



Thank you for choosing The Hanover for your Workers' Compensation needs. We are pleased to provide you with some information regarding future filing of claims, and other state specific information that will assist you with your claims reporting. You will find this information in the enclosed packet.

The Hanover has four methods for reporting new workers' compensation losses:

Phone In: Call 1-800-628-0250, follow prompts for reporting WC new losses.

Fax In: Fax completed First Report to 1-800-762-7788

Online: www.hanover.com Choose "Report a Claim" at the top of the page, then choose "Workers' Compensation Claim" under Business Claims.

E-Mail: E-mail completed First Report of Injury to WCNEWLOSSES@hanover.com

All four options are available 24 hours per day, 7 days per week. Upon receipt and entry of your claim into our system, your agent will receive a notification of the claim for their records. This occurs within 1 business day of receipt of your report.

The most essential part of a workers' compensation claim is prompt notification to us to allow prompt investigation, payment of benefits to your injured worker if appropriate, and to avoid any potential for late filing penalties that may be assessed by your state.

Welcome to The Hanover.

We look forward to working with you.



DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation

P.O. Box 58, Jefferson City, MO 65102

573-751-4231

The Hanover Insurance Company
440 Lincoln Street P.O. Box 15063
Worcester, MA 01615
(508) 855-1000

EMPLOYEE INFORMATION

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the injury/or 30 days when reasonably aware of the work-relatedness of occupational illness or disease) by contacting Carol Kilgore, 317-388-4007.
employer representative phone number

**Failure to do so may jeopardize your ability to receive benefits*

2. Seek medical attention (your employer/insurer is responsible for providing medical treatment and paying the medical fees and charges unless you choose to treat with another doctor at your own expense without your employer/insurer's approval).
3. Get more information about the benefits available under the Workers' Compensation Program or about the steps you may take to get the benefits you need.

Visit www.labor.mo.gov/DWC or call 800- 775- COMP.

Benefits for Injured Employees

Medical Care:

The employer or insurer is required to provide medical treatment and care to cure and relieve the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, contact your employer or the insurance company immediately. The employer/insurer has the right to choose the healthcare provider or treating physician. You may select a different healthcare provider or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages:

- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability (TTD)** benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:

If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:

If an employee dies on the job, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage for the year immediately preceding the injury, along with funeral expenses up to \$5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC.

The Division of Workers' Compensation does not discriminate against individuals with disabilities as mandated by P.L. 101- 336, The Americans With Disability Act. Alternative format available upon request.

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

With some exceptions, all employers with five or more employees, and construction industry employers with one or more employees, are required to insure their workers' compensation liability, either by purchasing a policy or obtaining self-insurance authority. Workers' compensation insurance provides benefits to workers injured on the job. Employers also are required to post this notice in the workplace for employees to view. This poster is required by section 287.127, RSMo, and is available to employers and insurers free of charge by contacting the Division at 800-775-Comp.

Steps to Take When an Injury Occurs

1. Be sure first aid is administered and the employee is taken to a physician or hospital for further medical care, if necessary.
2. Report the injury to the insurance company or Third Party Administrator (TPA) within five days of the date of injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. The insurer, TPA, or admitted self-insurer is responsible for filing a First Report of Injury with the Division of Workers' Compensation **within 30 days** of knowledge of the injury.
3. Pay medical bills related to the work injury to cure and relieve the employee of the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. The employer/insurer has the right to choose the healthcare provider or treating physician. (The employee may select a different healthcare provider or treating physician, but if the employee does so, it may be at his/her own expense.)
4. For more liability and insurance information relating to the Workers' Compensation Program, visit www.labor.mo.gov/DWC or call 800-775-COMP.

Workplace Safety

The Missouri Department of Labor offers free safety services to employers through its Missouri Workers' Safety Program (MWSP) to help employers reduce occupational injuries and workers' compensation costs.

Call 573-751-3403 or e-mail mwsp@labor.mo.gov for more information or for a registry of certified consultants and safety engineers. **Employees are urged to report all safety hazards or concerns to the Occupational Safety and Health Administration (OSHA) at 816-483-9531 or 314-425-4249.**

Fraud/Noncompliance

Employee Fraud - knowingly making a claim for workers' compensation benefits to which an employee knows he/she is not entitled or knowingly presenting multiple claims for the same occurrence is a class D felony, punishable by a fine of up to \$10,000, or double the value of the fraud, whichever is greater. A subsequent violation is a class C felony.

