PMA COMPANIES

Midlands Claim Administrators, Inc.
P.O. Box 238808 Oklahoma City, OK 73123
Phone: 888-799-6642 Fax: 888-799-5628

CLAIMS FORMS

Review these forms immediately so you will know how to report an injury when it occurs

Claims are handled by:
Midlands Claim Administrators, Inc.

To Report Claims:

Midlands Claim Administrators, Inc.

Attention:	Claims Department
Phone Number:	888-799-6642
Fax Line:	888-799-5628
Email:	txnsclaims@midman.com

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Midlands is committed to providing the most efficient and cost effective claims administration services in the market today. We have numerous resources available to ensure that we are able to fulfill these promises.

When you have an employee that is involved in a work related accident, we are available by phone, facsimile, or email. Midlands has a dedicated staff of adjusters and nurse case managers that can assist you in getting your injured employees the care they need in a timely manner. In addition, Midlands will thoroughly investigate your claim and ensure that all costs associated with these claims are appropriate. Upon completion of the investigation, all related costs will be paid in a timely manner which is usually within 7-10 days.

For your convenience, the following is a list of contacts:

First Notice of Injury
Phone Number: 888-799-6642
Fax Line: 888-799-5628
Email: txnsclaims@midman.com

Claims Adjuster: Melanie Thompson
Email: mathompson@midman.com
Phone: 405-767-1757
Fax Line: 405-767-1212

Claims Supervisor, Pat Brooks
Email: pbrooks@midman.com
Phone: 405-767-1791
Fax Line: 405-767-1212

We look forward to working with you. Please call with any questions or concerns.

Sincerely,

Louis Pippin
Vice President
Midlands Claim Administrators

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TRANSMITTAL SHEET FOR ON-THE-JOB INJURY INFORMATION

Date of Transmittal:	

The attached information is provided as notice/follow-up of an on-the-job injury.

Insured/Employer Name:	
Policy Number:	
Contact Name & Phone Number:	
Contact Fax Number:	

IN ORDER TO PROCESS A NEW CLAIM, PLEASE INCLUDE THE FOLLOWING FORMS:

- Employer's Report of Injury
- Employee's First Report of Accident/Injury (completed and signed by the employee)
- Employee Information Sheet
- Authorization for Release of Medical Records

IF THE EMPLOYEE WILL LOSE TIME BEYOND THE ELIMINATION PERIOD OF THE POLICY ALSO INCLUDE:

- Employer's Report of Disability Request For Wage Benefit Reimbursement
- Wage History

WHEN COMPLETED PLEASE FAX OR EMAIL TO

- Fax: 888-799-5628
- E-Mail: txnsclaims@midman.com

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EMPLOYER'S REPORT OF INJURY

Policy #

Name of injured employee (Last, First, MI)	Sex F M	Date of Injury	Time of Injury Am Pm	Date Lost Time Began (M-D-Y-)	Expected Return to work date

Social Security #	Home Phone ( )	Birth Date (M-D-Y-)	Part of body Injured	Type of Injury(i.e. Strain, Sprain,Fatality etc.)

Does this employee speak English? If No, specify Language	Cause of Injury (Fall, Tool, Machine, etc.)
Employee's mailing address Street or P.O. Box City State Zip County	How & Why the Injury/Illness Occurred
Marital Status? Married Widowed Separted Single Divorced Number of dependant Children Spouses Name	Address of Location where Injury or Exposure Occurred. Mailing address Street or P.O. Box City State Zip County Worksite Location (IE. Stairs, Dock etc…)
Injured Taken to: Phone Number	Name of any witnesses
Doctor's Mailing Address	Was the employee doing his regular job at the time of Injury/Exposure?
City State Zip	Supervisor's Name and phone #

Personnel Information

Date of Hire (M-D-Y)	Was employee hired or recruited in Texas	Length of service in current position Years Months	Length of service in occupation Years Months

Occupation of Injured Worker		Applicable Classification code From Policy (4 digit code)	

Contact Information

Name & Title of person completing this form	Name of employer (Including DBA)
Employer mailing address Phone Number	Business location (if different from mailing address)
City State Zip	City State Zip

