SOUTHERN MUTUAL CHURCH INSURANCE COMPANY

201 Greenlawn Dr ▪ P.O. Box 9346 ▪ Columbia, SC 29290-0346 ▪ 1-800-922-5332 ▪ 803-776-9365 ▪ 803-776-4260 FAX

Planned Administrator's Inc. (PAI) will manage your Workers' Compensation claims on behalf of Southern Mutual Church Insurance Company. This packet contains all the information needed to report your Workers' Compensation losses. Please take a moment to review this material and contact us with any questions you have. You may report injuries by mail, fax, email or phone.

PLEASE REPORT ALL CLAIMS TO THE FOLLOWING:

Mailing Address:	**Planned Administrator's Inc.** **Post Office Box 100159, Columbia, SC 29202**
Phone Number:	**1 (800) 827-5794 Option #3**
Fax Number:	**1 (844) 230-8259**
Claims Reporting Email:	**tpaclaims@companiontpa.com**

When reporting a claim by phone, you will be asked questions similar to those on the First Report of Injury form (see below). The more information you have on hand the less time the call will take and the less need for follow-up. Phone reports generally take approximately 10 minutes.

-Tax ID Number
-Policy Number
-When/where/how injury occurred
-Type of injury (cut, burn, etc.)
-Name of exact part of body injured
-Name and address of injured person
-Social Security Number
-Age, sex, and marital status
-Wage information
-Anticipated return to work date
-Name and address of physician
-Name of witnesses
-Date of hire and year on current job
-Number of dependents

We are excited about the opportunity to partner with you and believe that you will find us to be a valuable tool in the overall management of your insurance programs. As always we welcome the opportunity to answer any questions you may have about the contents of this packet or Workers' Compensation in general.

Welcome to Planned Administrator's Inc.!

Enclosed is a copy of your Claims Packet. We hope this information will be useful to you. Included in this packet is the following information:

- Contact Information for your PAI team members
- SC Form 12A FIRST REPORT OF INJURY OR ILLNESS Complete this form immediately upon notice of an accident with as much information as possible. The form should be immediately mailed, faxed or emailed to Planned Administrator's Inc. You should complete the form any time a work related injury is reported to you even if you feel the employee is not entitled to benefits. We will investigate the claim and defend you accordingly. *Planned Administrator's Inc. mailing address, fax number, and email address are listed on the next page.*
- SC Form 20 STATEMENT OF EARNINGS OF INJURED EMPLOYEE Complete this form for all claims other than minor medical cases. The instructions are on the form. This form along with Form 12A FIRST REPORT OF INJURY OR ILLNESS should be immediately mailed, faxed or emailed to Planned Administrator's Inc. *Planned Administrator's Inc. mailing address, fax number, and email address are listed on the next page.*
- Claims Reporting Instructions
- Pharmacy Information from our preferred pharmacy vendor, Corporate Pharmacy Services.
- Useful reference links

We look forward to working with you as a member of your Risk Management team.

Workers' Compensation Contact Information

Mailing Address: Planned Administrator's Inc.
17 Technology Circle, Suite E2AG, Columbia, SC 29203
Post Office Box 100159, Columbia, SC 29202

Phone Number: 1 (800) 827-5794 Option #3

Fax Number: 1 (844) 230-8259

Claims Reporting Email: tpaclaims@companiontpa.com

PAI Claims Team

Jonathan Duarte
Senior Claims Adjuster

Direct Dial: (803) 264-4492
Toll-Free #: (800) 827-5794 ext. 44492
Fax #: (844) 230-8259
E-Mail: jonathan.duarte@companiontpa.com

Sherry Branham
Medical Only Assistant

Direct Dial: (803) 264-6260
Toll Free #: (800) 827-5794 ext. 46260
Fax #: (844) 230-8259
E-Mail: sherry.branham@companiontpa.com

Linda McCallister
Claims Supervisor

Direct Dial: (803) 264-0423
Toll Free #: (800) 827-5794 ext. 40423
Fax #: (844) 230-8259
E-Mail: linda.mccallister@companiontpa.com

S.C. WORKERS' COMPENSATION COMMISSION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
SOUTHERN MUTUAL CHURCH INSURANCE CO. PO BOX 9346 COLUMBIA SC 29290-0346 1-800-922-5332	TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	PLANNED ADMINISTRATOR'S INC. PO BOX 100159 COLUMBIA SC 29202 1-800-827-5794 OPTION #3

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX ☐ Male ☐ Female ☐ Unknown	MARITAL STATUS ☐ Unmarried/Single/Divorced ☐ Married ☐ Separated ☐ Unknow	OCCUPATION/JOB TITLE EMPLOYMENT STATUS NCCI CLASS CODE	
PHONE	# OF DEPENDENTS			

RATE PER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	DID SALARY CONTINUE?
☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER:		☐ YES ☐ NO	☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	LAST WORK DATE	DATE EMPLOYER NOTIFIED DATE DISABILITY BEGAN
☐ AM ☐ PM		☐ AM (☐) CANNOT BE DETERMINED ☐ PM		

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL	CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	WERE THEY USED?
		☐ YES ☐ NO	☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 ☐ No Medical Treatment
		1 ☐ MINOR: BY EMPLOYER
		2 ☐ MINOR CLINIC/HOSP
		3 ☐ EMERGENCY CARE
		4 ☐ HOSPITALIZED > 24 HOURS
		5 ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:
Enter all dates in MM/DD/YYYY format.

