Massachusetts Groups

Claims Kit

Massachusetts Retail Merchants Workers' Compensation Group, Inc.
Massachusetts Care Self-Insurance Group, Inc.
Massachusetts Healthcare Self-Insurance Group, Inc.
Massachusetts Manufacturing Self-Insurance Group, Inc.
Massachusetts Trade Self-Insurance Group, Inc.

CoveRisk Services, LLC

P.O. Box 859222-9222 / Braintree, MA 02185 / (781) 843-0005 / 800-790-8877

Self-Insurance Groups Proudly Administered by

Massachusetts Retail Merchants Workers' Compensation Group, Inc.
Massachusetts Care Self-Insurance Group, Inc.
Massachusetts Healthcare Self-Insurance Group, Inc.
Massachusetts Manufacturing Self-Insurance Group, Inc.
Massachusetts Trade Self-Insurance Group, Inc.

Claims Administration Procedures

Instructions for Reporting Workers' Compensation Claims:

Please report claims using any browser (Google Chrome, Firefox or Internet Explorer version 10 or newer)!

Please read the following instructions entirely.

Our preferred method of reporting is by completing an injury report via our website: **www.coverisk.com**. Click on Report an Injury.

For Lost Time claims please use Form 101. For all other claims, please use Form 118.

- Have all employee demographic information and accident information handy.
- Click on the link to the form you want to complete to report your claim. (Links are found on our website under "Report an Injury.")
- Complete the form filling in ALL FIELDS. Missing information could result in delays in the claim being set up.
- We are a mandatory reporter to CMS (Medicare) and MUST have the full SSN for the employee.
- Press the SUBMIT button. The injury report will be submitted electronically to us.
- You will immediately receive an email confirmation and a PDF version of your injury report. Add our email address to your contacts. If you don't receive an email please call us at 800.790.8877 option 1.
- You may email supplemental documents such as witness statements, medical reports or accident investigation forms to **FROI@coverisk.com** or via fax to 800-382-8891.

Cove Risk reports claims electronically on your behalf with the required state agency.

If you are unable to complete an injury report online, you can:

- Print a blank report, complete it manually, and submit it via fax to 800-382-8891 Attn: New Claims Reporting.
- Email it to FROI@coverisk.com. (Do not email individual employees with injury reports.)
- Call us at 800-790-8877, option 1.

Have you registered for our new Safety Services? Please see **www.coverisk.com/safety** to learn more.

Our new Safety Awareness for Everyone (S.A.F.E.) Program has all of the resources you need to promote workplace health and safety, answer frequently asked questions, and support a successful risk safety program.

P.O. Box 859222-9222 / Braintree, MA 02185 / 800-790-8877 / FAX 800-382-8891

Claims Administration Procedures

I. Introduction

This claims guideline has been provided to reflect current legislation in the workers' compensation law for the Commonwealth of Massachusetts.

These procedures will streamline the claims reporting process thereby allowing the timely and efficient payment of employee claims. The implementation of these procedures will allow us to effectively monitor the claims and permit us to make appropriate recommendations to the Board of Trustees of your self-insured group.

Since one of the primary functions is to serve members, it is essential that emloyees familiarize themselves with this guide so that they will be aware of the services we provide. Feel free to call us for information and guidance.

Fundamentals of Efficient Claims Service

- Prompt payment of compensation on legitimate claims.
- Early and thorough investigation and determination of questionable cases.

This service cannot be rendered without the immediate and complete cooperation of employers with our investigators and claims examiners. The time element is of utmost importance not only because it affects the speed with which benefits may be paid or determined, but also because the law provides that:

1. The first payment of compensation is due no later than 14 days of receipt of the employer's notice of injury.

2. In cases where the right to compensation is controverted, notice to that effect must be filed on or before the 14th day of receipt of the employer's notice of injury. (Severe penalties may be imposed for violations of these provisions. For example, failure to file on time may force payment of an otherwise questionable claim.)

