COMMONWEALTH OF KENTUCKY
WORKERS COMPENSATION NOTICE

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

Employer Name:

Address:

Workers Compensation Carrier

(or third party administrator): **, effective** **to**

Policy #:

Address:

Telephone: _____ **, Contact Person** _____

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

This employer IS ☐ IS NOT ☐ participating in a Managed Care Plan for medical Care. The name of the Managed Care Plan is _____; its representative is _____, phone number _____.

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

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

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

01/10/97 (rev 10/09)
Form WC 88 16 02 C Printed in U.S.A.