the 3rd calendar day** - Complete boxes 1-9; 10A; 11-15; 18
- Employee has started losing time – **Due by the 3rd calendar day** - Complete boxes 1-9; 10C; 11-14; 15 if applicable and/or 16
- Employee resigns or is terminated – **Due by the 10th calendar day -** Complete boxes 1-9; 10D; 11-14; 19
- Employee is working partial days or a different job earning different wages on restricted duty- **File at the end of each week, but no later than the 10th calendar day** – Complete boxes 1-9; 10B; 11-14; 20; 21

Employers' Wage Statement for School Districts: **DWC3-SD** *(Requires Member to log in at www.tasbrmf.org.)*

Due within **30 days of the earliest from:**

- Employee's 8th day of disability
- Date employer is notified employee is entitled to benefits
- Date of the employee's death as a result of a compensable injury

Please note the deadlines listed above are mandated by the Statute and failure to file the FROI, Supplemental Report and Employers' Wage Statement are subject to fines.

Please contact Laura Romaine, WC Claims Program Consultant, laura.romaine@tasb.org or (800)482-7276 ext. 8402 for further assistance.

Employer Logo

Employer Name
Address
City, TX
Phone

Verification of Employment for a Reported Workers' Compensation Injury or Illness

Employee Name _____ Date of Injury _____

Date of Birth_____ Social Security _____

Reported Work Related Injury or Illness:

_____

Post-Accident Drug Test Requested _____
(Drug Testing is directed by only the Employer and must be billed separately and directly to the *Employer Name*.)

Employer's Name's workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance.) For emergencies, an injured employee may go to the nearest emergency room. Otherwise, all other treatment must be from an Alliance Provider listed at www.pswca.org.

Please submit all claim and medical billing information to:

TASB Risk Management Fund
PO Box 2010
Austin, TX 78768-2010
Phone: (800) 482-7276
Fax: (800) 580-6720
Pre-Authorization
Phone: (800) 482-7276 ext. 6654
Fax: (888) 777-8272

Supervisor Signature _____ Title _____

Phone Number_____ Date _____

Providers please submit Work Status Reports and all Job Description enquiries to

Employer WC Contact Name
Phone
Fax
Email

HELIOS
P.O. Box 152539
Tampa, FL 33684-2539

TASB RISK MANAGEMENT FUND

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Helios has been chosen to manage your workers' compensation pharmacy benefits for TASB Risk Management Fund. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to a Helios Tmesys network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including all major chains, such as Walgreens, CVS, Rite Aid, WalMart, Target, and more, are included in the network. To find a network pharmacy call 866.599.5426 or visit www.tmesys.com and click on "Pharmacy Locator."

Questions? Need Help?

866.599.5426

tmesys®

TASB RISK MANAGEMENT FUND

TASB Risk Management Fund — CARRIER/TPA

Elgin ISD — EMPLOYER

INJURED WORKER NAME

SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: www.tmesys.com\pharmacy-locator

Download Free Mobile App: www.tmesys.com\MyWorkComp

HELIOS

Attention Pharmacists: Enter RxBIN, RxPCN, and GROUP. Member ID # format is the date of injury, and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient. **This card is not valid for compound medications.**

Tmesys Pharmacy Help Desk 800.964.2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	T015		

HELIOS

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

HELIOS
P.O. Box 152539
Tampa, FL 33684-2539

TASB RISK MANAGEMENT FUND

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Helios ha sido elegido para administrar los beneficios farmacéuticos de TASB Risk Management Fund. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Helios Tmesys. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo las grandes cadenas, tal como Walgreens, CVS, Rite Aid, WalMart, Target, y más, forman parte de la red. Para encontrar una farmacia de la red, llame al 866.940.4459 o visite www.tmesys.com y haga clic en “Pharmacy Locator” (Localizador de farmacias).

¿Tiene alguna pregunta?
¿Necesita ayuda?

866.940.4459

tmesys®

TASB RISK MANAGEMENT FUND

TASB Risk Management Fund — Elgin ISD
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

NUMERO DE SEGURO SOCIAL — FECHA DE LA LESION (YYMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para su lesión relacionada con su trabajo. Para ubicar una farmacia, visite www.tmesys.com\pharmacy-locator

Descargue la aplicación móvil gratuita en www.tmesys.com\MyWorkComp

HELIOS

Attention Pharmacists: Enter RxBIN, RxPCN, and GROUP. Member ID # format is the date of injury, and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient. **This card is not valid for compound medications.**

Tmesys Pharmacy
Help Desk 800.964.2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	T015		

HELIOS

NOTA: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1414-36-TASB

Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the State agency that administers and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. **You have the right to hire an attorney to help you with your workers' compensation claim.**
   For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or http://www.texasbar.com/. Attorney referral information can also be found on OIEC's website at www.oiec.texas.gov.

2. **You have the right to receive assistance from OIEC if you do not have an attorney.**
   OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. **You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.**
   Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. **You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.**
   You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. **You may have the right to receive income benefits for your work-related injury.**
   There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. **You may have the right to dispute resolution regarding income and medical benefits.**
   You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. **You have the right to choose a treating doctor.**

If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however, changing your treating doctor must be pre-approved by the DWC if you are not in a network. If you are employed by a political subdivision (e.g. city, county, school district,) you must follow its rules for choosing a treating doctor. It is important to follow all the rules in the workers' compensation system**. If you do not follow these rules, you may be held responsible for payment of medical bills.** OIEC staff can help you to understand these rules.