X _____ Date _____

Signature & Title of person completing this form

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EMPLOYEE'S FIRST REPORT OF ACCIDENT/INJURY

ALL ACCIDENTS, NO MATTER HOW SMALL OR SLIGHT MUST BE REPORTED
PLEASE WRITE LEGIBLY

ANSWER ALL QUESTIONS

_____ POLICY NO._____
NAME OF EMPLOYER (INCLUDING DBA)

_____
DATE OF INJURY

NAME OF INJURED EMPLOYEE _____
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

TITLE_____ JOB DESCRIPTION_____

HOME ADDRESS_____
(STREET & HOUSE NUMBER) (CITY) (STATE) (ZIP) (AREA CODE) (PHONE NUMBER)

DATE OF BIRTH_____ SOCIAL SECURITY NO. _____ NAME OF SUPERVISOR_____

WAS MEDICAL ATTENTION RECEIVED?_____ NAME OF DOCTOR OR CLINIC_____

1. WHAT TIME DID INJURY OCCUR?_____ AM/PM (CIRCLE ONE)
2. HOW DID ACCIDENT OCCUR?_____
3. WHAT ACTIVITY WERE YOU DOING WHEN INJURED_____
4. WHAT PART OF YOUR BODY WAS HURT?_____
5. DESCRIBE THE INJURY. (EXAMPLE: CUT, BRUISES, BROKEN BONE, ETC._____
6. WHAT OBJECT OR ITEM DIRECTLY CAUSED THE INJURY?_____
7. HOW MANY DAYS DID YOU MISS FROM WORK, IF ANY?_____ LAST DAY WORKED?_____
8. IF NOT RETURNED TO WORK, HOW LONG DID THE DOCTOR SAY THAT YOU WILL BE OFF WORK?_____
9. HAVE YOU EVER HAD SIMILAR INJURY?_____ IF YES, EXPLAIN & WHEN?_____

_____

10. DID THIS ACCIDENT HAPPEN BECAUSE YOU FAILED TO USE OR WEAR EQUIPMENT PROVIDED TO HELP YOU DO THE TASK SAFELY? **YES** OR **NO** (CIRCLE ONE)
11. LIST NAMES OF ALL WITNESSES TO THE ACCIDENT:_____

_____

I DO, BY MY SIGNATURE BELOW, CERTIFY THAT INJURIES DESCRIBED IN THE ABOVE INCIDENT WERE SUSTAINED ON COMPANY PREMISES OR IN THE COURSE OF PERFORMING DUTIES REQUIRED OF MY POSITION AS A

_____(Job Title)

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS ACCIDENT REPORT IS A TRUE, COMPLETE AND CORRECT STATEMENT OF FACT AND THAT I HAVE MADE THIS STATEMENT IN MY OWN WORDS.

I HEREBY AUTHORIZE FOR RELEASE TO EMPLOYER ANY INFROMATION ACQUIRED IN THE COURSE OF EXAMINATION OR TREATMENT FOR THE ACCIDENTAL INJURY REFERRED TO ABOVE.

DATED_____ SIGNATURE_____

WITNESS_____

13. WRITE YOUR DETAILED DESCRIPTION OF WHAT HAPPENED. DESCRIBE WHAT YOU WERE DOING BEFORE THE ACCIDENT, WHAT CAUSED THE ACCIDENT TO HAPPEN. DESCRIBE HOW YOU WERE DOING THE TASK, AND WHO WAS WITH YOU. (USE EXTRA PAPER, IF NEEDED) GIVE A THOROUGH AND COMPLETE EXPLANATION.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

COPY IN EMPLOYEE PERSONNEL FILE

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EMPLOYEE INFORMATION SHEET

The following will explain your responsibilities under the company job injury benefit plan. You must comply with the guidelines of the company plan EXACTLY. Failure to follow these guidelines and directions will result in a delay, denial or stoppage of payment of medical bills and/or job-injury payments that may be provided to you under the company plan.