Employer Fraud - knowingly misrepresenting an employee's job classification to obtain insurance at less than the proper rate is a class A misdemeanor. A subsequent violation is a class D felony. An employer who knowingly makes a false or fraudulent statement regarding an employee's entitlement to benefits to discourage the worker from making a legitimate claim or who knowingly makes a false or fraudulent material statement or material representation to deny benefits to a worker is guilty of a class A misdemeanor punishable by a fine of up to \$10,000. A subsequent violation is a class C felony.

Insurer Fraud - knowingly and intentionally refusing to comply with workers' compensation obligations to which an insurance company or self-insurer knows an employee is entitled is a class D felony, punishable by a fine of up to \$10,000 or double the value of the fraud, whichever is greater. A subsequent violation is a class C felony.

Employer Noncompliance - knowingly failing to insure workers' compensation liability under the law is a class A misdemeanor punishable by a fine of up to three times the annual premium the employer would have paid had it been insured or up to \$50,000, whichever is greater. A subsequent violation is a class D felony. An employer who willfully fails to post the notice of workers' compensation at the workplace is guilty of a class A misdemeanor punishable by a fine of \$50 to \$1,000 or by imprisonment or both fine and imprisonment.



DIVISION OF WORKERS' COMPENSATION

División de Indemnización para el Trabajador de Missouri
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

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440 Lincoln Street P.O. Box 15063
Worcester, MA 01615
(508) 855-1000

INFORMACIÓN PARA EL EMPLEADO

La División de Indemnización para el Trabajador de Missouri (DWC) administra programas para los trabajadores que se hayan lesionado en el trabajo o que presenten una enfermedad laboral derivada de su trabajo o que hayan desarrollado durante su trabajo. Los Jueces del Derecho Administrativo de la División tienen autoridad para aprobar acuerdos u otorgar indemnizaciones después de una audiencia en relación con el derecho que un empleado lesionado tenga a recibir beneficios.

Medidas que tomar cuando haya un accidente en el trabajo

1. Avise inmediatamente a su empleador (se debe entregar notificación por escrito en un lapso de 30 días a partir del accidente/ o a los 30 días cuando se esté razonablemente consciente de la relación que la enfermedad laboral tenga con el trabajo), póngase en contacto con

Carol Kilgore, 317-388-4007
(representante del empleador) (teléfono)

**No hacerlo puede impedir que reciba beneficios*

2. Consiga atención médica (su empleador/la compañía aseguradora tienen la responsabilidad de proporcionar tratamiento médico y de pagar los gastos y honorarios médicos, a menos que usted decida que lo trate otro médico por su cuenta, sin la autorización de su empleador/aseguradora).
3. Consiga más información sobre los beneficios disponibles en el Programa de Indemnización por Accidentes Laborales o sobre lo que tiene que hacer para recibir los beneficios que necesita.

Ingresa a www.labor.mo.gov/DWC o llame al 800- 775- COMP.

Beneficios para empleados lesionados

Atención Médica:

Se exige que el empleador o la compañía aseguradora proporcionen tratamiento médico y atención que alivie y mitigue los efectos de la lesión. Esto incluye todos los gastos del tratamiento médico autorizado, recetas y aparatos médicos. No hay deducible; el empleador o la aseguradora para la indemnización por accidentes laborales cubrirán todos los gastos. Si usted recibe una cuenta, inmediatamente póngase en contacto con su empleador o su aseguradora. El empleador/La aseguradora tienen derecho a escoger al proveedor de atención médica o médico de cabecera. Usted puede escoger a otro proveedor de atención médica o médico de cabecera; pero al hacerlo, es posible que sea por su cuenta.

Pago de salarios perdidos:

- Si el médico le dice que usted no puede trabajar a causa de sus lesiones o para recuperarse de una cirugía, podrá tener derecho a beneficios por **discapacidad total temporal** (TTD). Si el médico le dice que puede desempeñar deberes laborales leves o modificados y su empleador se lo ofrece, es posible que no tenga derecho a los beneficios por TTD. Estos beneficios deben continuar hasta que el médico indique que usted ya puede regresar a trabajar o cuando ya haya concluido su tratamiento puesto que su condición de salud ha logrado "la máxima mejoría médica"; de esto, lo que ocurra primero.
- Si usted regresa para desempeñar tareas leves o modificadas y percibe menos de su salario, puede tener derecho a beneficios por **discapacidad parcial temporal**.