8. **You have the right for your workers' compensation claim information to be kept confidential.**
   In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.**

2. **You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).**
   If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. If there is something you do not understand, ask your employer or call OIEC. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at http://www.tdi.texas.gov/consumer/complfrm.html#wc.

3. **If you worked for a political subdivision (e.g., city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment.**
   Your employer should be able to provide you with the information you will need in order to determine which health care providers can treat you for your workplace injury.

4. **You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**

5. **You have the responsibility to send a completed Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.**
   You have one year to send the form after you were injured or first knew that your illness might be work-related. Send the completed DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. **You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.**

7. **You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages.** (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. **Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.**

9. **You are prohibited from making frivolous or fraudulent claims or demands.**

Aviso sobre los Derechos y Responsabilidades para los Empleados Lesionados en el Sistema de Compensación para Trabajadores de Texas

En Texas, usted como empleado lesionado tiene derecho a recibir ayuda gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel -OIEC, por su nombre y siglas en inglés). Esta ayuda se ofrece en las oficinas locales en todo el estado. Las oficinas locales también proporcionan otros servicios del sistema de compensación para trabajadores por parte del Departamento de Seguros de Texas (Texas Department of Insurance -TDI, por su nombre y siglas en inglés). TDI, es la agencia estatal que regula y administra el sistema de compensación para trabajadores mediante la División de Compensación para Trabajadores (Division of Workers' Compensation –DWC, por su nombre y siglas en inglés).

Muchos de los servicios que son proporcionados por parte de OIEC y de DWC pueden ser llevados a cabo por teléfono. Usted puede comunicarse con OIEC llamando al teléfono gratuito 1-866-EZE-OIEC (1-866-393-6432). Visite el sitio Web de OIEC en www.oiec.texas.gov, para obtener información adicional, incluyendo la ubicación de las oficinas. Usted puede comunicarse con DWC llamando al teléfono gratuito 1-800-252-7031. La información de DWC se encuentra disponible en la página de Internet: www.tdi.texas.gov.

Sus Derechos Dentro del Sistema de Compensación para Trabajadores de Texas:

1. **Usted tiene derecho a contratar a un abogado para asistirle con su reclamación de compensación para trabajadores.**
   Para obtener asistencia para encontrar a un abogado, llame al servicio de recomendación de abogados de la Barra de Abogados del Estado de Texas (State Bar of Texas, por su nombre en inglés) al 1-877-983-9227 o visite www.texasbar.com. La información sobre la recomendación de abogados también puede encontrarse en la página de Internet de OIEC en www.oiec.texas.gov.

2. **Usted tiene derecho a recibir asistencia por parte de OIEC si no cuenta con un abogado.**
   Los Representantes de Servicio al Cliente de OIEC, así como los Ombudsman están disponibles para responder a sus preguntas y proporcionarle asistencia con su reclamación de compensación para trabajadores ya sea llamando a OIEC o visitando una de las oficinas de OIEC. **Usted debe firmar una autorización por escrito antes que un empleado de OIEC pueda tener acceso a la información sobre su reclamación.** Llame o visite una oficina de OIEC para completar la autorización por escrito. Los Representantes de Servicio al Cliente de OIEC y los Ombudsman han sido entrenados en el campo de compensación para trabajadores y pueden ayudarle a programar un procedimiento de resolución de disputas, relacionado con su reclamación de compensación para trabajadores. Un ombudsman también puede asistirle en una Conferencia para Revisión de Beneficios (Benefit Review Conference –BRC, por su nombre y siglas en inglés), en una Audiencia para Disputar Beneficios (Contested Case Hearing –CCH, por su nombre y siglas en inglés), y en una apelación. Sin embargo, un Ombudsman no puede tomar decisiones por usted, ni dar opiniones por usted o proporcionar asesoramiento legal.

3. **Con ciertas excepciones, usted tiene derecho a recibir beneficios médicos y beneficios de ingresos sin importar quién tuvo la culpa de su lesión. Sus beneficiarios podían tener derecho a recibir beneficios por causa de muerte y beneficios de gastos para el entierro.**
   La información sobre las excepciones puede encontrarse en www.tdi.texas.gov o consultando al personal de OIEC.

4. **Usted puede tener derecho a recibir atención médica para atender su lesión o enfermedad que sucedió en el área de trabajo, durante todo el tiempo que sea médicamente necesario y relacionado con la lesión que sucedió en el área de trabajo.**
   Usted puede tener derecho a recibir un reembolso por los gastos incurridos después de viajar para asistir a una cita médica o a un examen médico requerido (required medical examination, por su nombre en inglés), si el viaje cumple con las condiciones de calificación.

5. **Usted puede tener derecho a recibir beneficios de ingresos por su lesión relacionada con el trabajo.**
   Existen varios tipos de beneficios de ingresos, así como requisitos de elegibilidad. La información sobre los tipos de beneficios de ingresos que pueden estar disponibles, y los requisitos de elegibilidad pueden ser encontrados en www.tdi.texas.gov o consultando al personal de OIEC.

6. **Usted puede tener derecho a una resolución de disputas con respecto a sus beneficios de ingresos y beneficios médicos.**
   Usted puede solicitar una Resolución de Disputas Médicas (Medical Dispute Resolution, por su nombre en inglés) si está en desacuerdo con la aseguradora sobre los beneficios médicos. Usted puede solicitar una Resolución de Disputas por Indemnización (Ingresos) (Indemnity (Income) Dispute Resolution, por su nombre en inglés), si está en desacuerdo con la aseguradora sobre los beneficios de ingresos. La ley establece que sus procedimientos de resolución de disputas sean llevados a cabo dentro de 75 millas del domicilio suyo.

