REPORTING GUIDELINES FOR WORK PLACE INJURIES (WORKER'S COMPENSATION INSURANCE) CATHOLIC MUTUAL GROUP

The State of Wisconsin Worker's Compensation Act provides for payment of reasonable medical expenses and compensation for lost wages resulting from work-related injuries or disabilities. Information regarding this state-mandated insurance program can be found at https://dwd.wisconsin.gove/wc/workers/

1) Effective January 1, 2016, Catholic Mutual Group (CMG) partnered with Church Mutual Insurance Company for the handling of Worker's Compensation claims for the Diocese of Madison. Previously PPIC (Preferred Professional Insurance Company) was the carrier. Catholic Mutual Group will continue to work as a third party administrator/advocate in handling claims of employee injuries for the Diocese of Madison.
2) Even in the safest of workplace environments, injuries can happen. If an employee is hurt and the injury is serious or life-threatening, call 911 immediately.
3) If an employee experiences a non-life threatening injury on the job, call the Church Mutual Nurse Hotline at 844-322-4662. The Church Mutual Nurse Hotline connects you with a medical professional that can advise you on next steps regarding treatment alternatives.
4) Parish should report all work-related injuries or ailments to CMG immediately, even if medical treatment through first aid or a medical clinic is not sought or recommended. Promptly reporting a claim will allow CMG and Church Mutual to conduct a proper investigation to determine compensability.
5) Complete the **Employer's First Report of Injury or Disease** reports soon after the employee reports an injury or accident. Details of the incident are always more accurate when information is fresh in one's mind. Please note that this injury report MUST be signed by an authorized representative of the employer, NOT signed by the employee.
6) All completed Employer's First Report of Injury or Disease reports must be sent to Kris Twining, Claims/Risk Manager as soon as possible via email to ktwining@catholicmutual.org , or via facsimile to 608-833-3794, or if necessary via U.S. Mail to 702 South High Point Road, Suite 221, Madison, WI 53719.
7) Contact Kris Twining immediately at 608-821-4566 immediately if any of the following occur:
    a. A previously reported medical only claim turns into a lost time claim.
    b. Any serious injury that results in hospitalization.
    c. Any incident or accident resulting in a fatality
    d. Any incident involving odd or questionable circumstances
8) Once a claim is reported, the following will occur:
    a. Catholic Mutual will interface with Church Mutual to file the claim. Church Mutual will report injuries to the State of Wisconsin in compliance with state reporting requirements. All Employer's First Report of Injury or Disease forms need to be completed in their entirety to expedite state reporting.

b. Church Mutual will take a direct approach to claims handling --they will investigate all lost time injuries by making contact with the employer, the injured worker, and the attending physician.
c. Any injured worker that has lost time from work is required to provide a written release from the attending physician prior to return to work.
d. Employers are encouraged to contact the injured worker while recovering at home to show interest in their recovery and to assure them that they are looking forward to their return to work. An injured worker often needs encouragement to get them back into the work force. Too often we hear "The employer does not care because I have never heard from them."
e. Catholic Mutual will work closely with Church Mutual's claims professionals in an effort to return the employee to gainful employment as soon as possible. In addition to getting your employees the treatment they need in a timely manner, the Nurse Hotline also helps ensure that if you need to file a claim, you do so in a timely manner, which helps reduce costs and confusion.

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to the Imaging Fax Server number on this form.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
http://www.dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].
(**Please read the instructions on page 2 for completing this form**)

EMPLOYEE

Employee Name (First, Middle, Last)	Social Security Number	Sex	Employee Home Telephone No.
	- -	☐ M ☐ F	( ) -

Employee Street Address	City	State	Zip Code	Occupation
			-	

Birthdate	Date of Hire	County and State Where Accident or Exposure Occurred?

EMPLOYER

Employer Name	WI Unemployment Ins. Acct No.	Self-Insured?	Nature of Business (Specific Product)
		☐ Yes ☐ No	

Employer Mailing Address	City	State	Zip Code	Employer FEIN
			-	-

Name of Worker's Compensation Insurance Co. or Self-Insured Employer	Insurer FEIN
Church Mutual Insurance Company	-

Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer	TPA FEIN
Catholic Mutual Group, P.O. Box 44983, Madison, WI 53744	-

WAGE INFORMATION

Wage at Time of Injury	Specify per hr., wk., mo., yr., etc.	In Addition to Wages, Check Box(es) if Employee Received:		
$	Per:	☐ Meals	☐ Room	☐ Tips
		No. of Meals/wk.	No. of Days/wk	Avg. Weekly Amt. $

Is Worker Paid for Overtime? ☐ Yes ☐ No If Yes, After How Many Hours of Work Per Week?

For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.

No. of Weeks:	Gross Amount Excluding Tips: $	If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	: ☐ AM ☐ PM			
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:				

Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? ☐ Yes ☐ No If yes, how many?	Number of **Full-Time** Employees Doing The Same Type Of Work:

INJURY INFORMATION

Injury Date	Time of Injury	Last Day Worked	Date Employer Notified	
	: AM : PM			☐ Date Returned to Work ☐ Estimated Date of Return

Did Injury Cause Death?	Date of Death	Was This a Lost Time or Other Compensable Injury?	Did Injury Occur Because of:		
☐ Yes ☐ No		☐ Yes ☐ No	☐ Substance Abuse	☐ Failure to Use Safety Devices	☐ Failure to Obey Rules

Was Employee Treated in an Emergency Room? ☐ Yes ☐ No Was Employee Hospitalized Overnight as an In-Patient? ☐ Yes ☐ No

Name and Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.

What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)

What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)

Report Prepared By	Work Phone Number	Position	Date Signed
	( ) -		

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.