1. Your employer is a NON-SUBSCRIBER to the Texas Workers' Compensation Act. We do not carry Workers' Compensation Insurance on our employees who work in a Texas facility.

2. Any injury you sustain while directly performing your job duties must be reported immediately to your supervisor or manager. Do not wait until the end of your shift, the end of the day, or tomorrow to report the incident. Immediately means directly following the mishap. Failure to report may void benefits.

3. Following your verbal report to your supervisor, you must complete a written report on the "EMPLOYEE'S FIRST REPORT OF ACCIENTAL INJURY" form and submit it to your supervisor within 48 HOURS following the mishap. Failure to report may void benefits.

4. Your supervisor/manager and you will make a determination regarding when, and if, a trip to the doctor is necessary. If the incident is a seemingly minor one, you have exercised your reporting duty. Sometimes, injury soreness works itself out with no problem. And, sometimes a minor problem progresses into greater problems.

5. For injuries requiring prompt medical attention, you will be taken to a medical clinic or hospital for treatment. If this initial visit is to a medical provider other than the normal company approved physician, you must go to the approved physician to submit to a urinalysis drug screen and follow-up care. The approved physician will assume control of medical care and management of your injury problems. He/she may refer you to specialists, if deemed advisable. Medical care and treatment by doctors not approved is only acceptable under the company injury benefit plan for emergency treatment immediately following an injury to stabilize your condition, relieve pain, or stop bleeding.

6. You must remain cooperative in investigating and documenting the injury incident. Unless the injury causes serious physical incapacity, you shall return to your supervisor and assist him/her in fulfilling obligations to complete various forms. The “Employee’s First Report of Accident Injury” is for you to list information concerning yourself, and to express your thoughts and views regarding the injury incident. The other forms are required documents that your supervisor must complete following each injury. The supervisor is directed to complete the written investigation and necessary paperwork as soon after the injury as possible. This is designed to aid our collection of information and statistical facts while they are fresh in the minds of those persons having knowledge about your incident. In the event you are not able to return to your supervisor to complete the necessary paperwork, your supervisor will come to your home, hospital room, or work with you at the first available opportunity to accomplish the reporting task.

7. You must follow the doctor’s orders and instructions regarding care, treatment, return-to-work and all appointment scheduling.

8. It shall be your responsibility to stay in communication with your supervisor regarding doctor appointments and doctor statements about your condition, including return-to-work (or no-duty) status. Prior to each doctor’s visit you shall advise your supervisor of the appointment. Telephone calls are sufficient to advise your supervisor of these scheduled appointments. Following each visit to the doctor you shall let your supervisor know the findings and outcome of the doctor’s examination. You must deliver the doctor’s written statement slip to your supervisor to keep him/her adequately informed of your condition and situation. Also, the doctor’s statement slip will be included in your injury incident file as part of your records. Acceptance of benefits under your employer’s Occupational Injury Benefit Program (the Plan) constitutes acceptance of all terms and conditions of that Plan.

Employee Signature _____

Date _____

_____
Signature of translator, if translated

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request and authorize any physician, hospital or health-care provider who has provided treatment to me to furnish my employer, Midlands Claim Administrators and Markel Services Incorporated any and all information and medical records they have concerning my care and treatment.

The matters to be released pursuant to this authorization include any and all records and information concerning my care and treatment, including but not limited to records of any illness, injury, medical histories, consultations, examinations, prescriptions, diagnoses, tests, reports or treatments, including copies of all hospital records, medical records or doctors' office records in your possession.

The release of the matters listed above is being authorized for purposes of investigation of a work related injury and/or to advise a treating physician (of a work related injury) about medical history issues. Acceptance of benefits under your employer's Occupational Injury Benefit Program (the Plan) constitutes acceptance of all terms and conditions of that Plan.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

Date:_____ Signature:_____

_____
Print Name

The signatures of witnesses are not required for the validity of this document, but are to be provided if reasonably available.