7. **Usted tiene derecho a escoger a su médico de tratamiento.**
   Si usted pertenece a una red de servicios médicos de compensación para trabajadores (Workers' Compensation Health Care Network), (red), debe escoger a su médico de la lista de médicos de tratamiento de la red. Usted puede cambiar a su médico de tratamiento una sola vez sin la necesidad de obtener la aprobación de la red. Si no pertenece a una red, usted puede inicialmente escoger a cualquier médico que esté dispuesto a atender su lesión de compensación para trabajadores; sin embargo, si usted no pertenece a una red, el cambio de su médico de tratamiento debe ser pre-aprobado por DWC. Si es empleado de una subdivisión política, tal como la ciudad, el condado, o el distrito escolar, usted deberá seguir los reglamentos de dicha subdivisión política para escoger a un médico de tratamiento. Es importante seguir todos los reglamentos en el sistema de compensación para trabajadores. **Si usted no sigue estos reglamentos, podría ser considerado responsable por el pago de las facturas médicas.** El personal de OIEC puede ayudarle a entender estos reglamentos.

8. **Usted tiene derecho a que la información sobre su reclamación de compensación para trabajadores se mantenga confidencial.**
   En la mayoría de los casos, el contenido del expediente de su reclamación no puede ser obtenido por otras personas. Algunos participantes tienen derecho a conocer el contenido del expediente de su reclamación, tal como su empleador o la aseguradora de su empleador. También, un empleador que esté considerando contratarle a usted puede obtener información limitada por parte de DWC sobre su reclamación.

Sus Responsabilidades Dentro del Sistema de Compensación para Trabajadores de Texas:

1. **Usted tiene la responsabilidad de informar a su empleador si se ha lesionado en el trabajo mientras desempeñaba sus deberes de trabajo. Usted debe informar a su empleador dentro de 30 días a partir de la fecha en que sucedió su lesión o del día en que usted se dio cuenta que su lesión o enfermedad podría estar relacionada con su trabajo.**

2. **Usted tiene la responsabilidad de saber si pertenece a una Red de Servicios Médicos de Compensación para Trabajadores (red) (Workers' Compensation Health Care Network -network).**
   Si no sabe si pertenece a una red de servicios médicos, pregúntele al empleador para el cual usted trabajaba al momento en que ocurrió su lesión. Si pertenece a una red, es su responsabilidad seguir los reglamentos de dicha red. Si usted encuentra algo que no entiende, pregunte a su empleador o llame a OIEC. Si desea presentar una queja sobre una red, llame a la Línea de Ayuda al Consumidor de TDI (TDI's Consumer Help Line, por su nombre en inglés) al 1-800-252-3439 o presente su queja en línea en www.tdi.texas.gov/consumer/complfrm.html#wc.

3. **Si usted trabajó para una subdivisión política (p. ej. la ciudad, el condado o el distrito escolar) al momento en que sucedió su lesión, es su responsabilidad averiguar cómo recibir tratamiento médico.**
   Su empleador debe poder proporcionar la información que usted necesita para determinar cuáles son los proveedores de servicios médicos que pueden atender su lesión relacionada con el trabajo.

4. **Usted tiene la responsabilidad de informar a su médico cómo es que usted se lesionó y determinar si la lesión está relacionada con el trabajo.**

5. **Usted tiene la responsabilidad de completar y enviar a DWC el Formulario DWC-041, Reclamo del Empleado para Compensación por una Lesión Relacionada con el Trabajo o Enfermedad Ocupacional.**
   Usted cuenta con un año para enviar el formulario después de haberse lesionado o después de haberse enterado que su enfermedad podría estar relacionada con su trabajo. Complete y envíe el Formulario DWC-041 aun si ya está recibiendo beneficios. Usted puede perder su derecho a recibir beneficios si no envía a tiempo el formulario completo a DWC. Para obtener una copia del Formulario DWC-041 comuníquese con DWC o con OIEC.

6. **Usted tiene la responsabilidad de proporcionar su dirección actual, número de teléfono e información sobre su empleador a DWC y a la aseguradora. Usted puede comunicarse con DWC al 1-800-252-7031.**

7. **Usted tiene la responsabilidad de informarle a DWC y a la aseguradora cada vez que haya un cambio en el estado de su empleo o su salario.**
   (Algunos ejemplos de cambios incluyen: si deja de trabajar a causa de su lesión; si usted regresa a trabajar; o si recibe una oferta de trabajo).

8. **Los beneficiarios que son elegibles o las personas que buscan obtener beneficios por causa de muerte o beneficios de gastos para el entierro, tienen la responsabilidad de completar y enviar a DWC el Formulario DWC-042, Reclamación del Beneficiario para Obtener Beneficios por Causa de Muerte dentro de un año, a partir de la fecha en que el empleado falleció.**

9. **Usted tiene prohibido hacer reclamaciones o demandas injustificadas o fraudulentas.**

EMPLOYEE ACKNOWLEDGMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

I have received information that tells me how to get health care under my employer's workers' compensation coverage. If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the Alliance list of doctors designated as treating doctors.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go to any licensed medical professional within the United States.
3. Even though my treating doctor should refer me to a specialist of providers contracted with the Alliance, I understand that I need to verify that the referral doctor is a member of the Alliance provider panel.
4. The Texas Association of School Boards Risk Management Fund will pay the treating doctor and other Alliance providers for all health care related to my compensable injury.
5. I understand that my medical and/or income benefits may be disputed if I receive health care from a provider other than an Alliance provider without prior approval from the Fund.
6. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.
7. If I want to change doctors after my first choice, I can do so within the first 60 days of starting treatment, and I can only choose from the Alliance list of providers. A third choice requires approval from my adjuster.

