



OFFICIAL

Michigan Jobs Commission (MJC) Office of Workforce Development (OWD)

Policy Issuance (PI): 97-23

Index: I

Date: June 20, 1997

To: Michigan Works! Agency (MWA) Directors

Programs Affected: Work First

Subject: Workers' Compensation Coverage for Participants Placed into Unpaid Work Activities

Rescissions: None

Purpose: To issue MJC policy regarding Workers' Compensation coverage for Work First program participants that have been placed into unpaid work activities.

Background: With the implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), the placement of participants into Community Service programs has been encouraged as a viable alternative to help ensure that the State meets the 75 percent federal participation rate for two-parent families. While agencies that operate Community Services programs must provide reasonable work conditions and the Community Service program sites must not be in violation of the applicable federal, state or local health and safety standards, many of the agencies that utilize Work First participants at these work sites have expressed concerns regarding liability in Workers' Compensation claims. The following guidelines have been established for processing Workers' Compensation claims.

Policy: All active Work First participants who are engaged in unpaid work activities are covered by Workers' Compensation. By definition, unpaid work activities are Community Service programs, which includes participation in Community Work Experience Programs, internships, practicums and co-ops.

Workers' Compensation does not cover participants who are volunteers or participating in unpaid "non work" activities. Unpaid, "non work" activities include participants who are in attendance at orientations or those who are undergoing assessment. English as a Second Language programs, remedial education programs, secondary or post secondary educational programs, General Equivalency Diploma completion, job search and job readiness, vocational educational training, job skills training, and education directly related to employment are also considered to be "non work" activities.

Participants who are placed into unsubsidized, subsidized private or public sector employment, in on-the-job training are covered by employers in claims against Workers' Compensation.

If an injury occurs to a participant while engaged in "non work" activities, the injury must be reported within 24 hours after staff becomes aware of the injury, whether or not immediate or future medical care is required. Workers' Compensation claims are handled by the Accident Fund Company and the paperwork must be processed by the MWA. To avoid penalties, claims are to be reported promptly. The MWA must use form C-59L (Employer's Report on Medical Only Injury form - copy included in the attached Accident Fund handbook), and forward it along with copies of all medical bills for treatment of the injury to:

Family Independence Agency (FIA)
Office of Financial Assistance Programs,
Suite 1306, Grand Tower, 235 S. Grand Avenue
Lansing, MI 48909.

Participants that have missed ten working days due to injury are also required to have an "Employers Report of Injury" (MDL-1-100 form - copy included) forwarded to the Accident Fund Company. If a participant is unable to complete either form, his or her supervisor should do so in order to prevent a delay in medical treatment. In representing both the FIA and MWAs, staff at the Accident Fund Company may review the case record and obtain copies of the case materials. Although a signed FIA Release of Information form is not required, the MWA should have their own Release of Information Form (if the participant has signed such a form) in hard copy on file, as a part of the permanent Work First participant file.

The consent form should contain the following information:

- the participant's signature
- the current date
- person/agency to whom the information is released
- time period covered
- information to be released (either itemizing or stating a general release of any information).

In responding to a request for case record information about an accident, staff must apply confidentiality policies. Refer any attorneys who are seeking information that is not contained in the case record to The Accident Fund Company.

Community Service Program participants have the right to request a hearing with FIA concerning temporary or permanent disability that may have resulted from injury on a job. The Accident Fund Company attorneys will represent FIA and act on their behalf to resolve the case. The attorneys will consult with staff from FIA to settle the case prior to the hearing.

Please note that Community Service program agencies are liable for property damages that are incurred while their work crews perform their assigned duties.

Action: MWAs shall take the appropriate action to comply with this policy in processing and handling Workers' Compensation claims.

Inquiries: Questions regarding this policy memorandum should be directed to your Work First Grant Coordinator.

This information contained in this policy memorandum will be made available in alternative format (large type, audio tape, etc.) upon special request received by this office.

Expiration

Date: Continuing



Robert T. Pendleton, Director
Office of Workforce Development

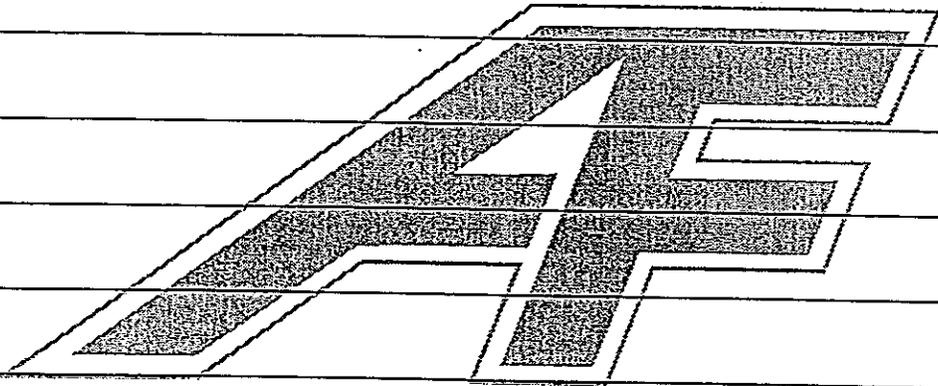
EMPLOYER'S CLAIM HANDBOOK FOR THE STATE OF MICHIGAN



AF *The Accident Fund Company*
232 S. Capitol Avenue
P.O. Box 40790
Lansing, MI 48901-7990
Phone: (517) 342-4200

Rev. June 1995

Notes



Claims Service

Our office to serve you:

The Accident Fund Company
232 S. Capitol Avenue
P.O. Box 40790
Lansing, Michigan 48901-7990

Telephone: (517) 342-4200
Fax (517) 342-4270
(517) 342-4268

Introduction

This manual has been produced to assist you in the initial filing of a workers' compensation claim with The Accident Fund Company. We are pleased to be able to offer this quick reference guide to you. We hope you find it helpful.

Please read the enclosed information and follow the instructions to ensure the timely filing of all your claims. You can certainly call the Accident Fund any time with questions you may have. As a quick reference, this booklet provides step-by-step guidance on what to do when your employee lets you know he or she has been injured.

To avoid a penalty situation, it is very important your claims be reported immediately.

By working together in the handling of your claims, we can contain and reduce your workers' compensation costs.

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What to do When an Employee is Hurt on the Job

Every year, between 65,000 and 85,000 Michigan workers suffer job-related injuries or illnesses which cause them to lose 8 or more days of work. Another 350,000 to 400,000 workers suffer job-related injuries or illnesses which require medical treatment only or which cause the employee to lose less than 8 days of work. A prompt and appropriate response from you can help to hold down the cost of either claim.¹ At a minimum, you should do the following:

1. **Promptly furnish medical treatment for any personal injury "arising out of and in the course of employment."**

This treatment may include "reasonable medical, surgical, and hospital services and medicines, or other attendance or treatment" as needed.

The employer or insurance carrier must also provide dental service, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus and other appliances "necessary to cure, so far as reasonably possible, and relieve the effects of the injury."

The state has established a maximum fee schedule which limits the amount health care providers can charge for their services to workers' compensation beneficiaries.

An employer has the option of requiring an injured worker to be treated by a health care provider chosen by the employer for the first 10 days following an injury. After 10 days have elapsed since the start of medical treatment, the worker is then entitled to consult with a provider of his or her own choice and to continue treatment with that provider, unless the employer or carrier demonstrates to the Workers' Compensation Bureau that this choice is unreasonable.

2. Report the injury promptly to the Accident Fund.
3. File an Employer's Basic Report of Injury (Form 100) with the Workers' Compensation Bureau in the event of an injury resulting in more than 7 consecutive days of lost work (or in the event of a death or a "specific loss" injury).
4. For injuries resulting in 8 or more days of lost time, your insurance carrier must notify the Workers' Compensation Bureau (on a Form 701) once indemnity (wage loss) benefits have begun to your injured employee. A copy of the 701 will be sent to you when payments have been initiated and terminated. The 701 can serve as a wage-loss payment record for you. Injured workers are entitled to benefits equal to 80% of their after-tax wages up to a maximum amount equal to 90% of the statewide average weekly wage.

