

# compUpdate

## Use toll-free number and connect directly

If you are calling from out of the Boise area, you can use our toll-free number and still reach your party directly.

Dial 1-800-334-2370. As soon as the automated attendant answers (you **do not** have to wait for the entire automated greeting to play), enter 1 and the four-digit extension of your party. The system will automatically connect you directly to your party. For example, if you want to call Client Relations, dial 1-800-334-2370. When the attendant answers, dial 1-2250 and your call will be connected directly to the Client Relations Department.

One of our goals at the State Insurance Fund is to provide you with quick assistance when you phone us. If the underwriter or examiner you are trying to reach is unavailable, please listen carefully to their voice mail message. The message will give you the option of transferring to another team member, holding for the party you want, or leaving a voice message. If you choose to leave a voice message, please leave your first and last name, your claim number or policy number and a telephone number where we can reach you. Numbers can be difficult to hear and understand, so please repeat your phone number. Our policy is to return your call within four business hours.

When you call our main number, if you have your policy number or claim number available, we can transfer you to the correct extension quickly and easily.

## Drug-free testing premium credit offered

The State Insurance Fund still allows a 5 percent premium credit to policyholders with a qualifying drug-free workplace policy. The credit is applied at audit. To qualify for the credit, your drug-free workplace program must meet certain criteria. For more information on how to qualify, contact your underwriter.

## Need a notice poster?

Idaho Code 72-312 requires employers who have workers compensation insurance to "post and maintain in a conspicuous place . . . in and about his place . . . of business" a notice stating that the employer has complied with the law in securing workers compensation for his employees. The notice must contain the name and address of the surety.

The State Insurance Fund supplies a notice poster with each new policy packet. If you did not receive your poster, or if you need a new one, please contact the Client Relations Department at 332-2250. The notice posters are also available in Spanish.

## Figuring out how to fill out injury report

Last year, as part of the State Insurance Fund's document imaging project, we developed a new First Report of Injury or Illness form specifically designed for optical reading. Since then, we've kept track of frequently asked questions and problems people have had in filling out the form. Inside this edition of *compUpdate* are instructions and tips on completing the form.

# First Report of Injury instructions

## ▲ Workers Compensation - First Report of Injury or Illness

Every work injury that requires medical services other than first-aid treatment must be reported within **TEN** days after the employer has knowledge of the injury. **Filing this report is not an admission of liability.** This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made.

Employer	Employer's name <b>1</b>	Employer status <b>4</b>
	Address	<input type="checkbox"/> Sole Proprietor <input type="checkbox"/> LLC <input type="checkbox"/> Public <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other
	City _____ State _____ ZIP _____	Is injured worker a Corporate Officer, Partner, LLC Member, or the Sole Proprietor? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Employer's location address (if different)	If a Sole Proprietorship, is the injured worker a household member? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address _____	
	City _____ State _____ ZIP _____	
	Policy number <b>2</b> _____	Organization code <b>3</b> _____
Employee	Employee's last name <b>5</b>	State where hired <b>6</b>
	Employee's first name _____ M.I. _____	Occupation <b>7</b>
	Address _____	Employment status <b>8</b>
	City _____ State _____ ZIP _____	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male
	Phone # _____	Social Security # _____
	Date of birth _____	Date Hired <b>9</b> _____
	Under what class code were wages reported? <b>10</b> _____	Injury date <b>11</b> _____
	Regular department _____	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Other <input type="checkbox"/> Married <input type="checkbox"/> Separated
	Wage rate <b>12</b> \$ _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Other _____	Hours worked per week _____
	# of days worked per week _____	Full pay for the day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No    Did salary continue? <input type="checkbox"/> Yes <input type="checkbox"/> No
If board, lodging, or other advantages furnished in addition to wages, give estimated value per week. \$ _____		
If gratuities (tips, etc.) were received in the course of employment, give estimated value per week. \$ _____		
Accident	Place of accident or exposure (address) <b>13</b>	City/State _____
	County _____	Did injury/illness occur on the employer's premises <input type="checkbox"/> Yes <input type="checkbox"/> No
	Time injury occurred <b>14</b> <input type="checkbox"/> AM <input type="checkbox"/> PM	Time employee began work <input type="checkbox"/> AM <input type="checkbox"/> PM
	Date last worked <b>15 A</b> _____	Date employer notified <b>16</b> _____
	Date returned to work <b>15 C</b> _____	Date disability began <b>15 B</b> _____
	_____	If fatal, date of death <b>15 D</b> _____
	_____	Injury type (strain, cut, etc) <b>17</b> _____
	Part of body affected _____	Body part injured before? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Injury reported to (name and phone #) <b>18</b> _____	
	Equipment, materials or chemicals employee was using upon occurrence <b>19</b> _____	
How injury or illness occurred (Describe the sequence of events. Include objects or substances that directly caused the injury.) <b>20</b> _____		
_____		
_____		
Was accident caused by failure of a machine or product? <b>21</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Was safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If accident was caused by any person or business other than the injured worker, co-worker or the employer, please identify _____	Was it used? <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____	Were other workers also injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____	List other workers' names _____	
Physician or hospital (name and address) <b>22</b> _____	<input type="checkbox"/> No medical treatment <input type="checkbox"/> Minor by Employer <input type="checkbox"/> Minor - clinic/hospital <input type="checkbox"/> Emergency care <input type="checkbox"/> Anticipated major med/lost time <input type="checkbox"/> Hospitalized overnight	
Did anyone witness the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, provide name, phone # _____		
<b>23</b> Preparer's name and title _____		
Preparer's Phone number _____	Date Prepared _____	