Employees should be instructed to report all work-related incidents no matter how trivial to their direct supervisor. The supervisor should report the incident to a designated individual in your company who will maintain accident records and act as a liaison between your company and Cove Risk Services, LLC or your self-insured group.

IF A FATALITY OCCURS AT YOUR LOCATION, CALL

Cove Risk Services, LLC*

IMMEDIATELY WITH THE INFORMATION

*During normal business hours call: 781-843-0005 or 800-790-8877
After hours call: 508-274-2362 or 617-967-1156

II. Accident, Investigation and Record Keeping

Employees should be instructed to report all work-related incidents no matter how trivial to their direct supervisor. The supervisor should in turn report the incident to a designated individual in your company who will maintain accident records and act as a liaison between members and your self-insured group. Maintenance of OSHA logs is also important.

III. Claims Reporting

First Report of Injury - Form 101

(WE FILE FORM 101 WITH THE STATE ON YOUR BEHALF)

A. Complete a Massachusetts First Report of Injury Form (Form 101). When an employee has lost five (5) or more calendar days from a work-related injury. Cove Risk Services, LLC will file the Form 101 with the Massachusetts Department of Industrial Accidents (DIA). A copy of this form is to be sent to the injured worker. A copy should be retained for your own records. **(The law requires that these forms be filed within seven (7) calendar days from your knowledge of a work-related injury.)**

Medical Only - Form 118

B. Complete and send to Cove Risk Services, LLC a First Report of Injury (Form 118) for all claims where disability involves four (4) or less calendar days.

DO NOT SEND FORM 118 TO THE DEPARTMENT OF INDUSTRIAL ACCIDENTS.

If a medical-only claim develops into compensable lost time, meaning five (5) or more calendar days. Please notify us immediately.

First Reports of Injury qualifying for disability (see Section A) must be filed within seven (7) days from your knowledge. Failure to comply may subject your company to fines of up to $100 per violation after the second violation in the same calendar year.

C. In cases of questionable compensability, attach a separate memorandum to the 101 or 118 form outlining the conditions or concerns you have involving the claim.

The Form 101 or 118 should be fully completed. The Workers' Compensation Board has not interpreted the employer's statements on a Form 101 or 118 to be admissions of fact. Failure to report losses could result in a penalty of $100 per violation after the second violation in the same calendar year.

The DIA does not provide the employer with the preprinted Forms 101 or 118. A supply of these forms will be provided by Cove Risk Services, LLC.

A permanent record of all work-related incidents, 101 and 118, should be maintained by the employer.

IV. Claims Correspondence

All claims correspondence should have the following information:

A. Your company's full name
B. Your certificate number
C. The claimant's full name
D. The date-of-accident

V. Workers' Compensation Law – Benefits

Benefits can be paid for a period of one hundred eighty (180) days from disability on a non-prejudiced basis, without admitting liability. This can be extended for an additional one hundred eighty (180) days with the claimant's approval, and the DIA's approval.

For compensable injuries and/or occupational diseases, medical benefits are available immediately. Indemnity payments for temporary disability are 60% of the average weekly wage. There is a maximum and a minimum amount under the state workers' compensation laws. If the claimant returns to work at a rate-of-pay below his average weekly wage, he may be entitled to a reduced-earning benefit. Death benefits are available to surviving spouses and certain dependents. Employees may also be entitled to "scheduled" awards for permanent loss of function of various body parts (i.e., legs, feet, toes, arms, hands, fingers) including scars, vision and occupational loss of hearing. The rates indicated below are subjected to legislation revisions.

A. **Burial Expenses** - Reasonable burial expenses not exceeding 8 times the average weekly wage.

B. **Death Benefits** - There is an allowance to pay death benefits to the widow or children under the age of 18. Also, dependents under the age of 18, physically or mentally incapacitated, are eligible for support under the death benefits. The maximum payment for a week would be the state average weekly wage. The weekly maximum and minimum benefits change yearly on October 1st.