The first payment is due and payable on the 14th day after you first received notice of, or had knowledge of, the injury or death. In most cases, this means the first loss-time payment will be due not more than 14 days following the day of the injury.

1. "Michigan Business Guide to Workers' Compensation, 1990"

Tips & Hints

Complete all information of your employee's injury the claim form(s) is requesting. State date of birth, not age of injured employee. Insert social security number from payroll records, not from medical bills.

Use proper and complete name of employee, not nickname. Please include his or her middle name.

If your State office has multiple locations, indicate the risk location where this injured employee works and his/her job classification and/or title.

The mailing address of the State office should be clearly designated.

After you have filed your employee's claim, you will receive a claim number from the Accident Fund. *Use this claim number* on all correspondence and medical bills relating to each specific claim.

Make sure all information is legible and clearly written.

Phone numbers of your office and the injured employee are very important. If these are missing from a claim form, it could result in unnecessary delays of processing.

If you do not know the return-to-work date of your injured employee, please indicate an estimated number of days/weeks off work.

Encourage your health care providers to send their medical bills directly to the assigned examiner at the Accident Fund.

If you have questions regarding a claim that has been filed, write or call the examiner assigned to the claim.

When the Accident Fund receives and establishes a claim for one of your injured employees, you will receive an acknowledgment letter from the Accident Fund. This letter will give you the assigned claim number, the claims examiner assigned to that particular claim, and what you must do as the employer:

- A sample letter to the employer for a medical only claim is on page 9.
- A sample letter for a compensation claim is on page 15.
- A sample letter to the injured employee for a compensation claim is on page 21.

Important Notice



Workers' Compensation Insurance Since 1912

IMPORTANT NOTICE

READ CAREFULLY

EMPLOYER PENALTY FOR LATE CLAIM REPORTING

Public Act No. 302 Effective March 30, 1978 provides for the following:

An EMPLOYER who has NOTICE or KNOWLEDGE of the disability or death of an employee and who fails to give notice to the insurance carrier within 30 days shall pay a PENALTY of \$50.00 per day commencing on the 31st day. Total payment not to exceed \$1,500.00.

*If weekly **COMPENSATION BENEFITS, ACCRUED WEEKLY BENEFITS** or **TRAVEL EXPENSE** are not paid within 30 days after becoming due, up to \$50.00 per day shall be added and paid to the worker for each day over 30 days of non-payment by the insurance carrier. **Medical bills** can also incur penalties, at the rate of \$50.00 per day, however total penalty cannot exceed amount of bill. Otherwise penalty will not exceed \$1,500.00.*

The Workers' Compensation Disability Act stipulates that compensation shall be paid promptly and directly to the person entitled thereto and shall become due and payable on the 14th day after the employer has notice and knowledge of the disability or death.

TO AVOID PENALTY PAYMENT, REPORT CLAIMS PROMPTLY TO THE ACCIDENT FUND OFFICES.

Procedures for Submitting a Workers' Compensation Claim to the Accident Fund Company

There are two types of claims:

- (1) **Medical Only** (Form C-59, "Employer's Report of Medical Only Injury")
 - for processing medical expenses with no lost wages
 - not disabled from employment for more than seven (7) consecutive days.

- (2) **Compensation Claim or Lost Time** (Form 100, "Employer's Basic Report of Injury")
 - for processing both medical expenses and lost wages
 - more than seven (7) consecutive days of disability
 - death claims and specific loss claims

Instructions for submitting each type of claim are included in this manual:

Medical claims, see pages 6-9

Compensation claims, see pages 10-14

If an employee reports an injury you may question or disagree on, it is still important to file an Employer's Basic Report of Injury (Form-100) or complete the Employer's Report of Medical Only Injury (C-59) as appropriate according to type of claim. Write a letter or note explaining your concerns, and the claims examiner assigned to the specific claim will respond and follow-up with you and discuss appropriate action.

To refrain from filing in a timely fashion hampers the efficient administration of the claim and could quickly increase the cost of the claim itself.

Procedures for Submitting a Workers' Compensation Claim to the Accident Fund Company



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PROCEDURES FOR SUBMITTING A WORKERS' COMPENSATION CLAIM TO THE ACCIDENT FUND COMPANY

When an employee is injured in the course of his/her employment, the employer is responsible for all medical care pertaining to the injury, lost wages, and possibly vocational rehabilitation.

There are two types of claims which can be submitted for payment. The most common is referred to as a MEDICAL-ONLY, (Form C-59, "EMPLOYER'S REPORT OF MEDICAL ONLY INJURY"), for processing medical expenses with no lost wages. The other claim is a COMPENSATION CLAIM, or LOST-TIME, (Form 100, "EMPLOYER'S BASIC REPORT OF INJURY"), for processing both medical expenses and lost wages.

It is very important that the claim be submitted on the proper claim form. This will assist in processing the claim and satisfying the injured employee.

The following is a guideline to completion of the claim forms:

MEDICAL ONLY:

The medical only is just that... It reports injuries for which the employee's only claim is for reimbursement or payment of medical charges and he/she is disabled from employment for not more than 7 consecutive days.

A medical-only claim should be submitted on the C-59 claim form (EMPLOYER'S REPORT OF NON - COMPENSABLE INJURY) which is attached to this correspondence with instructions on how to complete it.

COMPENSATION CLAIM:

A compensation claim is for reporting injuries with more than 7 consecutive days of disability resulting in lost wages. It is also used for reporting death claims and specific loss claims. Also, the form is used when a Notice of Dispute is filed.

When an employer is notified of a compensable claim, the employer MUST IMMEDIATELY complete a FORM 100 (EMPLOYER'S BASIC REPORT OF INJURY). Failure to report these in a timely manner can result in penalties up to \$50.00 per day.

It is very **IMPORTANT** that these claims be reported immediately to avoid a penalty charge.

Medical Only Claims

Medical-only claims may be submitted on our short-form claim form entitled "Employer's Report on Medical-Only Injury." The claim form looks like this. The specific line-by-line instructions are on the next two pages.



232 S. Capitol Avenue
P.O. Box 40790
Lansing, MI 48901-7990
Phone: (517) 342-4200

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EMPLOYER'S REPORT ON MEDICAL ONLY INJURY

(Not over 7 days disability)

Report on this form, all injuries including diseases which arise out of and in the course of employment and cause not more than seven (7) days of disability.

Employer: _____ Policy #: _____

Mailing Address: _____
(Number & Street or P.O. Box) (City) (State) (Zip)

Risk Location Address: _____
(Number & Street or P.O. Box)

(City) (State) (Zip)

Phone #: () _____ Federal I.D. #: _____
(Area Code)

Injured Employee: _____
(Last Name) (First Name) (Middle Initial)

S.S. #: _____ Date of Birth: ____/____/____
MM DD YY

Address: _____
(Number & Street or P.O. Box) (City) (State) (Zip)

Occupation: _____ Home Phone #: () _____
(Area Code)

Date of Accident
or First Report of Disease

Last Day Worked

Date Returned to Work
or No Lost Time

Type of injury: _____

Body part injured: _____

How did it happen? _____

Doctor's name: _____

Address: _____

Hospital (if any): _____

Date of report: _____ Signature of Employer (not agent or employee)

Mall To: The Accident Fund Company, P. O. Box 40790, Lansing, MI 48901-7990

OFFICE USE ONLY

CLAIM NUMBER	
ACCIDENT DATE	
POLICY NUMBER	
EFFECTIVE DATE	
REPORT DATE (REC'D)	
CLASS CODE	COV OK
CODING DATE	
BIRTH DATE	
STATE DEPT. CODE	
DIAGNOSTICS	BODY PART
COMP RESERVE	
MED RESERVE	
CLAIMS REP #	
NATL COUN. CODE	
INJURY STATUS CODE	PETITION #
AGENT	COUNTY CODE

DO NOT SEND A COPY OF THIS FORM TO THE BUREAU OF WORKERS' DISABILITY COMPENSATION.
C-59L Rev. 6/95

Instructions for Form C-59



Workers' Compensation Insurance Since 1912

EMPLOYER'S REPORT OF MEDICAL-ONLY INJURIES (Occupational Injuries & Illnesses)

The Purpose: To notify The Accident Fund Company of all Medical-Only Claims.

