



Workers' Compensation Claim Kit

CBLA
CONNECTICUT
BUSINESS & INDUSTRY
ASSOCIATION

FutureComp[®]

Contents

	Section
Welcome	I.
State of Connecticut Injury Reporting Form	II.
Wage Statement Form	III.
State of Connecticut Filing Status and Exemption Form	IV.
FutureComp Dedicated Claims Unit	V.
Frequently Asked Questions	VI.



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SECTION I

Welcome



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I am pleased to provide you the FutureComp Workers' Compensation Claim Kit. This kit contains all forms, instructions and contacts needed for the recovery of an employees' injury and/or illness including:

- **State of Connecticut Injury Reporting Form**
Used for reporting all accidents
- **Wage Statement Form**
Used for lost time accidents to calculate the average weekly wage for payment of benefits to an employee
- **State of Connecticut Filing Status and Exemption Form**
Used with the Wage Statement Form to calculate an employee's workers' compensation rate of pay
- **FutureComp Dedicated Claim Unit**
Your FutureComp contacts, their functions and telephone numbers.
- **Frequently Asked Questions**

We look forward to providing you the highest level of service for all your Workers' Compensation needs. Please call me if you have any questions.

Sincerely,

Anthony E. Szwez
Senior Vice President, FutureComp
(800) 443-6252 Ext. 4261



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Section II

State of Connecticut Injury Reporting Form



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State of Connecticut Injury Reporting Form

When to File

File this form within seven calendar days (excluding Sundays and legal holidays) of receiving notice of any injury alleged to have occurred in the course of employment. This form is not an admission of liability. It must be filed even if you believe the employee is not injured or that the employee is not entitled to benefits.

Where to File

E-mail or fax to:

FutureComp
jill.moulton@tdinsure.com
and
fonda.carmody@tdinsure.com
fax: (860) 257-0002



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State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 3-17-2005

FRI

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Date filed in Chairman's Office

(for WOC use only)

Employer (Name, Address & Zip)		Phone #	Carrier / Administrator Claim #	OSHA Log Case #	Report Purpose Code
SIC Code		FEIN	Jurisdiction	Jurisdiction Claim #	
Carrier (Name, Address & Zip)		Phone # (860) 244-1900	Claims Administrator (Name, Address & Zip)		Phone # (800) 443-6252 ext. 1864
CIBIA Comp Services, Inc 350 Church Street Hartford, CT 06103			FutureComp 100 Great Meadow Road, Suite 300 Wethersfield, CT 06109		
Policy / Self-insured #		<input checked="" type="checkbox"/> Check, if Self-Insured	Policy Period (MM/DD/YY)		
Employee: Last Name		First Name	Middle Name	Gender	Date Hired (MM/DD/YY)
Address (incl. Zip)		Phone #		<input type="checkbox"/> Male	State of Hire
Date of Birth (MM/DD/YY)		Social Security #		<input type="checkbox"/> Female	Occupation / Job Title
Date of Injury / Illness (MM/DD/YY)		Town of Injury / Illness		Rate of Pay \$ _____ per	
Time Employee Began Work		<input type="checkbox"/> a.m.	<input type="checkbox"/> p.m.	NCCI Class Code	
Time of Occurrence		<input type="checkbox"/> cannot be determined		<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other	
Date Employer Notified (MM/DD/YY)		Type of Injury / Illness		Physician / Health Care Provider (Name, Address & Zip)	
Date Disability Began (MM/DD/YY)		Part of Body Affected		Hospital (Name, Address & Zip)	
Date Last Worked (MM/DD/YY)		Type of Injury / Illness Code		Initial Treatment	
Date Return(ed) to Work (MM/DD/YY)		Part of Body Affected Code		<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Care	
If Fatal, Date of Death (MM/DD/YY)		Were Safeguards or Safety Equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Minor — by Employer <input type="checkbox"/> Hospitalized More Than 24 Hours	
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:		If provided, were they used? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Minor — by Clinic / Hospital <input type="checkbox"/> Future Major Medical — Lost Time Anticipated	
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:		How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:		Date Administrator Notified (MM/DD/YY)	
Contact Name		Cause of Injury Code		Date Prepared (MM/DD/YY)	
Phone #				Preparer's Name & Title	
				Phone #	

Section III

Wage Statement Form



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Wage Statement Form

When to File

File this form as soon as you know that the injured employee will be absent four or more days from work. This form is used to calculate the injured employee's average weekly compensation.

Where to File

E-mail or fax to:

FutureComp
fonda.carmody@tdinsure.com
fax: (860) 257-0002



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AVERAGE WEEKLY WAGE COMPUTATION SCHEDULE

PLEASE PRINT OR TYPE:

Date (MM/DD/YY): / /

Employer Name and Address		Insurer Case File Number
Employee Name	# Children Under 18 Years Old	Dependents Other Than Children
Date of Injury (MM/DD/YY):	First Date of Disability (MM/DD/YY):	Date Employed (MM/DD/YY):
Has Employee been certified by U.S. Veterans Administration for any type of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Indicate only those wages earned by the injured employee during the 52 week period immediately preceding the accident. If the injured employee has worked less than 52 weeks, report wages for the time worked and, for the remaining weeks on this schedule, substitute wages of a fellow employee in the same class of employment who has worked for one year or more.

