



PO Box 945927
Maitland, FL 32794-5927
321-214-5350 • Fax 321-214-0235
800-226-0666 • ffvamutual.com

Welcome to the FFVA Mutual family.

As a policyholder, your company has access to a variety of tools and resources to help provide a safe environment for your employees. Our services include support from our safety consultants, a library of online resources, access to *Safety Key*, and ongoing training programs to reduce workplace injuries and manage claim costs.

In this welcome packet you will find:

1. **Alabama Workers' Compensation Posting Notice** – This poster **must be posted** in a conspicuous place for your employees to see. This poster should be present at all locations for your business.
2. **When a Workplace Accident Occurs** – procedures to follow when reporting an injury.
3. **Initial Treatment Authorization** – to copy and send with your injured employee when treatment is sought.
4. **Pharmacy Benefits form** – to copy and send with injured employee to bring to the pharmacy when filling authorized prescriptions.
5. **First Report of Injury (FROI)** – We encourage employers to immediately report all workplace injuries. Report injuries 24/7 by phone, fax, email or online.

To access **state-specific forms**, visit www.ffvamutual.com/employers/claims/forms – click to expand state.

- **For medical emergencies, call 911**, and report the injury to FFVA Mutual's Claims Center at 800-226-0666 (available 24/7).
- For non-life-threatening injuries, call our Claims Center at 800-226-0666 (available 24/7). You may send injured workers to the closest walk-in clinic or hospital.
- After the claim is reported, your dedicated claims adjuster will begin to manage the injured worker's care and return to work transition.

Login assistance:

- Online Policyholder account, please contact our customer support staff at 800-346-4825 or customersupport@ffvamutual.com.

Rest assured your workers' compensation needs are covered with FFVA Mutual.



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WHEN A WORKPLACE ACCIDENT OCCURS

Immediately report all workplace injuries to our Claims Center at 800-226-0666 for 24-hour assistance and healthcare provider referrals. Notice of Injuries can be reported by email to claimsnoi@ffvamutual.com or by fax to 321-214-0235. **Please do not delay your call for lack of information.**

We will always ask for your tax ID number and policy number. Fill in below for quick reference:

Tax ID # _____ Policy # _____

Employee Information

Address and Phone
Date of birth
Gender
Marital status
Name
Social Security Number

Employee Job Information

Average hourly wages
Date disability began
Hire Date
Hours worked per day
Payroll job class code

Employer Information

Date employer first notified of injury
Did injury occur due to not using a safety device?
Do you agree with employee's description of the accident?
Name, address and phone number
Tax ID #
Type of business

Injury Information

Accident description
Date and time injury reported to employer
Time of day accident occurred
Where accident occurred (address and county)

Medical Care Information

Did employee request medical care?
Name, address, phone of doctor or hospital providing initial care
Was medical care provided?
Was medical treatment authorized?

Work Information

Has employee returned to work? (If yes, what date?)
Last day employee worked
What was the employee doing when injured?



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INITIAL TREATMENT AUTHORIZATION

To: Medical Facility:

From: Employer

Date:

RE: Claimant :
 D/B :
 Soc. Sec. No. :
 Employer :
 D/A :

Please accept this as authorization for initial medical treatment on the above-captioned injured employee. If this injured worker needs to be referred out, please call FFVA Mutual at 800-226-0666.

Please mail your bill and report to FFVA Mutual, PO Box 945927, Maitland, Florida 32794-5927; telephone number 800-226-0666; fax number (321) 214-0235.

Date: _____

_____ Full Duty

_____ Light Duty (as the employer participates in an Early-Return-to-Work Program)

Restrictions: _____

Diagnosis: _____

Next Office Visit: _____

Please provide the employee with a copy of the completed form.

Thank you for your prompt attention to the above.

»» To the Injured Worker:

On your first visit, please give this notice to any pharmacy to speed up the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? **Call the Patient Care Contact Center at 800.945.5951.**

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, **por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.**

»» To the Pharmacist:

myMatrixx, an Express Scripts company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-days supply or a cost of \$500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 888.786.9640.

Pharmacy Processing Steps

- Step 1: Enter BIN number 003858
- Step 2: Enter processor control WC
- Step 3: Enter the group number as it appears above
- Step 4: Enter the injured worker's nine-digit ID number
- Step 5: Enter the injured worker's first and last name
- Step 6: Enter the injured worker's date of injury

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: ____/____/____
MM/DD/YYYY

Group #: ZX3A

Employee Date of Birth: ____/____/____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

»» **To the Supervisor:** Please fill in the information requested for the injured worker.

Employee Information

First M Last

Street Address or PO Box

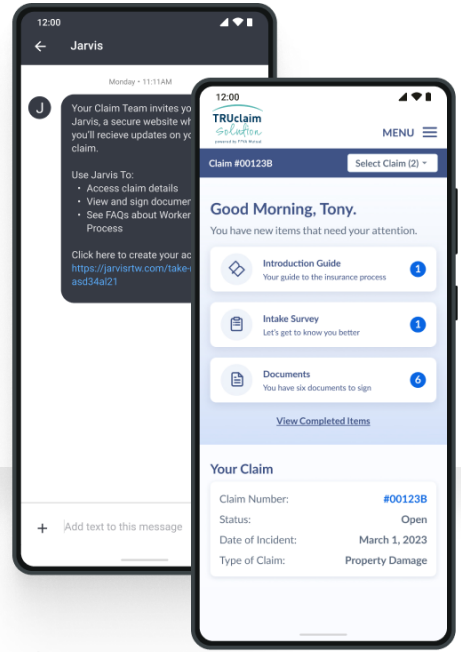
City State ZIP

Employer Name



Making Workplace Insurance Claims Easier

TRUclaim Solution is a website designed to support and guide injured workers through the Workers' Compensation process.