When Required: This form must be completed and filed promptly when no more than seven consecutive days have been lost and medical expenses have been incurred.

Item #	Description	Required Contents
1	Employer	Complete with full business name to include DBA's
2	Policy # or Dept. Code	Numeric - complete workers compensation policy # or Dept. code
3	Address (mailing)	Complete address - street #, street, or PO box, city, state, and zip
4	Risk Location	Complete address - street #, street, city, state, and zip of place of accident (where employee works at or out of)
5	Phone #	Complete phone # to include area code
6	Fed. I.D. #	Complete #
7	Name of Employee	Complete full name: last name, first name, full middle name. Include hyphens, titles such as Jr., Sr., III, etc.
8	Social Security #	Numeric - verify # as digit transposition is a problem
9	Date of Birth	Numeric (Month, day, year)
10	Address	Home address of employee: Complete #, street, city, state and zip
11	Occupation and Home Phone #	List employee's job title Home Phone #
12	Injury	Describe what injury was sustained - i.e. strain, cut, etc.
13	Body Part	Describe body part injured - i.e. left leg, right arm, etc.
14	How did it happen	Describe how the injury occurred
15	Doctor Name	Name of treating Doctor
16	Address	Full Address of Doctor treating the injury
17	Hospital	If treated at hospital, list name and location
18	Date of Accident	Date employee was injured
18a	or First Report of Disease	Date of notification or diagnosis
19	Last Day Worked	Last date employee worked
20	Returned to Work	When did the employee return?
20a	or No Lost Time	Employee did not lose any time
21	Date of Report	Date report completed
22	Signature of Employer	Signed by preparer

Medical - Only C-59 Numbered Sheet



The Accident Fund Company

232 S. Capitol Avenue
P.O. Box 40790
Lansing, MI 48901-7990
Phone: (517) 342-4200

Workers' Compensation Insurance Since 1912

EMPLOYER'S REPORT ON MEDICAL ONLY INJURY

(Not over 7 days disability)

Report on this form, all injuries including diseases which arise out of and in the course of employment and cause not more than seven (7) days of disability.

Employer: _____ (1) _____ Policy #: _____ (2)

Mailing Address: _____ (3) _____ (City) _____ (State) _____ (Zip)
(Number & Street or P.O. Box)

Risk Location Address: _____ (4) _____ (City) _____ (State) _____ (Zip)
(Number & Street or P.O. Box)

Phone #: (_____) _____ (5) Federal I.D. #: _____ (6)
(Area Code)

Injured Employee: _____ (7) _____ (Last Name) _____ (First Name) _____ (Middle Initial)

S.S. #: _____ (8) Date of Birth: _____ / _____ / _____ (9) _____
MM DD YY

Address: _____ (10) _____ (City) _____ (State) _____ (Zip)
(Number & Street or P.O. Box)

Occupation: _____ (11) Home Phone #: (_____) _____
(Area Code)

Date of Accident (18)
or First Report of Disease (18A)

Last Day Worked (19)

Date Returned to Work (20)
or No Lost Time (20A)

Type of injury: _____ (12)

Body part injured: _____ (13)

How did it happen? _____ (14)

Doctor's name: _____ (15)

Address: _____ (16)

Hospital (if any): _____ (17)

Date of report: _____ (21) _____ (22)

Signature of Employer (not agent or employee)

Mail To: The Accident Fund Company, P. O. Box 40790, Lansing, MI 48901-7990

OFFICE USE ONLY

CLAIM NUMBER	
ACCIDENT DATE	
POLICY NUMBER	
EFFECTIVE DATE	
REPORT DATE (REC'D)	
CLASS CODE	COV OK
CODING DATE	
BIRTH DATE	
STATE DEPT. CODE	
DIAGNOSTICS	BODY PART
COMP RESERVE	
MED RESERVE	
CLAIMS REP #	
NATL. COUN. CODE	
INJURY STATUS CODE	PETITION #
AGENT	COUNTY CODE

Acknowledgment Letter to Employer for Medical - Only



(Current Date)

Name and Address
of Employer

Dear Employer:

The Accident Fund Company has received the claim of your

Employee:	John Doe
Whose Date of Injury is:	01/01/91
His/Her Claim Number is:	1234567
His/Her Social Security Number is:	123-45-6789

It is imperative to use this above claim number on all medical reports and related correspondence mailed to us for this employee claim.

Please alert all necessary parties such as doctors, hospitals, industrial clinics, etc., of this claim number, and be sure to insert it on correspondence directed to our office.

Please feel free to contact our office regarding any further information you might have on this claim. We are always pleased to answer any of our insured's questions as they pertain to our claim handling.

Thank you for your assistance in providing us with the information that will allow efficient, prompt service in the processing of this claim.

Sincerely,
THE ACCIDENT FUND COMPANY

(Name of assigned examiner)
Claims Department

LL/II

Instructions for Filing Form 100

Employer's Basic Report of Injury — Form MDL—1—100

The Purpose: To notify the Bureau of Workers' Disability Compensation of an alleged injury.

When Required: This form must be completed and filed promptly when:

- more than seven (7) days of consecutive disability have occurred
- death occurred
- specific loss occurred
- when a Notice of Dispute is filed

Compensation Claims

Employer's Basic Report of Injury, Form 100, looks like this.



EMPLOYER'S BASIC REPORT OF INJURY

Michigan Department of Labor
Bureau of Workers' Disability Compensation
P.O. Box 30016, Lansing, MI 48909

AN EMPLOYER SHALL REPORT IMMEDIATELY TO THE BUREAU ON FORM MDL-1-100 ALL INJURIES, INCLUDING DISEASES, WHICH ARISE OUT OF AND IN THE COURSE OF THE EMPLOYMENT, OR ON WHICH A CLAIM IS MADE AND RESULT IN ANY OF THE FOLLOWING: (A) DISABILITY EXTENDING BEYOND SEVEN (7) CONSECUTIVE DAYS, NOT INCLUDING THE DATE OF INJURY, (B) DEATH, (C) SPECIFIC LOSSES. IN CASE OF DEATH, AN EMPLOYER SHALL ALSO IMMEDIATELY FILE AN ADDITIONAL REPORT ON MDL-1-106.

I. EMPLOYEE DATA

1. SOCIAL SECURITY NUMBER		2. DATE OF INJURY		3. EMPLOYEE NAME (LAST, FIRST, M I)	
4. ADDRESS (NUMBER AND STREET)			5. CITY		6. STATE
7. ZIP CODE	8. DATE OF BIRTH (MM/DD/YY)	9. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	10. NUMBER DEPENDENTS	11. TELEPHONE NUMBER ()	12. WORK PERMIT DATE IF UNDER AGE 18
13. TAX FILING STATUS		<input type="checkbox"/> A. SINGLE <input type="checkbox"/> B. SINGLE, HEAD OF HOUSEHOLD		<input type="checkbox"/> C. MARRIED, FILING JOINT <input type="checkbox"/> D. MARRIED, FILING SEPARATE	

II. CURRENT EMPLOYER DATA

14. EMPLOYER NAME			15. FEDERAL I.D. NUMBER		
16. INJURY LOCATION CODE	17. MAILING LOCATION CODE		18. MESC NUMBER	19. TYPE OF BUSINESS (SIC)	
20. ADDRESS (NUMBER AND STREET)		21. CITY		22. STATE	23. ZIP CODE

III. SECOND EMPLOYER DATA

24. SECOND EMPLOYER NAME		25. SECOND EMPLOYER AWW \$		26. NUMBER WEEKS USED	
27. ADDRESS (NUMBER AND STREET)		28. CITY		29. STATE	30. ZIP CODE