Employer should keep yellow copy of this form for their records.

Send original to: **State Insurance Fund, PO Box 83720, Boise ID 83720-0044**, Phone 1-800-334-2370 or 1-208-332-2100

SIF 2-01

## Essential information for filing a claim

*When reporting an injury, it is important to fill out the form as completely as possible. The following information is necessary to get the claim registered.*

- Injured worker's first and last name.**
- Injured worker's Social Security number.**
- Date of the injury.**
- Policy number and/or policyholder's business name.**
- Time loss information as indicated in No. 15 on the FROI.**
- How the injury occurred and type of injury and body part affected.**

- 1 Enter the complete name of your business and address as shown on your workers compensation policy. If your location is different than your mailing address, complete the section of your location address.
- 2 The policy number field must be completed with your workers compensation policy number as shown on your State Insurance Fund policy documents.
- 3 If you don't use organization codes, you can ignore this section. Policyholders with large facilities, or multiple locations, utilize the organization code to sort the quarterly report of claims. If you are interested in using an organization code, contact the State Insurance Fund.
- 4 Check the Employer Status box that accurately describes your business (Sole Proprietor, LLC, Partnership, Corporation, Public, or Other). Check the box to indicate if the injured worker was a corporate officer, partner, LLC member or sole proprietor. Indicate if the injured worker was a household member.
- 5 The employee's last name, first name, middle initial (make sure last name and first name are entered in the appropriate fields), address, and phone number should be completed showing the most current information available to you. Also enter the claimant's sex, Social Security number, date of birth, and marital status.
- 6 Enter the state where the employee was hired.
- 7 The occupation field should indicate the primary occupation of the claimant at the time of the accident or exposure.
- 8 Employment status indicates the employee's work status. Valid choices are Full-Time, Part-Time, Seasonal, Piece Worker, or Volunteer.
- 9 The date of hire should indicate the most recent hire date.
- 10 The class code should indicate the class code where the injured worker's wages were reported on your payroll. If you are unsure of the appropriate class code, make sure the occupation has been entered. This will help the Registration Unit determine the appropriate class code.
- 11 The injury date should indicate the date the accident happened. If the claim is for an ongoing problem or occupational disease (such as dermatitis or carpal tunnel), indicate the date that the employee informed you of the problem or date the employee first sought medical attention.
- 12 The wage rate – whether the rate is hourly, daily, weekly, monthly or other, the hours worked per week, and the number of days worked per week – must be entered on all claims involving time loss. If the injured employee works a different number of hours and/or days each week, or the injured worker is seasonal, indicate "other" in the wage rate and leave the hours worked per week and number of days worked per week blank. Attach a copy of the injured worker's gross earning for the 52 weeks preceding the date of injury. If the injured worker has various hours and days worked, the gross earning must be broken down into weekly increments. For "seasonal" employee, the gross wages can be submitted in one amount. If board, lodging, other advantages, or gratuities are provided to the injured worker,

the value must be entered in the appropriate field.

- 13 Indicate the address where the accident occurred. The county field is a reporting requirement of the Industrial Commission and must be entered. Also indicate if the injury occurred on the premises.
- 14 Indicate the time the injury occurred and the time the employee began work on the date of injury, if applicable.
- 15 To identify claims with time loss from work, enter:
  - a. Date Last Worked
  - b. Date Disability Began
  - c. Date Returned to work
  - d. If fatal, enter the date of death
- 16 Indicate the date the employer was notified of the injury.
- 17 The injury type (strain, cut, etc.), part of body affected (right arm, left leg, etc.), and whether the body part was injured previously must be completed. Please be sure to indicate which side of the body was injured, right or left.
- 18 Indicate to whom the injury was reported and a phone number where that person can be contacted.
- 19 List equipment, materials or chemicals that were involved in the accident (scaffolding, paintbrush, paint, electric sander, etc.). This information also should be recorded for possible third party claims.
- 20 A detailed description of the accident should be entered in the How Injury/Illness Occurred field. Example: "The worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall." If the claim is for an ongoing problem or occupational disease, describe the type of work the employee does that could have caused the problem they are having.
- 21 Information regarding failure of a machine or product, whether safety equipment was provided and used, if accident was caused by any person or business other than the injured worker, co-worker or the employer, and if other workers were involved in the accident should be recorded for possible third party claims.
- 22 The original physician or hospital name (please do not abbreviate name) and address should be recorded in the appropriate field so the Fund can obtain the appropriate medical information. The box for the type of treatment received must be marked for reporting purposes.
- 23 Mark the box indicating if anyone witnessed the accident. The person who prepared the report should indicate his or her name and title, a phone number where he or she can be reached, and the date the form was completed.