Beneficios por discapacidad permanente:

Si la lesión o enfermedad da como resultado una discapacidad permanente, es posible que tenga derecho a recibir beneficios por discapacidad ya sea parcial permanente o total permanente.

Beneficios para los sobrevivientes:

Si un empleado fallece en el trabajo, sus dependientes que le sobrevivan pueden recibir beneficios semanales por deceso que se paguen a 66 2/3% del salario semanal promedio del empleado en el año inmediato anterior al accidente, además de gastos funerarios por hasta \$5,000 del empleador/la aseguradora. Para más información sobre los beneficios para los sobrevivientes, incluyendo las oportunidades de becas universitarias para los hijos, ingrese a www.labor.mo.gov/DWC.

Según lo exige la Ley de Derecho Público 101- 336, la Ley para Estadounidenses con Discapacidades, la División de Indemnización para el Trabajador no discrimina a las personas que tengan alguna discapacidad. Disponemos de otros formatos previa solicitud.

Ley sobre Indemnización al Trabajador

Funciones y responsabilidades de los empleadores y los empleados

INFORMACIÓN PARA EL EMPLEADOR

Salvo algunas excepciones, se exige que todos los empleadores que tengan cinco empleados o más, así como los empleadores de la industria de la construcción con uno o más empleados, aseguren su responsabilidad de indemnización por accidentes laborales ya sea al adquirir una póliza o al conseguir autoridad para tener un autoseguro. El seguro de indemnización por accidentes laborales otorga beneficios a aquellos trabajadores que resulten lesionados en el trabajo. También se exige que los empleadores publiquen esta notificación en el lugar de trabajo para que los empleados la vean. El Artículo 287.127 de RSMo exige este cartel que se encuentra disponible para los empleadores y compañías aseguradoras sin costo alguno si se comunican a la División al 800-775-Comp.

Medidas que hay que tomar cuando haya una lesión

1. Asegúrese de que se administren primeros auxilios al empleado y que lo lleven al médico o a un hospital para que reciba más atención médica en caso de ser necesario.
2. Reporte el accidente laboral a la compañía aseguradora o al Administrador de Terceras Personas (TPA) en un lapso de cinco días a partir de la fecha de la lesión o cinco días a partir de la fecha en que el empleado lo haya reportado al empleador, lo que suceda en segundo término. La aseguradora, el TPA o el autoseguro reconocido tienen la responsabilidad de presentar un Primer Informe de Accidente Laboral a la División de Indemnización para el Trabajador en un lapso de 30 días a partir de que se sepa de la lesión.
3. Pague los gastos médicos en relación con el accidente laboral a fin de subsanar al empleado de los efectos de la lesión. Esto incluye todos los gastos del tratamiento médico autorizado, recetas y aparatos médicos. El empleador/La aseguradora tiene derecho a escoger al proveedor de atención médica o médico de cabecera. (El empleado puede elegir a otro proveedor de atención médica o médico de cabecera, pero si lo hace, es posible que sea por su cuenta).
4. Para más información sobre la responsabilidad y el seguro en relación con el Programa de Indemnización por Accidentes Laborales, ingrese a www.labor.mo.gov/DWC o llame al 800-775-COMP.

Seguridad en el lugar de trabajo

El Departamento del Trabajo de Missouri ofrece a los empleadores servicios gratuitos de seguridad mediante su Programa de Seguridad para los Trabajadores de Missouri (MWSP) con el fin de ayudarles a reducir las lesiones laborales y los gastos de indemnización por accidentes en el trabajo. Llame al 573-751-3403 o envíe un correo electrónico a mwsp@labor.mo.gov para obtener más información o para solicitar un registro de los asesores certificados y los ingenieros de seguridad. Se exhorta a los empleados a que reporten todo riesgo o duda de seguridad a la Administración de Seguridad y Salud Ocupacional (OSHA) al 816-483-9531 o al 314-425-4249.