_____
Witness to Signature

_____
Witness to Signature

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CALCULATION OF DISABILITY BENEFITS AND INSTRUCTIONS FOR COMPLETING WAGE HISTORY

Start the Wage History form by using the last full pay period before the injury as week one. Use gross pay figures. Complete the remainder of the form going back for a total of fifty-two weeks. Add the gross pay figures and divide by fifty-two to get the average weekly wage. Multiply the average weekly wage by the percentage given in the Schedule of Benefits in the policy to calculate the weekly indemnity benefit. This is the amount you will use as a gross pay figure as the benefits are taxable and reportable as income. The maximum weekly indemnity benefit amount can be found on the Declarations page of your policy under Limits of Coverage.

When filing for reimbursement under the policy, you will need to provide a copy of the check paying the employee's disability wages as well as a copy of the off work slip from the doctor. Provide a copy of the completed Wage History with the first submission for reimbursement and the Employer's Report of Disability/Request for Wage Benefits Reimbursement covering the pay period involved.

These are guidelines based on the reimbursement provided by your policy. You will need to check your policy for specifics regarding the "Elimination Period" and "Weekly Indemnity".

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WAGE HISTORY

Please use the following form to report salary/wage history for your injured employee.

To complete this wage history form, begin with week 1, using earnings for the week preceding the date of injury and counting back 52 weeks. If the employee has not been employed 52 weeks, use the salary of an employee performing the same or similar function. PLEASE NOTE NAME OF EMPLOYEE, THE APPROPRIATE LOCATION, IF YOU ARE USING A SAME OR SIMILAR EMPLOYEE'S WAGE HISTORY.

EMPLOYER NAME_____ TODAY'S DATE_____

INJURED EMPLOYEE_____ DATE OF INJURY_____

SAME OR SIMILAR EMPLOYEE (name)_____

WEEK	DATE FROM	DATE TO	# DAYS WORKED	TOTAL HOURS	GROSS PAID
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					

WEEK	DATE FROM	DATE TO	# DAYS WORKED	TOTAL HOURS	GROSS PAID
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
36					
37					
38					
39					
40					
41					
42					
43					
44					
45					
46					
47					
48					
49					
50					
51					
52					

TOTAL PAY _____
DIVIDED BY 52 WEEKS =

AVERAGE WEEKLY WAGE
==========

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EMPLOYER'S REPORT OF DISABILITY

REQUEST FOR WAGE BENEFIT REIMBURSEMENT

Employee Information:

Name _____ Male ☐ Female ☐ Sex

Date of Injury _____ Date Lost Time Began _____

Social Security Number _____ Home Phone _____

Employer Information:

Employer Name _____ Policy Number _____

Employer's Street or P. O. Box _____ Claim Number _____

City _____ State _____ Zip Code _____

Reporting Period:
This report covers from: _____ Has employee returned to work? Yes ☐ No ☐

to: _____ Estimated return to work date: _____

COPIES OF PAYROLL CHECKS MUST BE ATTACHED AS WELL AS DISABILITY CERTIFICATION FROM A HEALTHCARE PROVIDER

Additional Comments:

_____

_____

_____

_____

X _____ _____
Signature & Title of Person Completing Form Date

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DECLINATION OF TREATMENT

Date: _____

Employee Name: _____

Date of Loss: _____

Description of accident:_____

The above employee was injured due to an accident working for _____
At this writing the claimant has elected to decline any medical treatment.

Signature of employee:_____

Date:_____

Supervisor signature:_____

Date:_____

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EMPLEADO HOJA DE LA INFORMACIÓN

La voluntad siguiente explica sus responsabilidades debajo de plan de ventaja de lesión del trabajo de la compañía. Usted debe conformarse con las pautas del plan de la compañía EXACTAMENTE. La falta de seguir estas pautas y direcciones da lugar a retrasa, la negación o la parada del pago de cuentas médicas y/o pagos de trabajo-lesión que se pueden proporcionarle bajo plan de la compañía.

1. Su el patrón es un NON-SUBSCRIBER al acto de la remuneración de los trabajadores de Tejas. No lleve el seguro de la remuneración de los trabajadores en nuestros empleados que trabajen en un Tejas facilidad.