Top Benefits for Employers

By quickly connecting your injured employees to claim and recovery resources, TRUclaim Solution helps maintain positive relationships while guiding your employees back to work.



Connect Employee to Insurer

Once the claim is in TRUclaim Solution, your employee will be contacted by their claims team within 24 hours.



Return to Work Faster

TRUclaim Solution helps to minimize prolonged claims through proactive check-ins and streamlined processing.

Top Benefits for your Injured Workers

By increasing transparency and access to resources, TRUclaim Solution empowers injured employees to understand and easily navigate the claims process to achieve better outcomes.



Send messages anytime

Securely communicate with your insurance claims team via text, email, or in-app messaging 24/7.



View & sign documents faster

Read, upload, and e-sign documents directly in TRUclaim Solution without waiting for mail.



Appointments and Reminders

Reminders for upcoming appointments and to share updates with their claims team.



Expectation-Setting Content

Access to a library of resources and FAQs to reduce anxiety and extra communications.

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE					
1. Insured Report Number	2. Filing Office Claim Number		3. OSHA Log Case Number		
EMPLOYER					
4. Employer Business Name			ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1			10. Mailing Address 1		
6. Physical Address 2			11. Mailing Address 2		
7. City	8. State	9. Zip	12. City	13. State	14. Zip
15. Federal ID Number		16. U.C. Account Number		17. NAICS	
INSURER / FILING OFFICE					
18. Insurer Name			21. Filing Office Name		
19. Insurer Federal ID Number			22. Mailing Address 1		
20. Type Insurer Ins Co <input type="checkbox"/> Self-Insurer <input type="checkbox"/> Group Fund <input type="checkbox"/>			23. Mailing Address 2 or Telephone Number		
			24. City	25. State	26. Zip
			27. Filing Office Federal ID Number		
EMPLOYEE / WAGES					
28. First Name			32. Employee ID Number		
29. Middle Name			33. Type Employee ID Number		
30. Last Name			SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)			Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1			40. Gender		41. Date of Birth
35. Mailing Address 2			Male <input type="checkbox"/>		42. Nbr of Dependents
36. City			Female <input type="checkbox"/>		
37. State			38. Zip		39. Phone
43. Marital Status Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>					44. Date Hired
45. Occupation Description				46. Number of Days Worked Per Week	
47. Wages \$			49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>			50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>		
INJURY / TREATMENT					
51. Date of Injury	52. Time of Injury a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>		53. Time Employee Began Work a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		54. Date Disability Began
55. Date of Death					
PLACE OF ACCIDENT, INJURY, OR EXPOSURE			61. Injury Occurred on Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>		
56. Site Address			62. Date Employer Notified		
57. City			58. State		59. Zip
60. County					
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)					
PROVIDE DESCRIPTION CODES to identify Nature of Injury, Part of Body that was affected, and Cause of Injury. (FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC)					
64. Nature of Injury Code		65. Part of Body Code		66. Cause of Injury Code	
67. Initial Treatment		No Medical Treatment <input type="checkbox"/>		68. Name of Treatment Facility	
First Aid By Employer <input type="checkbox"/>		Minor Clinic / Hospital <input type="checkbox"/>		69. Address	
Emergency Room <input type="checkbox"/>		Hospitalized Overnight <input type="checkbox"/>		70. City	
Hospitalized > 24 Hours <input type="checkbox"/>		Outpatient Treatment <input type="checkbox"/>		71. State	72. Zip
73. Name of Physician or Other Health Care Professional			74. Has Injured Returned to Work Yes <input type="checkbox"/> No <input type="checkbox"/>		If so, 75. Date 76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
OTHER					
77. Date Prepared	78. Preparer's First Name		79. Last Name		80. Title
					81. Preparer's Telephone Number



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SAFETY & LOSS CONTROL

What sets FFVA Mutual apart is our hands-on approach to loss control provided by expert safety consultants. We offer a variety of services, training and resources at no additional cost to our policyholders.

Safety Services

- Ergonomic assessments
- Hazard identification
- Incident and accident analysis
- Industrial hygiene evaluations
- On-site and off-site training courses
- Regulatory compliance assistance
- *Safety Key*, an online toolkit
- Webcasts

Training Courses and Events

- Defensive driving
- First aid
- Hazardous communications
- Job hazard analysis (JHA)
- OSHA (10-hour) for construction and general industry
- Personal protective equipment (PPE)
- Recordkeeping
- Safety Foundations
- Safety Leadership Academy



Unlock Safety Resources

Safety Key is an online area that provides access to:

- Customizable programs and policies
- Meeting materials, forms and checklists by topic
- On-demand webcasts and short talks
- Safety program guides, general and by industry
- Workplace safety tips

To request a Safety Key login, visit go.ffvamutual.com/get-safetykey

For in-person training, visit go.ffvamutual.com/get-training