Fraude/Incumplimiento

Fraude por parte del empleado - reclamar deliberadamente los beneficios de indemnización por accidente laboral a los cuales un(a) empleado(a) no tenga derecho o presentar deliberadamente múltiples reclamaciones por el mismo suceso son delitos graves clase D que son penados con una multa de hasta \$10,000 o el doble del valor del fraude; de estos, el monto que sea mayor. Una infracción posterior se considera delito grave clase C.

Fraude por parte del empleador - falsear deliberadamente la clasificación del trabajo de un empleado con el fin de obtener un seguro por menos del valor correcto es un delito menor clase A. Una infracción posterior se considera delito grave clase D. El empleador que deliberadamente haga una declaración falsa o fraudulenta sobre el derecho que un empleado tenga a beneficios, con el fin de evitar este que haga una reclamación legítima, o el que deliberadamente haga una declaración material falsa o fraudulenta que niegue beneficios a un trabajador, será culpable de un delito menor clase A penado con una multa de hasta \$10,000. Una infracción posterior se considera delito grave clase C.

Fraude por parte de la compañía aseguradora - rehusarse deliberada e intencionalmente a cumplir con las obligaciones en cuanto a la indemnización por accidente laboral que la aseguradora o el autoasegurado saben que es derecho de un empleado, es un delito grave clase D penado con una multa de hasta \$10,000 o el doble del valor del fraude; de estos el monto que sea mayor. Una infracción posterior se considera delito grave clase C.

Incumplimiento por parte del empleador - no asegurar deliberadamente la indemnización al trabajador según las leyes constituye un delito menor clase A penado con una multa de hasta tres veces la prima anual que el empleador habría pagado si la hubiera asegurado o de hasta \$50,000; de estos lo que sea mayor. Una infracción posterior se considera delito grave clase D. El empleador que premeditadamente no exhiba en el lugar de trabajo la notificación sobre la indemnización por accidentes laborales será culpable de un delito menor clase A penado con una multa de \$50 a \$1,000 o con encarcelamiento, o multa y encarcelamiento.

REPORT OF INJURY

(To complete form,
see attached instructions)

GENERAL	EMPLOYER (NAME, ADDRESS, INCL ZIP CODE)		CARRIER ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE	
	JURISDICTION		JURISDICTION CLAIM NUMBER			
	INSURED REPORT NUMBER					
	EMPLOYERS LOCATION ADDRESS (IF DIFFERENT)				LOCATION #	
	SIC CODE	EMPLOYER FEIN	PHONE #			
CARRIER CLAIMS ADMIN	CARRIER (NAME, ADDRESS & PHONE NO.)		POLICY PERIOD to		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)	
	CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE					
	CARRIER FEIN	INSURANCE POLICY NUMBER				ADMINISTRATOR FEIN
	AGENT NAME & CODE NUMBER					
EMPLOYEE	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY #	DATE HIRED	STATE OF HIRE
	ADDRESS (INCLUDE ZIP)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	OCCUPATION JOB TITLE	
	PHONE #		# OF DEPENDENTS	EMPLOYMENT STATUS		
				NCCI CLASS CODE		
WAGE	RATE PER <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER		# OF DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
OCCURRENCE	TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM		DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED
	CONTACT NAME PHONE NUMBER		TYPE OF INJURY ILLNESS		PART OF BODY AFFECTED	
	DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE	
	ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		
	SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		
	HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.					CAUSE OF INJURY CODE
	DATE RETURN TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
TREAT- MENT	PHYSICIAN HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT <input type="checkbox"/> 0 - NO MEDICAL TREATMENT <input type="checkbox"/> 1 - MINOR: BY EMPLOYER <input type="checkbox"/> 2 - MINOR CLINIC HOSPITAL <input type="checkbox"/> 3 - EMERGENCY CASE <input type="checkbox"/> 4 - HOSPITALIZED > 24 HOURS <input type="checkbox"/> 5 - FUTURE MAJ. MED. LOST TIME ANTICIPATED	
OTHERS	WITNESS (NAME & PHONE #)					
	DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER

NOTE > This form constitutes both the original notification of injury and detailed report of injury required by §287.380, RSMo (2000) and rules applicable thereto. An injury that requires immediate first aid, which does not result in further medical treatment or lost time from work, need not be reported to the Division. Employers should report all injuries to their workers' compensation insurance carrier or third-party administrator (TPA) within five days of the date of the injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. See §287.380, RSMo. If the employer has been granted self-insurance authority by the Division pursuant to §287.280, RSMo, and rules applicable thereto, please report all injuries to your TPA or Service Company to enable them to file this report with the Division.