_____ ____/____/____
Signature Date

_____
Printed Name

I live at:_____
Street Address
_____, _____ _____
City State Zip Code

Name of Employer: ____

Name of Direct Contracting Program: Political Subdivision Workers' Compensation Alliance (the Alliance)

Direct contracting service areas are subject to change. To locate a treating doctor within your area, visit the PSWCA web site at www.pswca.org or call your adjuster at 800-482-7276.

To be completed by the employer only

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification (Date of Injury: ____/____/____)

DO NOT RETURN THIS FORM TO THE TASB RISK MANAGEMENT FUND UNLESS REQUESTED.

EMPLOYEE ACKNOWLEDGMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

RECONOCIMENTO DEL EMPLEADO PARA EL PROGRAMA DE CONTRATAR DIRECTAMENTE CON MEDICOS

He recibido la informacion que explica como obtener tratamientos medicos si me lastimo en el trabajo. Si estoy lastimado en el trabajo y vivo en un área de servicio descrita en esta información, entiendo que:

1. Tengo que escojer un doctor de la lista de la Alliance (PSWCA), que son señalados para tartar.
2. Debo ir a este doctor para todo el tratamiento médico para mi lesión. Si necisito un especialista, el doctor que me trata me referirá. Si necesito tratamientos de emergencia, yo entiendo que puedo ir a cualquier profesional médico licenciado dentro de los Estados Unidos.
3. Si el doctor me refiere a un especialista, yo entiendo que necesito verificar que el doctor sea un miembro del la Alliance.
4. TASB le pagara al doctor escojido y a doctores tambien que son partidos de PSWCA.
5. Puedo ser responsable de la cuenta si recibo tratamento medico de doctores que no son miembros de la Alliance y sin la aprobacion anterior de TASB.
6. Reportando un reclamo de lastimaduara falsa o fraudulenta es un crimen que puede resultar en multas y o al encarcelamiento.
7. Si deseo cambiar doctores despues de mi primera opción, puedo hacerlo dentro 60 dias de comensar mi tratamieto. Puedo solamente escojer de la lista de doctores que estan en el Alliance. La tercer opción necesita probacion de mi ajustador antes de cabiar doctor.

Signature (Firma):____ _____ Date (Fecha): ____/____/____

Printed Name (Nombre en imprenta): _____

Address (Direccion de domicilio incluindo cuidad, estado y zip):

_____

Employer (Nombre de empleo):_____ _____ __

Name of Direct Contracting Program (Nombre del programa de contratar doctores directament): Political Subdivision Workers' Compensation Alliance (the Alliance)

El servicio de contratar doctores directamente en las areas de servicio, son subjetivos a cambiar. Para localizar un doctor de tratamiento en su area, visite al Internet en: www.pswca.org o llame a su ajustador al numero: 800-482-7276.

To be completed by the employer only

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification (Date of Injury: ____/____/____)

DO NOT RETURN THIS FORM TO THE TASB RISK MANAGEMENT FUND UNLESS REQUESTED.

FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION (NO OFFSET)

Name _____ **Employee number** _____

Position _____ **Department/Campus** _____

This employee is absent from duty because of a job-related illness or injury beginning on *(date of first absence attributable to illness or injury)*. If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

_____ _____

District authorized signature Date

Employee choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on **paid** leave and/or family and medical leave (FMLA). I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave that is not FMLA leave. I choose the following option:

- ❑ I choose to use only _____ days of available paid leave at this time.
- ❑ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or -injury wage.
- ❑ I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Elgin ISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will only receive workers' compensation wage benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

_____ _____

Employee signature Date

For Claims Reporting Purposes Only:	
For all employees: Amount of leave paid to employee: $ ____.__ Daily rate: $ _____ Period of payment: from___/___/___ through___/___/___ for ____ days **or** ____ weeks	*For hourly employees only:* Hourly rate: $____.___ Number of hours paid: _____

FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION (NO OFFSET)

Nombre _____ **Número de empleado** _____

Posición _____ **Departamento/campus** _____

Este empleado está ausente de su trabajo debido a una enfermedad o lesión relacionada con el trabajo que comenzó en *(fecha de la primera ausencia que se atribuye a enfermedad o lesión)*. Si fuera elegible, el seguro de compensación de los trabajadores puede comenzar a pagar un porcentaje de los salarios actuales del empleado en el octavo día de ausencia del trabajo, en caso de que se requiera una licencia extendida.

_____ _____

Firma autorizada de distrito Fecha

Elección del empleado:

Me ausenté del trabajo debido a una enfermedad o lesión relacionada con el trabajo. Comprendo que no soy elegible para los beneficios de ingreso semanales de compensación para trabajadores hasta que mi ausencia exceda los siete días calendario. También comprendo que el distrito continuará abonando su aporte al costo de mi cobertura de seguros médicos (si fuera aplicable) siempre que esté en licencia **con goce de sueldo** y/o licencia familiar o médica (FMLA). Asimismo, comprendo que seré responsable de abonar todas las primas de seguros médicos si estoy de licencia **sin goce de sueldo** que no sea una licencia FMLA. Elijo la siguiente opción:

- ❑ Elijo utilizar solamente _____ días de licencia disponible con goce de sueldo en esta oportunidad.