IV. ALLEGED INJURY DATA

31. LAST DAY WORKED	32. DATE EMPLOYEE RETURNED TO WORK (IF APPLICABLE)		33. DID EMPLOYEE DIE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
34. INJURY CITY	35. INJURY STATE	36. INJURY COUNTY	37. DID INJURY OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> *NO (IF NO, SEE ITEM 50)		
38. DESCRIBE THE NATURE OF INJURY OR ILLNESS (EXAMPLE: AMPUTATION, BURN, CUT, FRACTURE)					
39. PART OF BODY DIRECTLY AFFECTED BY THE INJURY OR ILLNESS (EXAMPLE: HAND, ARM, CIRCULATORY SYSTEM)					
40. DESCRIBE THE EVENTS WHICH CAUSED THE INJURY (EXAMPLE: FELL, OPERATING MACHINERY, CHEMICAL EXPOSURE)					
41. NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE (EXAMPLE: KNIFE, ACID, FLOOR, OIL)					

V. OCCUPATION AND WAGE DATA

42. DATE HIRED	43. TOTAL GROSS WEEKLY WAGE (HIGHEST 39 OF 52) \$		44. NUMBER WEEKS USED		45. VALUE OF DISCONTINUED FRINGES \$
46. OCCUPATION (BE SPECIFIC)		47. WAS EMPLOYEE A VOLUNTEER WORKER? <input type="checkbox"/> YES <input type="checkbox"/> NO		48. WAS EMPLOYEE CERTIFIED AS VOCATIONALLY HANDICAPPED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
49. DATE EMPLOYER NOTIFIED BY EMPLOYEE		50. IF TEMPORARY SERVICE AGENCY, PROVIDE NAME/ADDRESS OF EMPLOYER WHERE INJURY OCCURRED.			

VI. PREPARER DATA - I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

51. PREPARER'S SIGNATURE		52. TELEPHONE NUMBER ()		53. DATE PREPARED
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NOTICE TO EMPLOYEE: QUESTIONS OR ERRORS SHOULD BE REPORTED IMMEDIATELY TO THE INDIVIDUAL LISTED ABOVE IN LINE 51.

AUTHORITY: WORKERS' DISABILITY COMPENSATION ACT, R409.3(1)(3) COMPLETION: MANDATORY PENALTY: WORKERS' DISABILITY COMPENSATION ACT, 418.631	THE DEPARTMENT OF LABOR WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, HANDICAP, OR POLITICAL BELIEFS.
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Employers Basic Report of Injury – Form MDL-1-100

The Purpose: To notify the Bureau of Workers Disability Compensation of an alleged injury.

When Required: This form must be completed and filed promptly when:

- *seven or more days of continuous disability have occurred
- *death
- *specific loss
- *when filing a Notice of Dispute

Instructions For Completion: This form will always be completed by the employer and sent to the Accident Fund. This list should be used as a means of checking the accuracy of the information.

Item #	Description	Required Contents
1	Social Security #	Numeric-verify number as digit transposition is a problem.
2	Date of Injury	Actual injury date (numeric – month/day/year)
3	Employee Name	Last name, first name, middle initial.
4 – 7	Employee Address	Street number, street, city, state, zip code
8	Date of Birth	Employee (numeric-month/day/year)
9	Sex	Check appropriate box.
10	Number of Dependents	Enter total number of dependents. NOTE: Spouse or other family members must be at least 50% supported by injured employee to be counted as dependent. Include all minor children living with employee.
11	Employee Telephone #	Area code + telephone number
12	Work Permit Date	Complete if employee is a minor. Attach copy of work permit.
13	Tax Filing Status	Check appropriate box.
14	Employer Name	Enter complete name. Also include your Accident Fund policy #.
15	Employer Fed ID #	Enter numeric federal ID number.
16	Injury Location Code	Leave blank. No entry required at present time.
17	Mailing Location Code	Leave blank. No entry required at present time.
18	MESC Number	Enter numeric employer MESC number.
19	Type of Business	Enter specific business, i.e. manufacturing, food service, nursing care, etc.
20 – 23	Employer Address	Street number, street, city, state, zip code
24	Second Employer	Complete name if employee has another job.
25	Second Employer Average Weekly Wage	Average of highest 39 weeks, or actual weeks worked if less than 39; may have to be obtained from employee.
26	Number Weeks Used	Enter number of weeks used in calculation of Item 25.
27 – 30	2nd Employer Address	Street number, street, city, state, zip code
31	Last Day Worked	Complete (numeric-month/day/year)
32	Return to Work Date	Complete if employee has returned (numeric-month/day/year) or give estimated return date.
33	Did Employee Die?	Check appropriate block.
34 – 36	Injury City, State, County	Enter appropriate data to include risk location address if applicable.
37	Injury On Premises?	Check appropriate block.
38	Nature Of Injury	Enter complete, concise information.
		See other side for items 39 through 53.

Employer's Basic Report of Injury, Form MDL-1-100, side two, looks like this.

Employers Basic Report of Injury – Form MDL-1-100 (Continued)

Item #	Description	Required Contents
39	Body Part Injured	Enter complete, concise information.
40	Event Which Caused Injury	Enter complete, concise information.
41	Object Or Substance That Caused Injury	Enter complete, concise information.
42	Date Hired	Self explanatory (numeric-month/day/year)
43	Total Gross Average Weekly Wage	Average of highest 39 weeks, or actual weeks worked if less than 39. Attach copy of employee's payroll record for one year back so calculations can be verified.
44	Number Weeks Used	Enter number of weeks used in calculation of Item 43.
45	Value Of Discontinued Fringes	Total value of any employer paid fringe benefits that have been discontinued.
46	Occupation	Be specific with job description to include job classification or job title.
47	Volunteer	Check appropriate block.
48	Vocationally Handicapped	Check appropriate block. Attach copy of "certificate" if applicable.
49	Date Employer Notified	Specific date employer aware of injury.
50	Temporary Service	If applicable, enter complete information.
51	Preparer's Signature	In addition to signing, type or print name of person signing form.
52	Telephone #	Be sure to include area code.
53	Date Prepared	Enter date form complete (numeric-month/day/year)

Form 100 should be typed or printed. Make sure the employer's federal identification number is on the Form 100.

**WHEN FORM 100 IS COMPLETED, MAIL TO THE
THE ACCIDENT FUND COMPANY**

Lansing Claims Office, P.O. Box 40790,
Lansing MI 48901-7990

Employer's Basic Report of Injury, instructional Form C-100 (i), looks like this.



EMPLOYER'S BASIC REPORT OF INJURY

Michigan Department of Labor
Bureau of Workers' Disability Compensation
P.O. Box 30016, Lansing, MI 48909

AN EMPLOYER SHALL REPORT IMMEDIATELY TO THE BUREAU ON FORM MDL-1-100 ALL INJURIES, INCLUDING DISEASES, WHICH ARISE OUT OF AND IN THE COURSE OF THE EMPLOYMENT, OR ON WHICH A CLAIM IS MADE AND RESULT IN ANY OF THE FOLLOWING: (A) DISABILITY EXTENDING BEYOND SEVEN (7) CONSECUTIVE DAYS, NOT INCLUDING THE DATE OF INJURY, (B) DEATH, (C) SPECIFIC LOSSES. IN CASE OF DEATH, AN EMPLOYER SHALL ALSO IMMEDIATELY FILE AN ADDITIONAL REPORT ON MDL-1-106.