PRINT QUALITY > All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division **MUST** be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

Data Element Table for First Report of Injury – Hard Copy and EDI

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Employer (Name & Address)	The name of the employer where the employee was employed at the time of the injury.	This is the name the employer does business under followed by the FULL address including mailing address, city, state and zip code.	M
Industry Code	<p>The code which represents the nature of the employer's business which is contained in the North American Industry Classification System Manual published by the Federal Office of Management and Budget.</p> <p>See implementation note below:</p> <p>The industry code selected should represent the primary nature of the employer's business. If the employer is assigned multiple industry codes, use the code that relates to the specific business operation for which the employee was employed at the time of the injury. The data element may contain an SIC code or NAICS Code. SIC code will be identified with the characters 'SC' as the last two characters of the data element. If SC is not present, the code is presumed to be NAICS.</p>	This is the Standard Industrial Classification Code for the employer. SIC/NAICS codes can be found at www.census.gov/epcd/naics02	M
Employer FEIN	The FEIN of the employer where the employee was employed at the time of the injury.	Must be the primary FEIN for the Employer listed above.	M
Report Purpose Code (RPC)	<p>Defines the specific purpose of the report being filed with the state of Missouri.</p> <p>00 = Original FROI</p>	The original or Initial First Report of Injury that the employer is required to file with the Division of Workers' Compensation (Division) through the insurance carrier or third party administrator (TPA)	M
Claims Administrator's Number	Identifies a specific claim within a claim administrator's claims processing system.	Number used by the organization adjusting the claim (insurance company, third party administrator, etc.).	M
Jurisdiction	The governing body or territory whose statute applies.	This must always be Missouri.	M
Jurisdiction Claim Number		The injury number assigned by the Division upon receipt of the First Report of Injury with all mandatory information provided. The reporting entity is to leave this field blank.	
Insured Report Number	A number used by the insured to identify a specific claim.		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Employer's Location Address	List the physical address of where the employee sustained the accident or illness if that location is different from where the employer wishes to have correspondence sent.		O
Insured Location Number	A code defined by the insurer/employer, which is used to identify the employer's location of the accident.		O
Phone Number	List a phone number of the employer location where the employee worked at the time of the accident.		O
Carrier (insurer) Name & Address	The name and mailing address of the carrier or self-insured entity assuming the employer's financial responsibility for the workers' compensation claim.	If the employer is individually self-insured, the individual self-insured employer's name and mailing address would be indicated in this field. The FEIN and Name must match. If the employer is self-insured by a trust, the trust's name would be submitted in this field.	M
Carrier (insurer) FEIN Number	The FEIN of the carrier or self-insured assuming the employer's financial responsibility for the workers' compensation claim(s).		M
Carrier Policy Number	The number assigned to the contract/policy for the employer or association group.	A number assigned by the insurance company, (Not a number assigned by a TPA) for the specific workers' compensation policy for that employer. Not a required field for Division <u>approved</u> self-insureds.	M
Policy Period	List the effective and expiration dates of the contract/policy.	The date that the policy became effective and the date the policy expires or is no longer in effect. No date is required in this field if the injury falls within the Division approved self-insurer's self-insurance period.	M
Self-Insured Indicator	An indicator that identifies the employer as one who retains the risks arising from its operations and bears the financial responsibility. Check box if applicable.	An indicator used for an individually self-insured employer or an employer authorized to self insure through a trust by Missouri Division of Workers' Compensation and is financially responsible for workers' compensation claims.	C
Claim Administrator (TPA) Name & Address	The name and mailing address of the Third Party Administrator (TPA), independent administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	Name and mailing address of the Third Party Administrator (TPA), independent adjuster, contracted to adjust the claim and phone number of the office adjusting the claim. If there is not a TPA, independent adjuster/administrator, contracted to adjust the claim please leave blank.	C
Claim Administrator (TPA) FEIN Number	The FEIN of the Third Party Administrator (TPA), independent adjuster/administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	FEIN number for the company hired as a TPA. Note: If there is no Third Party Administrator, please leave blank.	C

