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. **Georgia Workers' Compensation Panel of Physicians** – this panel **must be posted** in a conspicuous place for your employees to view. A specific panel has been created for each of your business locations.
2. **Georgia Workers' Compensation Bill of Rights** – this poster **must be posted** in a conspicuous place for your employees to view.
3. **When a Workplace Accident Occurs** – procedures to follow when reporting an injury.
4. **Initial Treatment Authorization** – to copy and send with your injured employee when treatment is sought.
5. **Pharmacy Benefits form** – to copy and send with injured employee to bring to the pharmacy when filling authorized prescriptions.
6. **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).
- For initial treatment have the injured worker select a provider from the **Panel of Physicians** form.
- 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:

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 a referral is to be made, please refer the injured employee to the employer's posted Panel of Physicians or 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.

Workers' Compensation Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

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.**

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 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-day 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

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

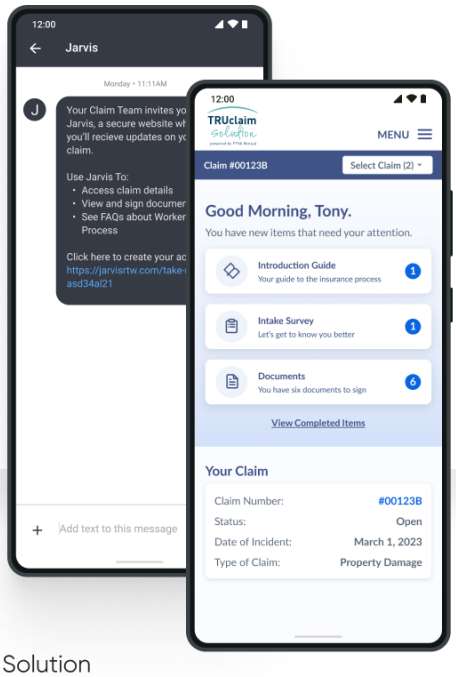
_____

FFVA mutual

gain life | TRUclaim Solution powered by FFVA Mutual

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.

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	❑ Male ❑ Female	Birthdate	Phone Number	Employee E-mail
Mailing Address		City	State	Zip Code
EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)	
Mailing Address		Phone Number	Employer FEIN	
City	State	Zip Code	Employer E-mail	
INSURER / SELF-INSURER	Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #	
CLAIMS OFFICE	Name	Claims Office FEIN #	Claims Office Phone	Claims Office E-mail
SBWC ID# (five digit no.)	Mailing Address	City	State	Zip Code

EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: ❑ per Hour ❑ per Day ❑ per Week ❑ per Month
Insurer Type Code ❑I – Insurer ❑S-Self-insurer ❑Group Fund	List Normally Scheduled Days Off			

INJURY/ILLNESS & MEDICAL	Time of Injury ❑ am ❑ pm	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
Did Employee Receive Full Pay on Date of Injury? ❑ Yes ❑ No	Did Injury/Illness Occur on Employer's premises? ❑ Yes ❑ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address)	Initial Treatment Given: ❑ None ❑ Minor: By Employer ❑ Minor: Clinical/Hospital ❑ Emergency Room ❑ Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: / Returned at what wage per Week / If Fatal, Enter Complete Date of Death

Report Prepared By (Print or Type)	Telephone Number	Date of Report

❑ B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only ❑ Yes ❑ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability:

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

❑ Temporary total disability ❑ Temporary partial disability ❑ Permanent partial disability of _____ % to _____ for _____ weeks.

UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

❑ C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

❑ D. MEDICAL ONLY INJURY (No indemnity benefits are due and/or have NOT been controverted.)

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Phone Number	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.

2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY**.
   Do not send this form to the State Board of Workers' Compensation.

3. If you need additional help, call your insurance company or self-insurer claims office.

4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

Upon receipt of this form, check to see that it is complete and accurate. Be sure to list the correct Insurance Company and their SBWC ID number.

Complete Section B, Co or D and file with the Board and send a copy of both sides of the form to the employee and all counsel of record within 21 days of the employer's knowledge of disability, injury or death.

Section B is completed when indemnity benefits are paid or due, including salary in lieu.

Section C is completed when claim is controverted in full or in part.

Section D is completed when no indemnity benefits are due and/or have NOT been controverted.

Form WC-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

   If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

   If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

   If Section D is completed, you will receive medical benefits only. At this time, indemnity benefits are not due. If your medical bills are not paid, call your employer or your employer's insurance company or self-insured claims office.

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682
In Atlanta: (404) 656-3818

http://www.sbwc.georgia.gov

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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New Employee Georgia Panel of Physicians Acknowledgement

I _____, understand that if I am injured at work, I should immediately report my injury to my supervisor so I am able to seek medical treatment.

I acknowledge that I have received and reviewed the Panel of Physicians and I understand that my employer is not responsible for any treatment I receive if I do not report my injury and select a physician listed on the Georgia Panel of Physicians.

_____ _____

Employee Signature Date

_____ _____

Employer Representative Date

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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