2. Cualquier lesión que usted sostiene mientras que directamente la ejecución de sus deberes del trabajo debe ser divulgada inmediatamente a su supervisor o encargado. No espere hasta el final de su cambie de puesto, el final del día, o divulgar mañana el incidente. Inmediatamente medios que siguen directamente la desgracia. La falta de divulgar puede anular ventajas.

3. Siguiente su informe verbal a su supervisor, usted debe terminar un informe escrito encendido el PRIMER INFORME “del EMPLEADO la forma de LESIÓN de ACCIDENTAL” y la somete a su supervisor que sigue cuanto antes la desgracia. La falta de divulgar puede ventajas vacías.

4. Su supervisor/administrador y usted harán una determinación en relación con a cuando, y si, un viaje al doctor es necesario. Si el incidente es aparentemente de menor importancia, usted ha ejercitado su deber de divulgación. A veces, el dolor de lesión sí funciona sin problema. Y, a veces un problema de menor importancia progresa en problemas mayores.

5. Para lesiones que requieren la atención médica pronto, le llevarán a clínica u hospital médica para el tratamiento. Si esta visita inicial está a abastecedor médico con excepción del médico aprobado compañía normal, usted debe ir al médico aprobado a someter a una pantalla y a una carta recordativa de la droga del urinalysis cuidado. El médico aprobado asumirá control de la asistencia médica y gerencia de sus problemas de lesión. El puede referirle a los especialistas, si juzgado recomendable. La asistencia médica y el tratamiento de los doctores no aprobados está solamente aceptable bajo plan de ventaja de lesión de la compañía para el tratamiento de la emergencia inmediatamente después de lesión para estabilizar su condición, releve el dolor, o pare el sangrar.

6. Usted debe seguir siendo cooperativo en investigar y la documentación de lesión incidente. A menos que lesión causa incapacidad física seria, usted vuelva a su supervisor y asista a el en obligaciones satisfacientes a llene el formulario varios. El primer informe "del empleado de lesión del accidente" es para usted para enumerar la información referente se, y para expresar sus pensamientos y opiniones con respecto al incidente de lesión. Se requieren las otras formas documentos que su supervisor debe terminar el siguiente de cada lesión. Ordenan al supervisor terminar la investigación escrita y necesario papeleo tan pronto después de lesión como sea posible. Esto se diseña para ayudar nuestra colección de información y hechos estadísticos mientras que están frescos en mentes de esas personas que tienen conocimiento sobre su incidente. En el acontecimiento usted no pueda volver a su supervisor para terminar el papeleo necesario, su supervisor vendrá a su hogar, sitio del hospital, o trabajo con usted en primera oportunidad disponible de lograr la tarea de divulgación.

7. Usted debe seguir las pedidos y las instrucciones del doctor con respecto a cuidado, el tratamiento, volver-a- trabaja y todo el programar de la cita.

8. Será su responsabilidad permanecer en la comunicación con su supervisor con respecto citas del doctor y a declaraciones del doctor sobre su la condición, incluyendo volver-a trabaja (o ninguno-deber) estado. Antes de cada uno la visita del doctor usted aconsejará a su supervisor de la cita. Teléfono las llamadas son suficientes aconsejar a su supervisor de éstos programar citas. Después de cada visita al doctor usted dejara a su supervisor sepa los resultados y el resultado de la examinación del doctor. Usted debe entregar el resbalón escrito del doctor a su supervisor a la subsistencia el informado adecuadamente su condición y situación. También, el doctor el resbalón de la declaración será incluido en su archivo del incidente de lesión como parte de sus expedientes. Aceptación de ventajas bajo su lesión ocupacional del empleador el programa de ventaja (el plan) constituye la aceptación de todos los términos y condiciones de ese plan.

Observe por favor la advertencia del fraude debajo:

"Es un crimen par proporcionar falso o información engañosa a un asegurador con el fin de defraudar el asegurador o cualquier otra persona. Las penas incluyen el encarcelamiento y/o multas. Además, un asegurador puede negar ventajas de seguro si información falsa relacionado materialmente con una demanda fue proporcionado por el aspirante."

Firma del Empleado _____

Fecha_____

Firma del traductor, si está traducido_____