Week No	Year		Gross Amount Paid Including Overtime	No. of Meals Per Week	Week No	Year		Gross Amount Paid Including Overtime	No. of Meals Per Week	Week No	Year		Gross Amount Paid Including Overtime	No. of Meals Per Week
	Week Ending					Week Ending					Week Ending			
	Month	Day				Month	Day				Month	Day		
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									
18					36									
										TOTAL:				
Was Room Furnished To Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No					If Tips or Other Benefits Were Eamed, Describe and State Value Per Week:									
Comments														

THIS IS A TRUE COPY OF THE PAYROLL RECORDS OF THE ABOVE NAMED EMPLOYEE OR OF A FELLOW EMPLOYEE IN THE SAME CLASS OF EMPLOYMENT.

Name of Fellow Employee	Employer Preparer's Signature	Preparer's Title
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Section IV

State of Connecticut Filing Status and Exemption Form



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State of Connecticut Filing Status and Exemption Form

When to File

File this form as soon as you know that the injured employee will be absent one or more days from work. This form is used with the Wage Statement Form to calculate the injured employee's compensation.

Where to File

E-mail or fax to:

FutureComp
fonda.carmody@tdinsure.com
fax: (860) 257-0002



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State of Connecticut
Workers' Compensation Commission
FILING STATUS AND EXEMPTION FORM
 THIS FORM MUST BE EXECUTED IN EVERY CASE OF
 COMPENSABLE DISABILITY, FOR INJURIES OCCURRING ON OR AFTER
OCTOBER 1, 1991

Name: _____ SS#: _____

Address: _____

In order for this company to determine your weekly benefit rate, as per Public Act 93-228, an Act concerning comprehensive Workers' Compensation reform, we need the following information:

1. There are four (4) filing statuses provided. You must select one, based upon your IRS filing status on the date of your injury and the position you took in filing your prior year's Federal and State Tax Returns. (i.e. D.O.I. 6/15/96, last tax return 12/31/95)

- A. Single B. Head of Household C. Married filing jointly D. Married, filing separately

2. How many exemptions (include yourself) did you list on your last Federal and State Tax Returns? _____

3. Check all appropriate boxes:

- 65 years of age or older legally blind spouse - 65 years of age or older spouse - legally blind

4. List name (yourself first), date of birth and relationship to you for all exemptions listed on your last Federal and State Tax Returns: (Question #2 above):

	Name	Birth Date	Relationship
1.	_____	_____	SELF
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

5. **IMPORTANT:** To be certain that you receive all the benefits to which you are entitled please provide the following information if you were engaged in any other employment at the time of your injury or are currently engaged in any other employment. If you have no other employment insert the word "none".

Other Employers: Names _____ Addresses _____

Weekly hours: _____ Weekly wages: _____ Date of hire: _____

Are you currently working: _____ Type of Work Performed: _____

6. This form must be completed in its entirety. Any person who intentionally misrepresents or fails to disclose any material fact related to a claimed injury may be guilty of a felony.

EMPLOYEE'S SIGNATURE

DATE

Section V

FutureComp Dedicated Claims Unit



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Dedicated Claims Unit

Tony Szwez
Senior Vice President, FutureComp
(800) 443-6252, Ext. 4261
tony.szwez@tdinsure.com

Steve Grahn
Claims Manager
(800) 443-6252, Ext. 4250
steven.grahn@tdinsure.com

Judy Burke R.N.
Medical Case Management Supervisor
(800) 443-6252, Ext. 4247
judy.burke@tdinsure.com

Fonda Carmody
Senior Claims Adjuster
(800) 443-6252, Ext. 1864
fonda.carmody@tdinsure.com

Jill Moulton
Medical Only Adjuster
(800) 443-6252, Ext. 1863
jill.moulton@tdinsure.com

Melissa Bell
Medical Case Manager
(800) 723-2877, Ext. 3390
Melissa.bell@tdinsure.com

Sarah Depergola
MIS Manager
(800) 688-7256, Ext. 4273
sarah.depergola@tdinsure.com

100 Great Meadow Road, Suite 300
Wethersfield, CT 06109
fax: (860) 257-0002



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Section VI

Frequently Asked Questions



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Frequently Asked Questions

Q. Do the first reports of injury need to be completed in their entirety?

A. Yes, all the information is needed to input the claim accurately and monitor the information for loss runs.

Q. If an injured employee's medical appointment falls during regular work hours, what do we need to do?

A. You are obligated to allow an employee to use paid time off during the workday to attend medical appointments.

Q. I am the Workers' Compensation Coordinator, who do I call for claim reports?

A. Call Sarah Depergola, Data Coordinator, at (800) 688-7256, Ext. 4273 for loss run information or any customized report requests.

Q. May I fax or e-mail first reports of injury rather than mail them?

A. Yes. Faxing and e-mail are preferred delivery methods for first reports of injury.

Q. What information is needed to pay a medical bill?

A. An itemized bill and a medical report. If the bill is a balance forward or there is no medical report attached, the bill will be sent back to the provider requesting proper information.

Q. When mailing claims information or medical bills should we send them to FutureComp or our broker?

A. All information regarding workers' compensation claims should be sent to FutureComp.

Q. When are indemnity/medical/expense reimbursements mailed?

A. Reimbursement checks are mailed every Thursday. If Thursday falls on a holiday, checks will be mailed on Wednesday.

Q. Do injured employees get reimbursed for mileage, tolls and parking when they have medical visits?

A. Yes. The injured employee is paid \$.445 per mile. Tolls and parking are paid at face value.

Q. How quickly does a new injury need to be reported?

A. All injuries should be reported immediately. The sooner FutureComp receives the claim information, the sooner we can help you. The more time that elapses in claim reporting the less information can be gathered. *There is also a State-mandate that requires a claim to be reported within seven calendar days.*

Q. Are employees entitled to any financial remuneration for permanent disability due to work related injuries?

A. Yes. The amount of remuneration depends on type and extent of loss. These payments can be made even though the employee may already be back to work.



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