



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. **North Carolina Workers' Compensation Notice** – this poster **must be posted** in a conspicuous place for your employees to view. 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** – We encourage employers to immediately report all workplace injuries. Report injuries 24/7 by phone, fax, email or online.

To access **state-specific forms** online, 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

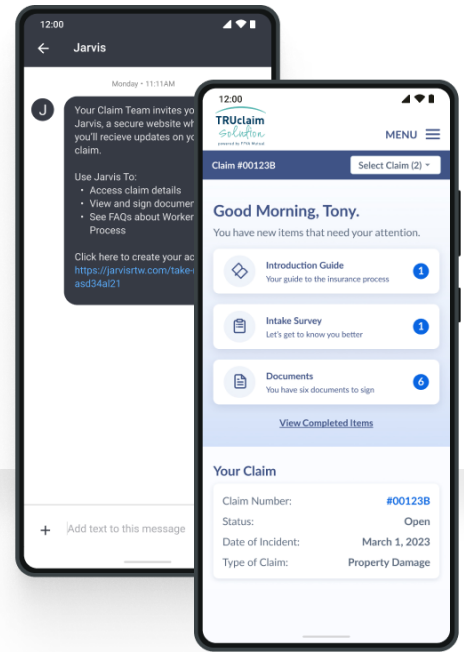
City State ZIP

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.

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

To the Employer:

A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.

This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:

This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed Form 18 and mail it to Claims Administration, N.C. Industrial Commission, 1235 Mail Service Center, Raleigh, NC 27699-1235 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

| | | | | | |
|------------------------------|-------------|---|-------------------------|--|------------------------|
| Employee's Name _____ | | Employer's Name _____ | | Telephone Number () - _____ | |
| Address _____ | | Employer's Address _____ | | City _____ | State _____ Zip _____ |
| City _____ | State _____ | Zip _____ | Insurance Carrier _____ | Policy Number _____ | |
| Home Telephone () - _____ | | Work Telephone () - _____ | | Carrier's Address _____ | |
| - - _____ | | / / _____ | | City _____ | State _____ Zip _____ |
| Social Security Number _____ | | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth _____ | Carrier's Telephone Number () - _____ | Fax Number () - _____ |

| | | | | | |
|--|---|--|--|---|---|
| Employer | 1. Give nature of employer's business _____ | | | | |
| | Time And Place | 2. Location of plant where injury occurred _____ County _____ Department _____ State if employer's premises _____ | | | |
| 3. Date of injury / / _____ | | 4. Day of week _____ | | Hour of day : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. | |
| 5. Was employee paid for entire day _____ | | 6. Date disability began / / _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. | | | |
| 7. Date you or the supervisor first knew of injury / / _____ | | 8. Name of supervisor _____ | | | |
| Person Injured | 9. Occupation when injured _____ | | | | |
| | 10. (a) Time employed by you _____ | | 10. (b) Wages per hour \$ _____ | | |
| | 11. (a) No. hours worked per day _____ | | 11. (b) Wages per day \$ _____ | | 11. (c) No. of days worked per week _____ |
| | 11. (d) Avg. weekly wages w/ overtime \$ _____ 11. (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. \$ _____ per _____ | | | | |
| Cause And Nature Of Injury | 12. Describe fully how injury occurred and what employee was doing when injured: _____ (Statement made without prejudice and without vouching for correctness of information) | | | | |
| | 13. List all injuries and specify body part involved (e.g. right hand or left hand): _____ | | | | |
| | 14. Date & hour returned to work / / at : .M. | | 15. If so, at what wages \$ _____ per _____ | | |
| | 16. At what occupation _____ | | 17. Employee's salary continued in full? _____ | | |
| | 18. Was employee treated by a physician _____ | | | | |
| Fatal Cases | 19. Has injured employee died _____ | | 20. If so, give date of death (Submit Form 29) / / _____ | | |

Employer name _____ Date Completed / / _____
Signed by _____ Official Title _____

OSHA 301 Information:

| | | | |
|-----------------------------|--|---|--|
| Case Number from Log: _____ | Date Hired: / / _____ | Time Employee began work on date of incident: : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. | If off-site medical treatment provided, answer entire next line. |
| Name of facility: _____ | Address: Street/City/Zip/Telephone _____ | | ER visit? <input type="checkbox"/> Yes <input type="checkbox"/> No Overnight stay? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

FOR IC USE ONLY

RESEARCHER: _____

CC: _____

EC: _____

DATA ENTRY: _____

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para cerciorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

**PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED
PUEDE HABLAR AL (800) 688-8349**

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN [I.C. FILE NUMBER] (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.



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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