## A few tips

- If you have already submitted a First Report of Injury and some of the information is not accurate, when you re-submit the form, please indicate at the top that it is an amended form.
- If you handwrite the information, please write clearly using black ink – never red ink.
- If you make a mistake on the form, please do not write over it, either white it out, or cross it out and write next to or above the error.
- Don't highlight, circle, underline or make any other mark in an attempt to draw attention to information. Highlighting can cloud or completely obscure information, and other marks often are interpreted as numbers or letters.
- If you have additional information to include regarding the injury and there is not enough room on the form, please use a separate piece of paper.
- If you question the injury, attach a separate sheet with comments.

### *Here's what Idaho law says about reporting injuries:*

**72-602(1)** states that a notice of injury or occupational disease must be submitted as soon as practicable but no later than ten (10) days after the occurrence of an injury or an occupational disease that requires treatment by a physician or results in absence from work for one (1) day or more. **72-602(5)** states that an employer who willfully fails or refuses to make any report required by this section shall be guilty of a misdemeanor.

**File claims using e-mail. See details on the back page.**

## Tips on filing forms via e-mail

Many of our policyholders have found it convenient to file the First Report of Injury and the Employer's Supplemental Report (IC Form 14) via e-mail.

The forms are on our Web site at [www2.state.id.us/isif](http://www2.state.id.us/isif).

Here are some tips on using the forms:

- You must have Microsoft Word 97 or newer. Older versions or other software will not properly translate the file, often resulting in garbled text and a multi-page form. It is important that we receive the form back in the document's original format. That will help lessen the chances of making errors when we process the form.
- In some instances when you download the files from our Web site, you may get a box asking for a user name and password. Just hit "cancel." You don't need a user name and password.
- The form is a protected or "locked" document. We suggest you NOT unprotect the form if you aren't familiar with how to protect and unprotect documents using Word.
- Return the form to us as a Word file attachment with a .doc extension. Do not send it embedded in your e-mail message or as a .pdf file created by Adobe Acrobat or as a scanned graphics file.
- If you e-mail a form to [reportclaim@isif.state.id.us](mailto:reportclaim@isif.state.id.us), you should receive an autoreply that says a message has been received at that address. If you don't get an autoreply within 24 hours, resend the form.
- If you are unsure if a form has been received or have problems with or questions about a form, send your inquiry to [forms@isif.state.id.us](mailto:forms@isif.state.id.us).

State Insurance Fund  
1215 West State Street  
P.O. Box 83720  
Boise, ID 83720-0044  
(208) 332-2100  
(800) 334-2370

### E-mail addresses:

*Underwriting:* [Underwriting@isif.state.id.us](mailto:Underwriting@isif.state.id.us)

*Audit:* [Audit@isif.state.id.us](mailto:Audit@isif.state.id.us)

*Claims:* [Claims@isif.state.id.us](mailto:Claims@isif.state.id.us)

*Risk Management:* [RiskManage@isif.state.id.us](mailto:RiskManage@isif.state.id.us)

*Client Relations:* [Client@isif.state.id.us](mailto:Client@isif.state.id.us)

*Manager's Office:* [Administration@isif.state.id.us](mailto:Administration@isif.state.id.us)

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[www2.state.id.us/isif/](http://www2.state.id.us/isif/)

ANTI-FRAUD HOTLINE 1-800-448-ISIF (4743)

## DON'T GET LOST IN THE MOVE. IT COULD COST YOU.

*If we don't have your current address, you might miss a refund or a dividend check. If you are planning to move, please send us a change of address.*

### 3 ways to let us know your new address:

Call 1-800-334-2370 or 208-332-2100

(Ask for your underwriter or give the information to the operator.)

Send an e-mail to [\*\*underwriting@isif.state.id.us\*\*](mailto:underwriting@isif.state.id.us)

Complete the change of address form on your premium notice and mail it to:

**State Insurance Fund**

**P.O. Box 83720**

**Boise, ID 83720-0044**

*Please be sure to provide your policy number with your address change.*