- ❑ Elijo utilizar todas las licencias con goce de sueldo disponibles. Comprendo que no recibiré los beneficios de ingresos semanales de compensación de los trabajadores hasta que haya agotado toda mi licencia con goce de sueldo o en la medida en que la licencia con goce de sueldo no equivalga a mi sueldo previo a la enfermedad o a la lesión.

- ❑ Elijo **no** utilizar la licencia con goce de sueldo disponible en esta oportunidad. Comprendo que no recibiré pagos de salario regulares de Elgin ISD mientras reciba los beneficios de ingreso semanales conforme a la compensación de los trabajadores. No se deducirá la licencia con goce de sueldo disponible de mi saldo de licencia. Asimismo, comprendo que, al seleccionar esta opción, recibiré solamente los beneficios de salario de compensación de los trabajadores para las ausencias que deriven de mi enfermedad o lesión relacionada con el trabajo, a menos y hasta que comunique al distrito un cambio en mi decisión.

_____ _____

Firma del empleado Fecha

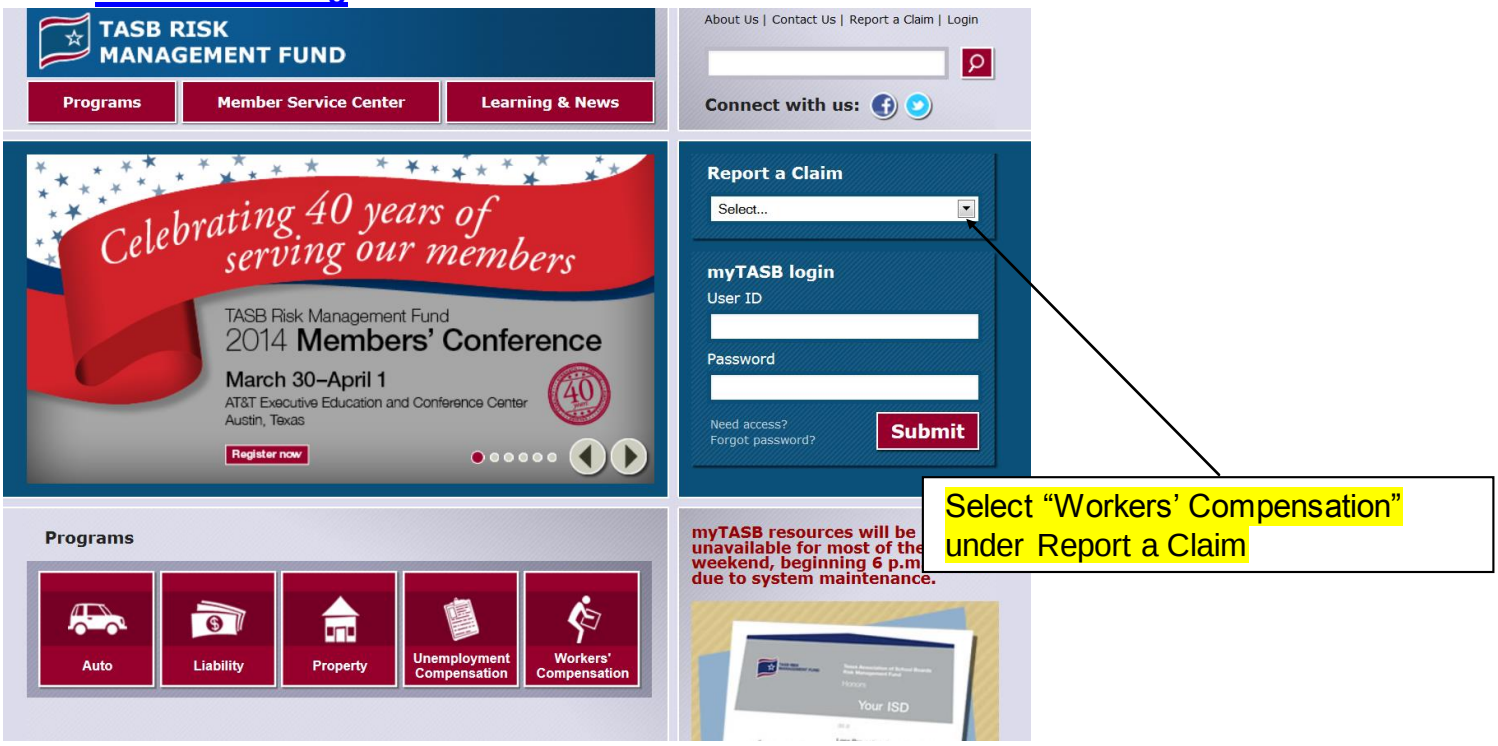
Para demandas que informen solamente fines:

FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION (NO OFFSET)

Para todos los empleados: Cantidad de licencia pagada al empleado: $ ____.__ Tasa diaria: $ _____ Periodo de pago: de___/___/___ a___/___/___ para ____ días **o** ____ semanas	*Solamente para empleados por horas:* Tasa por hora: $____.___ Cantidad de horas pagas: _____

How to File a First Report of Injury Online

Go to www.tasbrmf.org



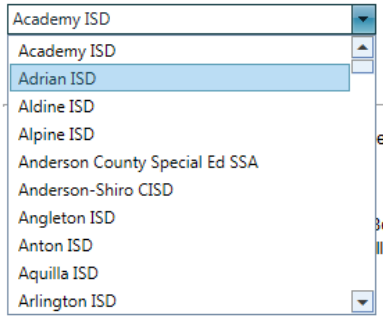
TASB RISK MANAGEMENT FUND

TASB Risk Management Fund Homepage

Workers' Compensation

First Report of Injury or Illness

Please select your district from the list below then click the submit button to continue entering your First Report of Injury.