I. EMPLOYEE DATA

① SOCIAL SECURITY NUMBER		② DATE OF INJURY		③ EMPLOYEE NAME (LAST, FIRST, M I)		
④ ADDRESS (NUMBER AND STREET)			⑤ CITY		⑥ STATE	⑦ ZIP CODE
⑧ DATE OF BIRTH (MM/DD/YY)	⑨ SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	⑩ NUMBER DEPENDENTS		⑪ TELEPHONE NUMBER ()	⑫ WORK PERMIT DATE IF UNDER AGE 18	
⑬ TAX FILING STATUS <input type="checkbox"/> A. SINGLE <input type="checkbox"/> B. SINGLE, HEAD OF HOUSEHOLD		<input type="checkbox"/> C. MARRIED, FILING JOINT		<input type="checkbox"/> D. MARRIED, FILING SEPARATE		

II. CURRENT EMPLOYER DATA

⑭ EMPLOYER NAME <i>(Be sure to include your AF Policy # here)</i>			⑮ FEDERAL I.D. NUMBER			
⑯ INJURY LOCATION CODE	⑰ MAILING LOCATION CODE		⑱ MESC NUMBER	⑲ TYPE OF BUSINESS (SIC)		
⑳ ADDRESS (NUMBER AND STREET)			㉑ CITY	㉒ STATE	㉓ ZIP CODE	

III. SECOND EMPLOYER DATA

㉔ SECOND EMPLOYER NAME		㉕ SECOND EMPLOYER AWW \$		㉖ NUMBER WEEKS USED		
㉗ ADDRESS (NUMBER AND STREET)		㉘ CITY	㉙ STATE	㉚ ZIP CODE		

IV. ALLEGED INJURY DATA

㉛ LAST DAY WORKED	㉜ DATE EMPLOYEE RETURNED TO WORK (IF APPLICABLE)		㉝ DID EMPLOYEE DIE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
㉞ INJURY CITY	㉟ INJURY STATE	㊱ INJURY COUNTY	㊲ DID INJURY OCCUR ON EMPLOYER'S PREMISES? (IF NO, SEE ITEM 50) <input type="checkbox"/> YES <input type="checkbox"/> NO			
㊳ DESCRIBE THE NATURE OF INJURY OR ILLNESS (EXAMPLE: AMPUTATION, BURN, CUT, FRACTURE)						
㊴ PART OF BODY DIRECTLY AFFECTED BY THE INJURY OR ILLNESS (EXAMPLE: HAND, ARM, CIRCULATORY SYSTEM)						
㊵ DESCRIBE THE EVENTS WHICH CAUSED THE INJURY (EXAMPLE: FELL, OPERATING MACHINERY, CHEMICAL EXPOSURE)						
㊶ NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE (EXAMPLE: KNIFE, ACID, FLOOR, OIL)						

V. OCCUPATION AND WAGE DATA

㊷ DATE HIRED	㊸ TOTAL GROSS WEEKLY WAGE (HIGHEST 39 OF 52) \$		㊹ NUMBER WEEKS USED		㊺ VALUE OF DISCONTINUED FRINGES \$	
㊻ OCCUPATION (BE SPECIFIC)		㊼ WAS EMPLOYEE A VOLUNTEER WORKER? <input type="checkbox"/> YES <input type="checkbox"/> NO		㊽ WAS EMPLOYEE CERTIFIED AS VOCATIONALLY HANDICAPPED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
㊾ DATE EMPLOYER NOTIFIED BY EMPLOYEE		㊿ IF TEMPORARY SERVICE AGENCY, PROVIDE NAME/ADDRESS OF EMPLOYER WHERE INJURY OCCURRED.				

VI. PREPARER DATA - I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

① PREPARER'S SIGNATURE		② TELEPHONE NUMBER ()	③ DATE PREPARED
------------------------	--	---------------------------	-----------------

NOTICE TO EMPLOYEE: QUESTIONS OR ERRORS SHOULD BE REPORTED IMMEDIATELY TO THE INDIVIDUAL LISTED ABOVE IN LINE 51.

AUTHORITY: COMPLETION: PENALTY:	WORKERS' DISABILITY COMPENSATION ACT, R408.31(1)(3) MANDATORY WORKERS' DISABILITY COMPENSATION ACT, 418.631	THE DEPARTMENT OF LABOR WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, HANDICAP, OR POLITICAL BELIEFS.
---------------------------------------	---	--

Acknowledgment Letter to Employer for Compensation Claim



(Current Date)

Name and Address
of Employer

Name and Address
of Agent

Dear Employer:

The Accident Fund Company has received the claim notice for:

Your Employee:	DOE, JOHN G.
Date of Injury:	01/01/1991
Social Security Number:	123-45-6789

This file has been assigned Claim Number: 1234567

Please write this claim number on everything you send us about your employee's claim. Please share this number with everyone who may need to send us information (doctors, hospitals, industrial clinics, etc.).

What we need from you right now:

Please fill out the enclosed forms and return them to us in the enclosed envelope:

- 1) Wage form
- 2) Fringe Benefit form

Please feel free to contact me about any further information you may have on this claim. I always try to answer any of my insureds' questions concerning claim handling.

Finally, please send all mail addressed to me.

Sincerely,
THE ACCIDENT FUND COMPANY

(Name of assigned examiner)
Claims Department

LL/II
Enclosures

Explanation of Wage and Benefit Forms and Return to Work Card

The following three pages contain sample copies of forms that you, the employer, will receive along with the acknowledgment letter and a copy of the Employer's Basic Report of Injury. Below are directions regarding completion of these forms.

- **Wage Form:** List by the week the injured employee's weekly gross earnings for the 52 weeks prior to the date of injury. Complete the top portion of the form and sign and date the form and return to us promptly.
- **Fringe Benefit Form:** Fill in the top portion of the form and then complete the benefit breakdown section. If the employee has no benefits, simply indicate N/A and return the form. If benefits are available, fill in monthly premium that is paid by employer and termination date. If benefits have not yet been terminated, enter date you plan to terminate. Complete bottom portion of form and return to us promptly.
- **Return To Work Card:** When an employee returns to work, weekly compensation benefits stop. You, the employer, should immediately telephone the assigned claims examiner and report the return to work to ensure this process takes place. Follow up by completing the Return To Work Card and mailing it to the Accident Fund.

Wage Form to be Filled Out by Employer



RETURN TO:
 The Accident Fund Company
 232 S. Capitol Ave.
 P.O. Box 40790
 Lansing, MI 48901-7990

WAGE FORM

CLAIM NUMBER _____ CLAIMANT NAME _____

SOCIAL SECURITY # _____

FIRST DAY WORKED _____ / _____ / _____ LAST DAY WORKED _____ / _____ / _____
MM DD YY MM DD YY

DATE OF INJURY _____ / _____ / _____ HOURLY RATE OF PAY _____
MM DD YY

PAY PERIOD TYPE: _____ WEEKLY _____ BI-WEEKLY _____ TWICE PER MONTH
 _____ MONTHLY _____ ANNUALLY _____ OTHER

Please list the gross earnings, including tips & commissions, for the 52 weeks prior to the date of injury.

Average days worked per week _____ First day of pay period (circle one) S M T W T F S

	Pay Period Ending	Gross Amount		Pay Period Ending	Gross Amount		Pay Period Ending	Gross Amount
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			AVERAGE WEEKLY WAGE		
18			36					

Employer Name _____ Phone # (_____) _____
Area Code

I certify that the above record is a true copy of the payroll information for the above captioned employee,

Signature of Employer Representative
 C-80L Rev. 6/95

Title

Date

Fringe Benefit Form to be Filled Out by the Employer



Workers' Compensation Insurance Since 1912

FRINGE BENEFITS PAID FOR BY THE STATE OF MICHIGAN

NAME OF DEPARTMENT _____

ADDRESS _____

NAME OF EMPLOYEE _____

SOCIAL SECURITY NUMBER _____

Dear Policyholder;

Under State law, we are obligated to take into consideration all FRINGE BENEFITS which have terminated or will terminate due to the work related injury. We ask your cooperation in reporting discontinued benefits to us so that we can avoid any penalties for improper payment of compensation benefits.

To complete this form, if the benefit is available to the employee, check so in the appropriate column. If that benefit has or will terminate, please advise us of the date of termination and the monthly premium you pay for this said benefit.

If the benefit listed is not one you provide to this employee, please mark accordingly.

NAME OF BENEFIT	AVAILABLE TO EMPLOYEE		TERMINATION DATE	EMPLOYER PORTION OF PREMIUM ON DATE OF INJURY
	Yes	No		
INSURANCE:				
Aetna / HMO Health Ins.				
Long Term Disability				
Life				
Dental				
Optical				
(% Contrib. by State) Pension				
LONGEVITY / BONUS				

VACATION / SICK / HOLIDAY PAY:

The above employee earns vacation, sick time and holiday pay as follows:

HOURLY RATE: \$ _____

VACATION: _____ DAYS PER YEAR

DATE OF HIRE: _____

HOLIDAY: _____ DAYS PER YEAR

LAST DAY OF WORK: _____

SICK: _____ DAYS PER YEAR

PLEASE RETURN THIS FORM TO THE CLAIM DEPARTMENT WITHIN THREE DAYS OF RECEIPT.