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Agent Name & Code Number	List the name and code number of the carrier or claim administrator agent who administers the workers' compensation claims for the employer.		O
Employee Name	The injured worker's legally recognized name which is used on legal documents, employment, Social Security, banking, records, etc.	Name to include last, first and middle initial.	M
Employee Date of Birth	The date the injured worker was born.	Must be a valid date.	M
Social Security Number	A number assigned by the Social Security Administration used to identify the employee.	Can use Missouri Driver's license after 7/1/03. <u>If neither a SSN or MO driver's license is available please call 888-837-6069.</u>	M
Date of Hire	The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.	Must be valid date.	O
State of Hire	List the state where the employer hired the employee.		O
Employee Address	The mailing address used by the injured worker.	The address should not be listed as unknown. Please include the last known address provided by the employee that is on file with the employer.	M
Employee Phone	A telephone number where the injured worker can be reached.	This is an optional field, although if the employer or insurance company has this information, please report it to the Division. This will improve communication between the parties. This will be a numeric field only 5736367777.	O
Gender Code	The code which indicates the sex of the employee. Gender of employee F=Female M=Male U=Unknown		M
Number of Dependents	The number of dependents as defined by the administrating jurisdiction.	Spouse, minor children or others if known. Required if date of death is entered. Numeric field 0-9.	C
Marital Status Code	The code, which indicates the marital status of the employee. U = Widowed, divorced, single, unmarried, M = Married, S = Separated, K = Unknown		O
Occupational/ Job Title or Description	Identifies the primary occupation of the employee at the time of the accident or injurious exposure.		O
Employment Status Code	Indicate the employee's primary work code status at the time of the injury with the covered employer.		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
NCCI Class Code	A code, which, corresponds to the primary occupation in which the employee was engaged at the time of the accident/injury or injurious exposure.	MO currently uses NCCI codes.	M
Wage	<p>The reported employee's pre-injury wage for the wage period.</p> <p>Implementation Note:</p> <p>This amount may include commission, piecework earnings, and other forms of income converted to a normal scheduled work week, plus the estimated value of lodging, food, laundry and other payments in kind; and concurrent employment earnings, as prejurisdictional requirement.</p>	<p>"Gross Wages" includes, in addition to money paid by the employer for services rendered by the employee, the reasonable value of board, rent, housing, lodging or similar advance by the employer, except if it continues to be provided to the employee for the period of disability, it is not included in calculating the average weekly wage. "Wages" also includes gratuity received in the course of employment from individuals other than the employer that are reported for income tax purposes. "Wages" does not include fringe benefits such as retirement, pension, health and welfare, life insurance, training, Social Security or other employee or dependent benefit plan provided by the employer.</p> <p><u>See Special Notes #1</u></p>	M
Wage Period	A code indicating the time period during which the wage was earned.	Please use the weekly wage rate paid to the employee.	M
Number of Days Worked	The number of the employee's regularly scheduled workdays per week.		O
Full Wages Paid for the Date of Injury Indicator	Indicates whether full wages for the date of the accident/injury or illness were paid by the employer.		O
Salary Continued Indicator	The employer has paid or is paying the employee's salary in lieu of compensation during an absence caused by a work-related injury.	Did the employer continue to pay salary to the employee after the injury? N=No Y=Yes	O
Time Employee Began Work	Time at which the employee began work on the day of the accident/injury or illness.		O
Date of Injury/Illness	For traumatic injury, the date on which the accident occurred. For occupational disease or cumulative injury, the date of injury is the date of last injurious exposure to the cause or substance creating the condition, unless otherwise defined by statute.	Date that injury/illness occurred or became known to employee; whichever is later.	M
Time of Occurrence	The time at which the accident occurred.	To the extent that the time of the occurrence of the accident/injury is available, you should provide it to the Division. Please indicate a.m. or p.m.	O
Date Last Day Worked	The last paid workday prior to the initial date of disability as defined by jurisdiction.	Must be valid date.	O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Date Employer Notified	The date that the injury was reported to a representative of the employer.		M
Date Disability Began	The first day on which the employee originally lost time from work due to the occupational injury or disease or as otherwise defined by jurisdiction.	<p>Date of disability must be greater than Date of Injury.</p> <p>First date employee starts losing time from work after the date of injury. This is the day after the date of injury or the first day of work missed, if later. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days.</p> <p><u>See Special Note #2</u></p>	C