Select your organization from the drop down list.

e e-mail us.

Box 2010, Austin, Texas 78767-2010 • 512-467-0222

TASB RISK MANAGEMENT FUND

TASB Risk Management Fund Homepage

Workers' Compensation

First Report of Injury or Illness

Asterisks denote required information for this report to be properly processed.

Never file a corrected copy or re-file a report without being told to do so.

Click here if this is a corrected copy: ☐

Please complete the form and note what items have changed in the other information field at the bottom of the form.

The form will fill in the information based on the Member selected.

EMPLOYER GENERAL INFORMATION

Employer Name:	Huntsville ISD
Street Address Line 1:	441 FM 2821 East
Street Address Line 2:	
City, State, Zip:	Huntsville , TX 77320-9223
Mailing Address Line 1:	441 FM 2821 East
Mailing Address Line 2:	
City, State, Zip:	Huntsville , TX 77340-9298
Tax ID Number:	7460014-28
Phone Number:	936-295-3421
SIC Code:	611110
Insured Report Number:	
Campus Code*:	ADMINISTRATION

Member's who have their own number system for their claims may input here. Please leave blank If you do not have a system.

Select the location of where the accident occurred from the drop down list.

EMPLOYEE INFORMATION

Employee Name (Last, First, MI)*:	
Street Address*:	
Street Address:	
City, State, ZIP*:	TX
Phone*:	- -
Date of Birth *(example: xx/xx/xxxx)*:*	
Social Security Number*:	
Date Hired *(example: xx/xx/xxxx)*:*	
State of Hire:	Texas
Sex*:	○ Male ○ Female ◉ Unknown
Marital Status*:	○ Unmarried ○ Married ○ Separated ◉ Unknown
Occupation/Job Title*:	
Employment Status*:	Apprenticeship Full-Time
# of Dependents:	

Complete all areas of Employee information.

Occupation Codes –
010 – Professional/Clerical/Administration
020 – Building Maintenance
030 – Food Service
040 – Custodial
050 – Driver & Vehicle Maintenance
060 – All Other
Example – 030/Cafeteria Cashier

Please use Regular or Part Time

WAGE INFORMATION

Rate - 0.00 *:

Per*: ○ Week ○ Bi-Weekly ○ Semi-Monthly ○ Month ○ Hour ○ Daily

Days Worked/Week*:

Full Pay for Day of Injury? ○ Yes ◉ No

Did Salary Continue? ○ Yes ◉ No

Gross Amount of Last Paycheck - 0.00: 0

Type of Pay: ◉ Weekly ○ Bi-Weekly ○ Semi-Monthly ○ Monthly

Has employee elected to use state, sick or vacation leave in lieu of temporary income benefits? ○ Yes ○ No ◉ Unknown

If so, how many leave hours have they elected to use?

Wage Information contains mandatory fields.

OCCURRENCE INFORMATION

Type of Claim*: ○ Record Only ○ Medical Only ○ Lost Time

Record Only – No Lost Time, No Expected Treatment, No Questions
Medical Only – Currently working, no more than 3 days of lost time, No Questions
Lost Time – All Else

Date of Injury/Illness *(example: xx/xx/xxxx)**:

Time Employee Began Work *(example: 08:15)**: ◉ AM ○ PM

Complete only if employee is not at work.

Time of Occurrence *(example: 08:15)**: ◉ AM ○ PM

Last Work Date *(example: xx/xx/xxxx)*:

This is the date the secretary, principal, nurse, or supervisor first knew of incident.

Date Employer Notified *(example: xx/xx/xxxx)**:

Date Disability Began *(example: xx/xx/xxxx)*:

First date of work missed due to the injury. (This is not the date of injury.) Leave blank if there was no lost time.

Supervisor Name:

Supervisor Phone Number: - -

Type of Injury/Illness:

Part of Body Affected:

Cause of Injury:

Consult the code lists below. Get as close as you can, understanding the codes don't always fit exactly. These are national codes we have no control over.

Did injury/illness exposure occur on employer's premise? ◉ Yes ○ No

Department or Location where accident or illness exposure occurred*:

Example: cafeteria or playground. If it did not occur on employer premises, enter address or location.

All equipment, material or chemicals employee was using when accident or illness exposure occurred:

List all equipment, materials and/or chemicals employee was using, applying, handling or operating when injury occurred. Enter "NA" if none used.

Specify activity the employee was engaged in when the accident or illness exposure occurred*:

Activity when accident occurred such as cooking, teaching, walking, etc.

Work process the employee was engaged in when accident or illness exposure occurred:

The work process employee was doing such at teaching, cooking, etc. Enter "NA" if employee was not working such as walking in hallway, eating, etc.

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*:

How injury occurred – be sure to clarify body part and side of body, ex. Student bit employee on right hand between thumb and index finger.