Return to Work Notice

Please return this postcard to the Accident Fund after you have telephoned your assigned examiner and reported the employee's return to work.

RETURN TO WORK NOTICE	
Claim No: _____	Date: _____
The Accident Fund Company	
Gentlemen:	
This is to advise you that our EMPLOYEE, _____	
	(full name)
Injured on _____, 19 _____	while in our employ, returned
to work on _____, 19 _____	
EMPLOYEE went to work elsewhere on _____, 19 _____.	
Doctor discharged employee as able to work effective _____, 19 _____.	
with no restrictions _____	
or with restrictions _____	Yours truly,
	Signature: _____
	TITLE: _____
	STATE DEPT.: _____
	COMPANY ADDRESS: _____
	COMPANY PHONE #: () _____
C-5L Rev 1/90	

Forms Sent to Employee

The following four pages contain sample copies of forms the injured employee will receive along with the acknowledgment letter. Below are directions regarding completion should your employee request your assistance.

- **Employee's Report of Injury:** To be completed by the injured employee. This is their description of the injury as well as personal information to assist us in the completion of our investigation.
- **Authorization:** To be signed by the injured employee and signature-witnessed and returned to us promptly. We need this completed form to enable us to obtain medical information regarding their injury.
- **Mileage Reimbursement Form:** The injured employee may submit their mileage to and from medical care as it relates to their injury for reimbursement. This form may be used as a record of those trips and submitted to us on a regular basis.
- **Physician's First Report of Injury:** The injured employee should take this form to their physician to complete and return to us promptly.

Compensation Claim Letter to Employee



(Current Date) Claim Number: 1234567
Name and Address of Claimant Social Security #: 000-00-0000
Date of Injury: 05/06/91

Dear Claimant:

The Accident Fund Company has received notice of your injury. Please write your claim number on everything you send us about your claim.

What we need from you right now:

Please fill out these forms and return them to us.

- 1) Employee's Report of Injury.
- 2) Authorization (Sign and date both copies. Have a witness sign them too. Please include the witness's address.

What we need from your doctor:

Have your doctor fill out the Physician's First Report of Injury and send it back to us immediately.

What we need from you to continue your claim handling:

Copies of all current medical reports and disability slips from each doctor's visit. Ask your doctor for copies and send them to us.

All wages earned while receiving benefits from us must be reported to the Accident Fund. Contact me when you return to work and/or earn any wages while receiving benefits from us.

We may compensate you for expenses related to your injury. Send copies of the following for review: medical bills, prescription bills, and mileage for doctor visits (must include the date of visit and round-trip mileage).

Let us know if your employer stops any of your fringe benefits. These include paid hospital stays; life, dental, and optical insurance; and others. It is to your advantage to let us know if this occurs.

Finally, please send all mail addressed to me.

Sincerely,
THE ACCIDENT FUND COMPANY

(Name of assigned examiner)
Claims Department

LL/II
Enclosures

Report of Injury to be Filled Out by Employee



This form must be completed and signed before further benefits are paid.

Employee's Report of Injury

(Answer all questions fully)

Name: _____ Social Security #: _____
First Name Middle Name Last Name

Address: _____
Street # Street Apt. No./RR No. City State Zip

Telephone #: (____) _____ Age: _____ Date of Birth: _____

Tax Filing Status: _____ Height: _____ Weight: _____ Education Completed: _____

Is Your Spouse Employed? _____ Weekly Earnings of Spouse: _____

DEPENDENTS: (First, Middle, Last Names)	Date of Birth	Relationship to Employee	Address	How Much Dependent		
				1/4	1/2	Tc
		SPOUSE				

Support through Friend of the Court: Where? _____ How Much Weekly? _____

Employer's Name: _____

Address: _____

Date of Hire: _____ Occupation: _____ Foreman: _____

Weekly Wage: _____ Hourly Rate: _____ Hours Per Week: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ LAST DAY WORKED: _____

Explain in detail what caused injury _____

What part of your body was injured? _____ Type of injury: _____

Was injury reported to employer? _____ When? _____ Who? _____

Name of witness to injury: _____

Have you had any previous injuries? _____ If so, when, where and what? _____

Did you receive compensation for these injuries? _____ If so, from whom and how much? _____

List names and addresses of doctors which you have been treated by: _____

Have you been hospitalized? _____ Where? _____ How long? _____

Diagnosis of your doctor: _____ Were you given time off? _____

How much? _____ Do you have a possible return to work date? _____ When? _____

Next Dr. appt.? _____ Are you receiving any type of Social Security, Pension, Unemploy wage continuance, or being reimbursed by a Self-Insured plan? _____

If so, who pays you and how much per month? _____

Were you working a second job when you were injured for this employer? _____

If you are losing time from that employer, who is it and what are your earnings? _____

All wages you earn while receiving benefits from us must be reported to the Accident Fund.

I certify I have read the information on this sheet and have answered the questions correctly to the best of my knowledge.

Signed: _____ Date: _____

Authorization to be Filled Out by Employee



The Accident Fund Company

232 S. Capitol Avenue
P.O. Box 40790
Lansing, MI 48901-7990
Phone: (517) 342-4200

Workers' Compensation Insurance Since 1912

AUTHORIZATION

I hereby authorize all medical doctors, physicians, surgeons, doctors of osteopathy, chiropractors, and all other persons who have examined me or attended me professionally at any time or who have been consulted concerning me at any time to release and furnish to The Accident Fund Company or its representatives any and all information in their records and within their knowledge concerning me. This authorization includes the furnishing and delivery to The Accident Fund Company of reproduced or photographic copies of notes, reports, and records.

I hereby authorize all hospitals, clinics, and medical centers to release and furnish to The Accident Fund Company or its representatives any and all information in their records concerning me. This authorization includes the furnishing and delivery to The Accident Fund Company of reproduced or photographic copies of notes, reports and records.

I hereby waive any doctor/patient privilege resulting from any consultation, examination, or treatment with or by you.

I also authorize any insurance company to release and furnish to The Accident Fund Company or its representatives any and all information in their records concerning me that might further aid in the review of my claim.

A photographic copy of this authorization shall be as valid as the original.

Signature: _____

Print Name: _____

Date: _____

Address: _____

Witness: _____

Mileage Reimbursement to be Filled Out by Employee



Name: _____

Claim #: _____

Please use this format when requesting travel expense reimbursement. Your cooperation will help us process your reimbursement more quickly. Thank You

Non-Reimbursable Items Include: Mileage to Retail Stores/Pharmacies
 Unverified Mileage
 Tolls and Parking without Receipts

Date	Destination	Tolls/ Parking	Round Trip Miles	Provider Verification Date/ Initials or Signature	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					

Please check here if you need more forms.

(Please submit every 30 days)

Employee Takes Injury Report to Physician for Completion



The Accident Fund Company
232 S. Capitol Avenue
P.O. Box 40790
Lansing, MI 48901-7990
Phone: (517) 342-4200

Claim No. _____

Workers' Compensation Insurance Since 1912

PHYSICIAN'S FIRST REPORT OF INJURY

The attending physician must send in this report as soon as possible after first treatment.
No compensation can be paid until it is received by The Accident Fund Company.
The employer is requested to hand this blank either to the injured employee or to the doctor.