Contact Name & Phone Number	List the name and phone number for a representative of the employer.		C
Type of Injury/Illness	List the type of injury/illness sustained by the employee.		O
Part of Body Affected	List the part of body to which the employee sustained injury.		O
Employer Premises Indicator	An indicator to denote whether the accident occurred at the employer's address provided.	If the injury/illness occurred on the employer's property indicate "YES." If it occurred elsewhere indicate "NO."	M
Type of Injury/Illness Code	The code, which corresponds to the nature of the injury sustained by the employee.	A list of codes with description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx (Sprain, strain, occupational disease, hernia, amputation, etc.)	M
Part of Body Affected Code	The code, which corresponds to the part of the body to which the employee sustained injury.	Choose from the list of code numbers, which corresponds with the part of body injured. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx	M
Zip Code of the Location Where Accident or Illness Exposure Occurred	The zip (postal code) that corresponds to the location where the injury occurred.	The code is required to assist with docket setting if needed.	M
All Equipment Using	List all the equipment; materials or chemicals the employee was using at the time of the accident/injury or illness exposure occurred.		O
Specific Activity Engaged In	Describe the specific activity that the employee was doing at the time the accident/injury or illness exposure occurred.		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Work Process Engaged In	Describe the work process the employee was doing when the accident/injury or illness exposure occurred.		O
How the Injury or Illness Occurred	A free form description of how the accident occurred and the resulting injuries.	Describe how the injury/illness occurred. Please include the events that led to the injury/illness and any objects or substances that directly injured the employee or made the employee ill. Maximum of 150 characters, including spaces. <i>For example: Employee was on ladder putting away product, fell on chemical barrel breaking lower arm; arm lacerations; exposed to chemical liquid and fumes (141 characters).</i>	M
Cause of Injury Code	The code which corresponds to the cause of injury.	Choose from the list of code numbers, which corresponds with the cause of the injury. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx (Struck by, fell, auto accident, exposure, etc.)	M
Date Returned to Work	The first date on which the employee returned to work following the injury. See special note *	Must be a valid date. Must be entered if employee lost days of work and returned to work before first report of injury is filed.	C
Employee Date of Death	The date the injured worker died.	Must be a valid date.	C
Safeguards	Indicate whether safeguards or safety equipment was provided by checking "Yes" or "No."		O
Were They Used	Indicate whether the safeguards or safety equipment was used by the employee by checking "Yes" or "No."		O
Physician/Health Care Provider	List the name and address of the physician or health care provider who provided initial medical treatment to the injured employee after the accident/injury or illness.		O
Hospital	List the name and address of the hospital where the employee received initial medical treatment.		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Initial Treatment	<p>A code used to identify the extent of medical treatment received by the employee immediately following the accident.</p> <p>0= No medical treatment</p> <p>1= Minor on-site remedies by employer medical staff</p> <p>2= Minor clinic/hospital medical remedies and diagnostic testing</p> <p>3= Emergency evaluation, diagnostic testing, and medical procedures</p> <p>4= Hospitalization > 24 hours</p> <p>5= Future major medical/lost time anticipated</p> <p><u>**Please see attached special notes for Missouri.</u></p>	<p>First Aid includes the administration of immediate and <u>temporary</u> medical aid to the employee that a lay person may provide, such as the application of Band-Aid to treat a minor scratch or the removal of a splinter that would not result in the need for a referral to a doctor or other health care professional for additional medical treatment. The on-site company nurse or physician may be the individual that provides the first aid. If the company nurse or physician provides service beyond first aid, then the injury must be reported even if the treatment occurs on-site.</p> <p><u>See Special Notes # 3 & 4</u></p>	M
Witness	List the name and address of all witnesses who were present when the employee sustained the accident/injury or illness.		O
Date Reported to Claims Administrator	The date the claim administrator who is processing the claim received notice of the loss or occurrence.		M
Date Prepared	List the date that the representative for the claims administrator prepared this report of injury.		O
Preparer's Name and Title	List the name and title of the claims administrator's representative who prepared this report of injury.		C
Phone Number	List the phone number of the representative preparing this report of injury.		C