Date Returned to Work *(example: xx/xx/xxxx)*:

If Fatal, Give Date of Death *(example: xx/xx/xxxx)*:

Actual date employee returned to work. Leave blank if employee still not working. (NO FUTURE DATES.)

Were Safeguards or Safety Equipment Provided? ◉ Yes ○ No

Were they used? ◉ Yes ○ No

TREATMENT INFORMATION

Physician/Health Care Provider Name (Last, First, MI):

Physician/Health Care Provider Street Address:

Physician/Health Care Provider City, State, ZIP:

Enter doctor/hospital information if known. Not a mandatory field.

Hospital Name:

Hospital Street Address:

Hospital City, State, ZIP:

Initial Treatment*:

- ◉ No Medical Treatment
- ○ Minor by Employer
- ○ Minor Clinic/Hosp
- ○ Emergency Care
- ○ Hospitalized > 24 Hrs
- ○ Future Major Medical/Lost Time Anticipated

Mandatory

OTHER INFORMATION

Witness (Name & Phone #):

Date Administrator Notified *(example: xx/xx/xxxx)*:

Date Prepared *(example: xx/xx/xxxx)*:

Preparer's Name & Title:

Preparer's Phone Number: - -

All Other Information:

E-mail address to receive confirmation:

For additional information or questions, please e-mail us.

Submit FROI Now | Clear Form

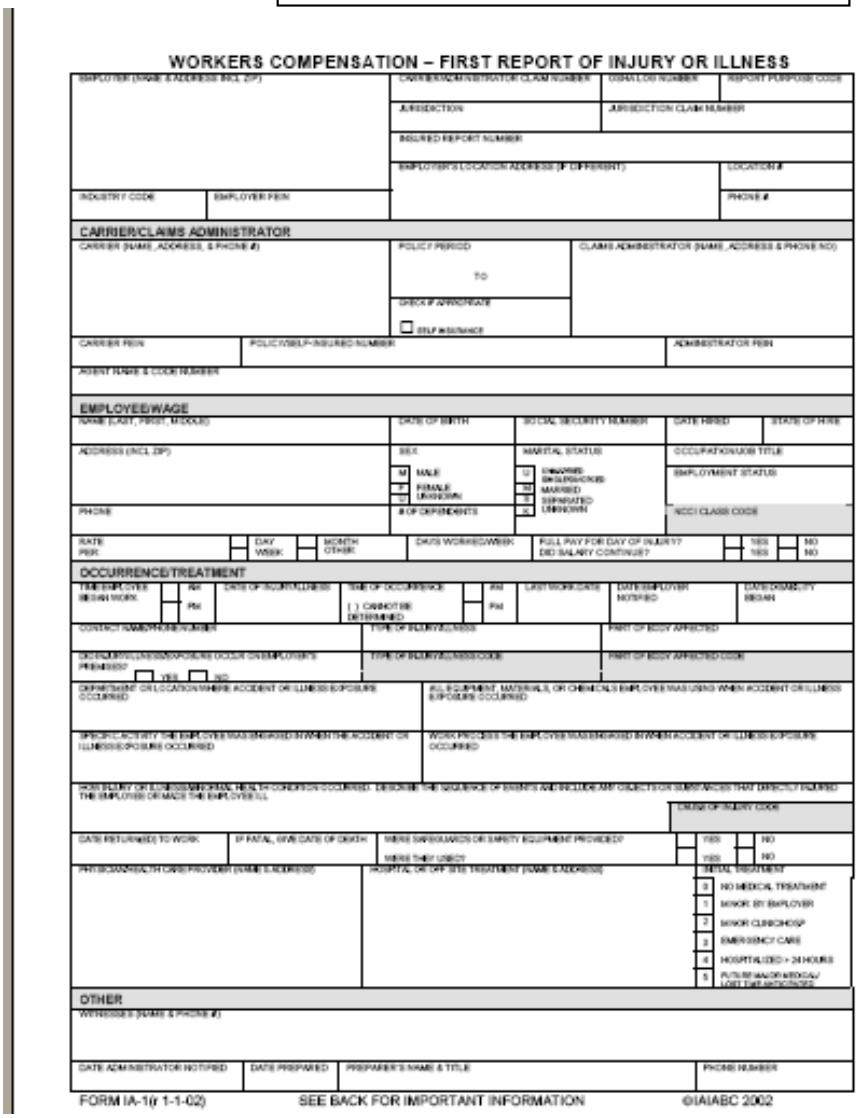
Please list witnesses if any are known.

Date Benefits/HR is notified.

This is a small area for additional info, example to complete the description of accident. Please be brief and direct. This will be copied to employee. Please use only when absolutely necessary.

Don't forget your email address!

Don't forget to Click Submit! It will then allow you to print and save the FROI in IA-1/PDF format. Keep a copy for your Record of Injuries and send a copy to Injured Worker with Rights & Responsibilities Notice.



WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

CARRIER/CLAIMS ADMINISTRATOR

EMPLOYEE/WAGE

OCCURRENCE/TREATMENT

OTHER

FORM IA-1(r 1-1-02) SEE BACK FOR IMPORTANT INFORMATION ©IAIABC 2002

Your First Report of Injury will print in this one page format.