Employer's name _____ Address _____

Injured employee's name _____ Age _____ Sex _____

Address _____

Date of injury _____ Date of first treatment _____

Employee's statement of how injury happened _____

Diagnosis _____

Where is employee hospitalized _____

Period of hospitalization _____

Has X-ray been taken _____ X-ray findings _____

Are symptoms wholly due to this injury Yes No If not, to what _____

Is employee disabled Yes No Total Partial

Date released to work _____

Anticipated disability _____

Prior to injury, was there any bodily disease or deformity _____

State nature _____

Remarks _____

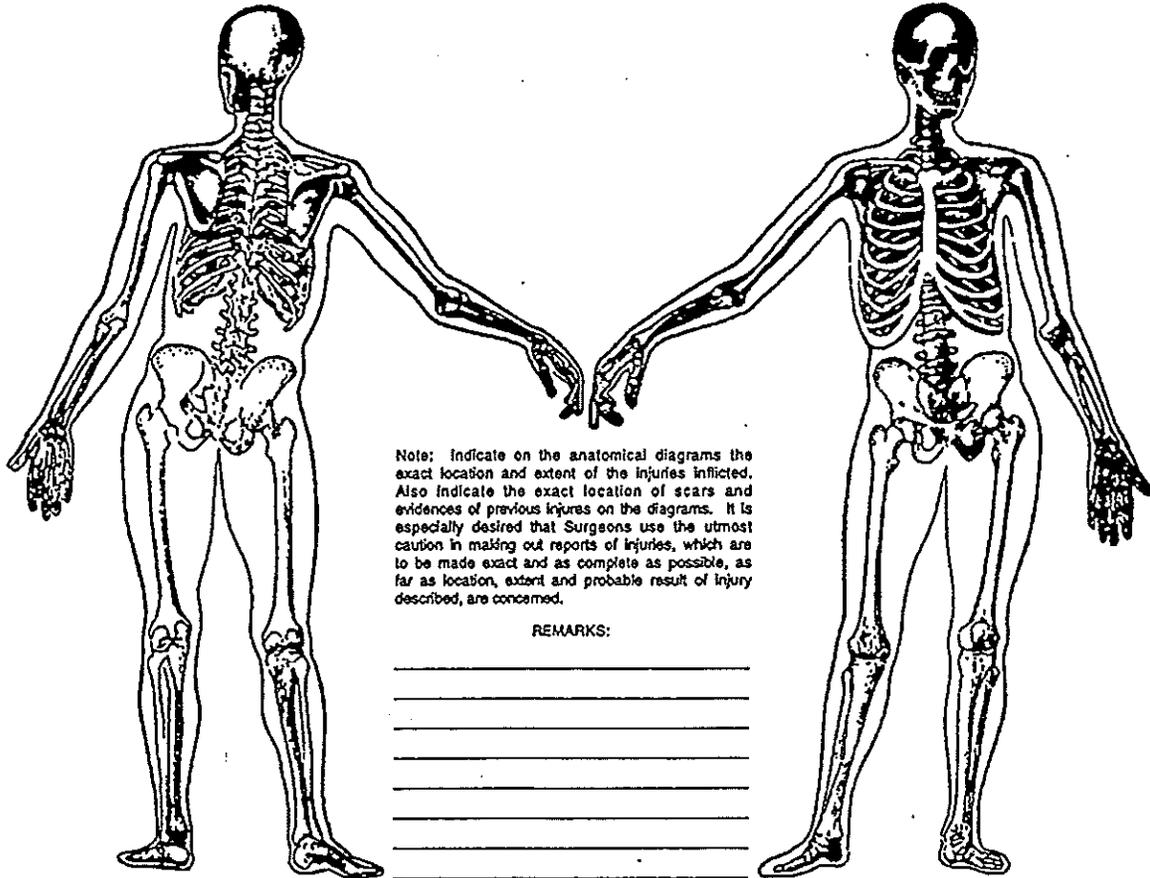
Date _____, 19 _____

Address _____

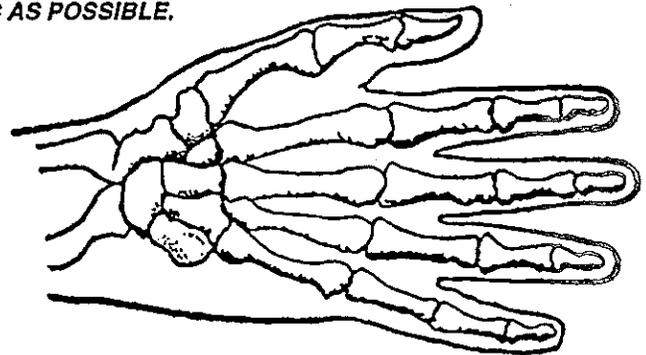
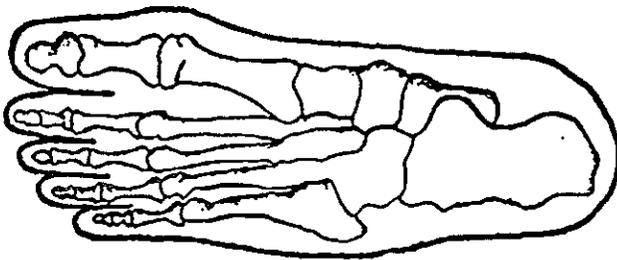
Attending physician — designate whether M.D., D.O., D.C., or D.S.C.
Employer's Identification
or
Social Security No. _____

Physician's First Report of Injury (back page)

In all cases of amputation, the diagram below should be used to designate the exact point of amputation, which must be marked and certified by the operating surgeon and him or her only.



**WHEN INJURIES ARE ON HAND OR FOOT USE DIAGRAM BELOW.
BE AS SPECIFIC AS POSSIBLE.**



I hereby certify that I marked the above diagram on _____, 19 _____, and that said
(Date of marking)

marking correctly indicates the amputation(s) made upon _____
(Name of injured employee)

on _____, 19 _____, and that the remarks above, if any, are in my handwriting.

(Signature of Operating Surgeon)

Supply of Forms

If you are in need of updated claim forms or related supplies, fill out a Supply Requisition and mail it to the Lansing office. Please indicate to whose attention these forms are to be sent. If there is an emergency, call the Lansing office at (517) 342-4200, and ask for the Master Desk. Your request can be taken by phone.



Workers' Compensation insurance Since 1912

SUPPLY REQUISITION

Contact Person: _____ Phone #: _____
Attention: _____ Policy #: _____
Company Name: _____
Mailing Address: _____
City: _____ Zip Code: _____

The forms listed below are available for filing a worker's compensation claim. Please use this requisition when ordering claim forms.

	<u>Quantity</u>
MDL-1-100 Employer's Basic Report of Injury	_____
C-59L Medical Only-Not Over Seven Days	_____
C-15L Order For Medical Exam	_____
C-9L Physician's First Report Of Injury	_____
C-5L Return To Work Card	_____
E-11 Self-Addressed Envelopes	_____
Employer's Claim Handbook	_____

Thank you for your cooperation

Claims Department

Master Desk



EMPLOYER'S BASIC REPORT OF INJURY

Michigan Department of Labor
Bureau of Workers' Disability Compensation
P.O. Box 30016, Lansing, MI 48909

AN EMPLOYER SHALL REPORT IMMEDIATELY TO THE BUREAU ON FORM MDL-1-100 ALL INJURIES, INCLUDING DISEASES, WHICH ARISE OUT OF AND IN THE COURSE OF THE EMPLOYMENT, OR ON WHICH A CLAIM IS MADE AND RESULT IN ANY OF THE FOLLOWING: (A) DISABILITY EXTENDING BEYOND SEVEN (7) CONSECUTIVE DAYS, NOT INCLUDING THE DATE OF INJURY. (B) DEATH. (C) SPECIFIC LOSSES. IN CASE OF DEATH, AN EMPLOYER SHALL ALSO IMMEDIATELY FILE AN ADDITIONAL REPORT ON MDL-1-106.