INDUSTRY CODE:
This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:
The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:
Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:
Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:
This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:
Indicate the employee's work status. The valid choices are:
Full-Time On Strike Unknown Volunteer
Part-Time Disabled Apprenticeship Full-Time Seasonal
Not Employed Retired Apprenticeship Part-Time Piece Worker

DATE DISABILITY BEGAN:
The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:
Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:
Briefly describe the nature of the injury or illness, (e.g. Lacerations to the forearm).

PART OF BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (e.g. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(e.g. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g. walking along a hallway).

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:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Insurance Carrier: SOUTHERN MUTUAL CHURCH INSURANCE

Preparer's Name: _____ Preparer's Phone #: _____

Date of Injury: _____
month day year

A. Total Wages Paid

1. Check Applicable Method:
   - ☐ Report of earnings of injured employee based on four completed quarters.
   - ☐ Report of earnings of injured employee who did not complete four quarters based on actual time worked.
   - ☐ Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire date: _____
   - ☐ Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just (attach documentation to show how average weekly wage and compensation rate were calculated).

2. List total wages paid as reported to the Employment Security Commission on the Employer Quarterly Contribution and Age Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

Quarter	Ending Date	Total Wages Paid
1st		$
2nd		$
3rd		$
4th		$

Total Paid 2. $ _____

3. List total value of other allowances of any character made in lieu of wages during four quarters above. 3. $ _____
4. Add lines 2 and 3. **TOTAL WAGES PAID:** 4. $ _____
5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. _____

B. Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5).
   AVERAGE WEEKLY WAGE: 6. $ _____

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667. Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. $ _____
8. The compensation rate is as follows (choose one):
   - ☐ When average weekly wage (line 6) is less than $75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
   - ☐ When the estimated compensation rate (line 7) is less than $75.00 and average weekly wage (line 6) is more than $75.00, the compensation rate is $75.00. Enter $75.00 on line 8.
   - ☐ When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
   - ☐ Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8. _____
   - ☐ The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.

WEEKLY COMPENSATION RATE: 8. $ _____

Employer's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED, THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803)737-5723.

Clients

How to submit a First Report of Injury to

pai
We make Benefits Better.

E-MAIL

tpaclaims@companiontpa.com

FAX

1-844-230-8259

PHONE

1-800-827-5794 Option #3

SNAIL MAIL

Planned Administrator's Inc.
P.O. Box 100159
Columbia, SC 29202

Pharmacy Program

In conjunction with

PRESCRIPTION PROCESS

- Complete the attached workers compensation prescription authorization form.
- Upon completion of the form ask the injured employee which pharmacy they would like to use and obtain the pharmacy phone number.
- Call the pharmacy to obtain their fax number or e-mail address.
- Fax or e-mail the authorization sheet to the selected pharmacy.
- The patient is loaded by the pharmacy.
- The authorization form will allow the injured employee to obtain prescriptions immediately for the first set of prescriptions only. The prescription authorization will be extended once the claim is received by Planned Administrator's Inc.
- The authorization may be extended or revoked by contacting CPS at (866) 429-1116.
- Network pharmacies can be found using a zip code search by going to www.corporatepharmacy.com and clicking on pharmacy locator.

SOUTHERN MUTUAL CHURCH INSURANCE COMPANY
WORKERS' COMPENSATION
PRESCRIPTION PAYMENT AUTHORIZATION FORM

Please keep this Authorization Form on file with script for auditing purposes.

Pharmacist:

This is a temporary workers' comp Rx payment authorization form. Please submit the prescription using the processing information listed below.

Please contact CPS Customer Care at (866) 429-1116 if you have any questions.

To transmit a prescription claim, please use the following information:

Processing information

Processor: EHO (Employer Health Options)

Bin #'s: NDC = 004527 (most pharmacies use this number)
Envoy/WebMD = 003241
CVS Condor Code = 15721
Walgreen's Bin # = ehowc
Eckerd's/Rite Aid Condor Code = 2185

(These specific pharmacy chains require special numbers to transmit prescriptions. All major chains and most independent pharmacies accept this plan.)

Version: D.O

Patient Information

Last Name: _____

First Name: _____

Group#: 70065 **Sex: Male [ ] Female [ ]**

ID# / SS#: _ _ _ _ _ _ _ _ _

D.O.B.: _ _ / _ _ / _ _ _ _

Prior Authorization #: _____ **(retain this # for future use)**

Date Sent: _____

Mail Order Program

Program Features

- Below state fee schedule pricing
- Pricing based on cost plus basis (averages 25%-30% below fee schedule pricing)
- 90 day supply of non-narcotic medications
- Prescriptions automatically filled with generics
- Generates savings and management reports
- Offers recommendations based on reports
- Prescriptions delivered directly to injured workers' home
- Adult signature required on narcotic packages
- In-house tracking capabilities of all packages shipped via Federal Express
- Toll free patient and physician phone numbers
- Screen medication for compensability to injury, early refills, duplicated drug therapy, etc.

Useful Reference Links

South Carolina Workers' Compensation Commission
www.wcc.sc.gov

Center for Disease Control & Prevention (CDC):
www.cdc.gov

National Safety Council (NSC)
www.nsc.org

U.S. Department of Transportation
www.dot.gov

American Industrial Hygiene Association
www.seinet.org