Nature of Injury

01 No Physical Injury	37 Inflamation	64 Silicosis
02 Amputation	40 Laceration	65 Respirtory Disorders (Fumes)
03 Angina Pectoris	41 Myocardial Infraction	66 Poisoning-Chemical: Not Metals
04 Burn	42 Poisoning-Not OD or Cumulative	67 Metal Poisoning
07 Concusion	43 Puncture	68 Dermatitis
10 Contusion	46 Rupture	69 Mental Disorder
13 Crushing	47 Severance	71 All Other Occupation Disease
16 Dislocation	49 Sprain	72 Loss of Hearing
19 Electric Shock	52 Strain	73 Contagious Disease
22 Enucleation	53 Syncope	74 Cancer
25 Foreign Body	54 Asphyxiation	75 Aids
28 Fracture	55 Vascular Loss	76 VDT - Related Disease
29 Not Used	58 Vision Loss	77 Mental Stress
30 Freezing	59 All Other	78 Carpel Tunnel Syndrome
31 Hearing Loss or Impairment	60 Dust Disease NOC	80 All Other Cumulative Injuries
32 Heat Prostration	61 Asbestosis	90 Mulitiple Inj - Physical Only
34 Hernia	62 Black Lung	91 Multiple Inj - Physical Psych
36 Infection	63 Byssinosis	

Cause of Injury

01 Chemicals	29 Fall/Slip On Same Level	67 Strike/Step Sand, Scrape, Clean
02 Hot Objects or Substances	30 Slipped, Did Not Fall	68 Strike/Step Stationary Obj.
03 Temperature Extremes	31 Fall/Slip Miscellaneous	69 Stepping on Sharpe Object
04 Fire or Flame	32 Fall/Slip: On Ice or Snow	70 Strike/Step Miscellaneous
05 Steam or Hot Fluids	33 Fall/Slip: On Stairs	74 Struck/Injured: Fellow Worker
06 Dust, Gases, Fumes or Vapors	40 Crash of Water Vehicle	75 Struck/Injured: Falling Object
07 Welding Operations	41 Crash of Rail Vehicle	76 Struck/Injured: Tools
08 Radiation	45 Collision With Another Vehicle	77 Struck/Injured: Vehicle
09 Burn: Miscellaneous	46 Collision With Fixed Object	78 Struck/Injured: Moving Machine
10 Caught In/Between Machine(ry)	47 Crash of Airplane	79 Struck/Injured: Obj. Lifted
11 Cold Objects or Substances	48 Vehicle Upset	80 Struck/Injured: Obj. HDLD. OTH
12 Caught In/Between Obj. Handled	50 Motor Vehicle Miscellaneous	81 Struck/Injured:Miscellaneous
13 Caught In/Between/Under, NOC	52 Strain/Injury: Continual Noise	82 Absorbed/Ingested/Inhaled NOC
14 Abnormal Air Pressure	53 Strain/Injury: Twisting	84 Contact With Electric Current
15 Cut/Scrapr by Broken Glass	54 Strain/Injury: Jumping	85 Animal or Insect
16 Cut/Scrape by Hand Tool	55 Strain/Injury: Hold or Carry	86 Explosion or Flare Back
17 Object Being Lifted or Handled	56 Strain/Injury: Lifting	87 Foreign Body in Eye
18 Cut/Scrape Power Tool	57 Strain/Injury: Push or Pull	89 Person in Act of a Crime
19 Cut/Scrape Miscellaneous	58 Strain/Injury: Reaching	90 Not a Physical Cause of Injury
20 Collapsing Materials	59 Strain/Injury: Using Tool/Mach	94 Rubbed/Abraded:Repetitive Motion
25 Fall/Slip From Diff. Level	60 Strain/Injury: Miscellaneous	95 Rubbed/Abraded: Miscellaneous
26 Fall/Slip From Ladder/Scaffold	61 Strain/Injury: Wield or Throw	97 Strain/Injury: Repetitive Motion
27 Fall/Slip From Grease/Liquid	65 Strike/Step Moving Parts	98 Cumulative (All Other)
28 Fall/Slip: Into Openings	66 Strike/Step Obj Lifted/Used	99 Other

Body Part Injured

10 Multiple Head Injury	32 Elbow	51 Hip
11 Skull	33 Lower Arm	52 Upper Leg
12 Brain	34 Wrist	53 Knee
13 Ear(s)	35 Hand	54 Lower Leg
14 Eye(s)	36 Finger(s)	55 Ankle
15 Nose	37 Thumb	56 Foot
16 Teeth	38 Shoulder(s)	57 Toe(s)
17 Mouth	39 Wrist(s) and Hand(s)	58 Great Toe
18 Soft Tissue: Head	40 Multiple Trunk	60 Lungs
19 Facial Bones	41 Upper Back Area (Thoracic)	61 Abdomen Including Groin
20 Multiple Neck Injury	42 Lower Back (Lumbar/Lumbo-Sacral)	62 Buttocks
21 Neck Vertebrae	43 Disc: Trunk	63 Lumber and or Sacral Vertebra
22 Neck Disc	44 Chest, Ribs, Sternum, Soft Tissue	64 Artificial Appliance
23 Spinal Cord (Neck)	45 Sacrum and Coccyx	65 Insufficient Info to Identify
24 Larynx	46 Pelvis	66 No Physical Injury
25 Soft Tissue: Neck	47 Spinal Cord	90 Multiple Body Parts
26 Trachea	48 Internal Organs	91 Body Systems-Single and Multiple
30 Multiple Upper Extremities	49 Heart	99 Whole Body Impairment
31 Upper Arm, Clav. Scapula	50 Multiple Lower Extremities	