I. EMPLOYEE DATA

1. SOCIAL SECURITY NUMBER		2. DATE OF INJURY		3. EMPLOYEE NAME (LAST, FIRST, MI)		
4. ADDRESS (NUMBER AND STREET)				5. CITY		6. STATE
7. ZIP CODE	8. DATE OF BIRTH (MM/DD/YY)		9. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	10. NUMBER DEPENDENTS	11. TELEPHONE NUMBER ()	12. WORK PERMIT DATE IF UNDER AGE 18
13. TAX FILING STATUS <input type="checkbox"/> A. SINGLE <input type="checkbox"/> B. SINGLE, HEAD OF HOUSEHOLD			<input type="checkbox"/> C. MARRIED, FILING JOINT <input type="checkbox"/> D. MARRIED, FILING SEPARATE			

II. CURRENT EMPLOYER DATA

14. EMPLOYER NAME				15. FEDERAL I.D. NUMBER		
16. INJURY LOCATION CODE		17. MAILING LOCATION CODE		18. MESC NUMBER		19. TYPE OF BUSINESS (SIC)
20. ADDRESS (NUMBER AND STREET)				21. CITY		22. STATE
						23. ZIP CODE

III. SECOND EMPLOYER DATA

24. SECOND EMPLOYER NAME			25. SECOND EMPLOYER AWW \$			26. NUMBER WEEKS USED
27. ADDRESS (NUMBER AND STREET)			28. CITY		29. STATE	30. ZIP CODE

IV. ALLEGED INJURY DATA

31. LAST DAY WORKED	32. DATE EMPLOYEE RETURNED TO WORK (F APPLICABLE)		33. DID EMPLOYEE DIE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
34. INJURY CITY		35. INJURY STATE		36. INJURY COUNTY		37. DID INJURY OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, SEE ITEM 50)
38. DESCRIBE THE NATURE OF INJURY OR ILLNESS (EXAMPLE: AMPUTATION, BURN, CUT, FRACTURE)						
39. PART OF BODY DIRECTLY AFFECTED BY THE INJURY OR ILLNESS (EXAMPLE: HAND, ARM, CIRCULATORY SYSTEM)						
40. DESCRIBE THE EVENTS WHICH CAUSED THE INJURY (EXAMPLE: FELL, OPERATING MACHINERY, CHEMICAL EXPOSURE)						
41. NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE (EXAMPLE: KNIFE, ACID, FLOOR, OIL)						

V. OCCUPATION AND WAGE DATA

42. DATE HIRED	43. TOTAL GROSS WEEKLY WAGE (HIGHEST 39 OF 52) \$		44. NUMBER WEEKS USED		45. VALUE OF DISCONTINUED FRINGES \$	
46. OCCUPATION (BE SPECIFIC)			47. WAS EMPLOYEE A VOLUNTEER WORKER? <input type="checkbox"/> YES <input type="checkbox"/> NO		48. WAS EMPLOYEE CERTIFIED AS VOCATIONALLY HANDICAPPED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
49. DATE EMPLOYER NOTIFIED BY EMPLOYEE		50. IF TEMPORARY SERVICE AGENCY, PROVIDE NAME/ADDRESS OF EMPLOYER WHERE INJURY OCCURRED.				

VI. PREPARER DATA I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

51. PREPARER'S SIGNATURE			52. TELEPHONE NUMBER ()		53. DATE PREPARED
--------------------------	--	--	-----------------------------	--	-------------------

NOTICE TO EMPLOYEE: QUESTIONS OR ERRORS SHOULD BE REPORTED IMMEDIATELY TO THE INDIVIDUAL LISTED ABOVE IN LINE 51.

AUTHORITY: WORKERS' DISABILITY COMPENSATION ACT, R408.31(1)(3)
COMPLETION: MANDATORY
PENALTY: WORKERS' DISABILITY COMPENSATION ACT, 418.631

THE DEPARTMENT OF LABOR WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, HANDICAP, OR POLITICAL BELIEFS.



Accident Fund of Michigan SM

232 S. Capitol Avenue
P.O. Box 40790
Lansing, MI 48901-7990
Phone: (517) 342-4200

FRINGE BENEFITS PAID FOR BY THE STATE OF MICHIGAN

NAME OF DEPARTMENT

ADDRESS

NAME OF EMPLOYEE

SOCIAL SECURITY NUMBER

Dear Policyholder;

Under State law, we are obligated to take into consideration all FRINGE BENEFITS which terminate when the employee is disabled from his / her job. We ask your cooperation in reporting discontinued benefits to us so that we can avoid any penalties for improper payment of compensation benefits.

To complete this form, if the benefit is available to the employee, check so in the appropriate column. If that benefit has or will terminate, please advise us of the date and the monthly premium you pay for this said benefit.

If the benefit listed is not one you provide to your employees, please mark accordingly.

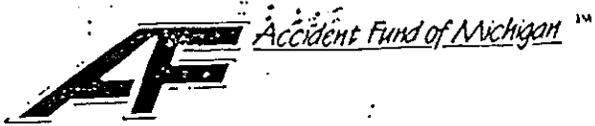
Table with 5 columns: NAME OF BENEFIT, NOT AVAILABLE TO EMPLOYEE, AVAILABLE TO EMPLOYEE, TERMINATION DATE, MONTHLY PREMIUM. Rows include INSURANCES (Aetna / HMO Health Ins., Long Term Disability, Life, Dental, Optical, Pension) and LONGEVITY / BONUS.

VACATION / SICK / HOLIDAY PAY:

The above employee earns vacation, sick time and holiday pay as follows:

HOURLY RATE: \$ _____ VACATION: _____ DAYS PER YEAR
TOTAL SERVICE TIME: _____ HOLIDAY: _____ DAYS PER YEAR
DATE OF HIRE: _____ SICK: _____ DAYS PER YEAR
LAST DAY OF WORK: _____

PLEASE RETURN THIS FORM TO THE CLAIM DEPARTMENT WITH EVERY FORM 100 WHICH YOU SUBMIT



WAGE FORM

RETURN TO:
 Accident Fund of Michigan
 232 S. Capitol Ave.
 P.O. Box 40790
 Lansing, Mi 48901 - 7990

CLAIM NUMBER _____ DATE OF INJURY _____

EMPLOYER NAME _____

CLAIMANT NAME _____

DATE OF HIRE _____ SOCIAL SECURITY NUMBER _____

Please list by week - ending date, the weekly gross earnings for the 52 weeks prior to the date of injury.

	WEEK ENDING	GROSS AMOUNT		WEEK ENDING	GROSS AMOUNT		WEEK ENDING	GROSS AMOUNT
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				AVERAGE WEEKLY WAGE	
18			36					

I certify that the above record is a true copy of the payroll information for the above captioned claimant,

 Signature of Employer

 Date



The Accident Fund Company

232 S. Capitol Avenue
P.O. Box 40790
Lansing, MI 48901-7990
Phone: (517) 342-4200

Workers' Compensation Insurance Since 1912

EMPLOYER'S REPORT ON MEDICAL ONLY INJURY

(Not over 7 days disability)

Report on this form all injuries including diseases which arise out of and in the course of employment and cause not more than seven (7) days of disability.

Employer: _____ Policy #: _____

Mailing Address: _____
(Number & Street or P.O. Box) (City) (State) (Zip)

Risk Location Address: _____
(Number & Street or P.O. Box)

(City) (State) (Zip)

Phone #: (_____) _____ Federal I.D. #: _____
(Area Code)

Injured Employee: _____
(Last Name) (First Name) (Middle Initial)

S.S. #: _____ Date of Birth: ____/____/____
MM DD YY

Address: _____
(Number & Street or P.O. Box) (City) (State) (Zip)

Occupation: _____ Home Phone #: (_____) _____
(Area Code)

Date of Accident
or First Report of Disease

Last Day Worked

Date Returned to Work
or No Lost Time

Type of injury: _____

Body part injured: _____

How did it happen? _____

Doctor's name: _____

Address: _____

Hospital (if any): _____

Date of report: _____ Signature of Employer (not agent or employee)

Mail To: The Accident Fund Company, P. O. Box 40790, Lansing, MI 48901-7990

OFFICE USE ONLY

CLAIM NUMBER	
ACCIDENT DATE	
POLICY NUMBER	
EFFECTIVE DATE	
REPORT DATE (REC'D)	
CLASS CODE	COV CK
CODING DATE	
BIRTH DATE	
STATE DEPT. CODE	
DIAGNOSTICS	BODY PART
COMP RESERVE	
MED RESERVE	
CLAIMS REP #	
NATL COUN. CODE	
INJURY STATUS CODE	PETITION #
AGENT	COUNTY CODE

OFFICE USE ONLY