M – Mandatory Error – Cases missing mandatory information will NOT be accepted by the Missouri Division of Workers' Compensation system.

C – Conditional – Data Elements with Conditional errors indicate a value is required based on another Data Element or pre-existing condition.

Examples: When a death case is reported then the death date would be required.

If the employee has returned to work prior to the report being filed, the date of return to work would be entered.

O – Optional – Data Elements identified as Optional may be entered but are not required.

Special Notes

- 1) Report the wage information as the average weekly wage (AWW) of the employee. These rules apply for calculating the average weekly wage.
 - a) If the employee's wage is fixed by the year, the AWW is the yearly wage divided by 52;
 - b) If the employee's wage is fixed by the month, the AWW is the monthly wage multiplied by 12 and divided by 52;
 - c) If the employee's wage is fixed by the week, that amount is the AWW;
 - d) If the employee's wages are fixed by the day, hour or output, the numerator is the actual gross wages earned by the employee in the last thirteen calendar weeks immediately preceding the week in which the injury occurred; and the denominator is 13 to calculate the AWW.
 - i) The formula is: Actual gross wages earned in prior 13 weeks/13=AWW. *For example, the employee's hourly wage is \$9.00/hour. The overtime rate is \$13.50/hour. The employee works 40 hours per week at \$9.00 an hour plus occasional overtime. Employee worked overtime of 44 hours in the 13-week period immediately preceding the week of the injury. The employer has employed the employee for 2 years.*
The gross wages are \$9.00 X 40 hours X 13 weeks = \$4,680. You also need to include the overtime 44 hours. Therefore, \$13.50 X 44 hours = \$594. The total wages are \$4,680 plus \$594 = \$5,274. The AWW is \$5,274/13=\$405.69.
 - ii) If the employee misses nonconsecutive workdays during the 13-week period in multiples of 5 and receives no compensation, such as sick or other leave, those days shall be subtracted from the denominator. *For example: if the employee misses 5 days, one week is subtracted from 13 and the denominator becomes 12; if the employee misses 10 days, two week are subtracted from 13 and the denominator becomes 11; and so on.*
 - iii) Partial weeks of time missed by the employee do not count to change the denominator. *For example: if the employee misses 4 days, the denominator is 13; if the employee misses 6 days, one week is subtracted from 13 and the denominator becomes 12; and so on.*
 - iv) If the employee works less than 13 weeks but more than 2 weeks, the AWW is the same formula with the numerator as the gross wages calculated for the number of weeks of employment and the denominator is the number of weeks of employment. *For example, the employee worked for the employer 8 weeks prior to the week of the injury. The employee was paid \$9.00 per hour and worked 40 hours per week. The employee worked 13 hours of overtime. The overtime rate is \$13.50. The gross wages are \$9.00 X 40 hours X 8 weeks plus \$13.50 X 13 hours = \$3,055.50. The AWW is \$3,055.50/8=\$381.94.*
 - e) If the employee works less than two weeks the AWW shall be equivalent to the AWW for the same or similar employment. However, if the employer has agreed to a certain hourly wage, then the hourly wage agreed upon multiplied by the number of weekly hours scheduled shall be the employee's AWW.
- 2) When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.
- 3) When Initial Treatment Code is reported as equal to 00, 01 or 02, the case will be considered as a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed. When the Initial Treatment Code is reported as equal to 03, 04 or 05, the case will be considered as an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.
- 4) The following are examples of First Aid treatment.
 - a) Use of non-prescription medication at non-prescription strength.
 - b) Cleaning, flushing or soaking wounds on the surface of the skin.
 - c) Using wound coverings such as bandages, Band-Aids, gauze pads, etc. or using butterfly bandages or Steri-Strips. (Other wound closing devices such as sutures, staples, glues, etc. are considered medical treatment.)
 - d) Use of any non-rigid means of support such as an elastic bandage, wrap, or non-rigid belt. (The use of devices with rigid stays or other systems designed to immobilize body parts is considered medical treatment.)
 - e) Use of temporary immobilization devices (e.g., splints, slings, neck collars, etc.) while transporting an accident victim.
 - f) Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs, or other simple means.
 - g) Use of finger guards.
 - h) Drinking of fluids for relief of heat stress.