C. **Medical Bills** - An employee sustaining a personal injury arising out of the course of his employment or disabled by occupational disease shall be entitled to benefits according to the Commonwealth of Massachusetts Rate Setting Commission Division of Health Care Finance and Policy, as illustrated in the fee schedule for Workers' Compensation 114.3 CMR 40.00. Employees can change health care providers within a given specialty only once, except in the case of emergency or approval by an administrative law judge.

D. **Permanent Total Disability Benefits** - The State of Massachusetts allows a 66-2/3 benefit per week and a COLA (cost of living adjustment) each October 1st.

E. **Temporary Total Disability Benefits** - The benefit rate is 60% of the average weekly wage, not to exceed the state average weekly wage. This section provides for the number of weeks payable under temporary total disability to be 156 weeks.

F. **Temporary Partial Disability Benefits** - The benefit rate is 60% of the difference between the average weekly wage and post-injury earning capacity provided that in no event can the partial compensation rate exceed 75% of what would have been the total compensation rate.

G. **Waiting Period** - There is a five-day (5) waiting period for temporary total disability benefits. However, benefits are payable retroactive to day one if the claimant is out of work for more than 21 days.

H. **Denied Claims** - The employer/insurer must pay the employee his/her benefits within 14 days of the employee's request for benefits via a form 110 or deny the claim with an official notice to the Workers' Compensation Commission (on a Form 104).

In cases that are actually controverted or challenged, a Form 104 (Insurer's Notification of Denial of Compensation) will be filed on behalf of the employer. It is imperative that the employer give as much information to the claims administrator as quickly as possible so a timely investigation and, if need be, controversy or denial can be filed with the State Workers' Compensation Board prior to the 14-day deadline.

VI. Posting Notices

The Workers' Compensation law requires that you post a notice furnished to you by your carrier indicating that you have secured coverage. The notice has the name, address of the carrier, policy number and the effective date-of-coverage. In these circumstances, Cove Risk Services, LLC will provide such notices to the employer. The notices will list your self-insured group as the insurer.

VII. Commonly Used Compensation Forms

A. 101 Forms to be filled out by the employer

1. Employers' report of injury for claims involving five (5) or more calendar days of disability.

   The first report of injury must be reported and filed with the claims administrator within seven (7) days from the 5th day of disability.

2. 118 - Employer's report of injury/medical-only claims

   This first report is sent only to Cove Risk Services, LLC.

3. OSHA Forms and Posting are the employer's responsibility.

4. 117 - Wage Statements

   On claims involving five (5) or more days of disability, indicate only those wages earned by the injured employee during the 52-week period immediately preceding the accident. If the injured employee has worked less than 52 weeks, report wages for that time.

B. Commonly used compensation forms to be filled out by your self-insured group

1. 103 - Insurer's notification of payment
2. 104 - Insurer's notification of denial of compensation
3. 105 - Insurer's extension of 180-day pay-without-prejudice period
4. 106 - Insurer's notification of termination or suspension of benefits
5. 107 - Insurer's notification of resumption or modification of weekly compensation
6. 108 - Insurer's request for reduction, suspension or discontinuance of compensation
7. 113 - Agreement to compensation
8. 114 - Notification of new participant or participant change
9. 120 - Insurer's offer to pay compensation
10. 121 - Appeal of conference proceeding
11. Medical authorization
12. 117 - Average weekly wage computation schedule
13. 110 - Employee's claim

The law requires that some of these forms be sent to all parties' via certified mail return receipt requested.

VIII. Workers' Compensation Board Notice

A. Notice of Hearing

When an informal or formal hearing is scheduled, the Workers' Compensation Board will indicate the time, date and place of the scheduled hearing via either a letter or form. It is not necessary for the employer to attend unless specifically requested or if they wish to do so. Your self-insured group enourages employer involvement at Industrial Accident Board hearings when needed.

B. Notice of Decision

This letter or form summarizes the hearing activity including awards. Workers' Compensation decisions can be appealed on any claim that originally had the possibility of any appeal process.

IX. Workers' Compensation Law (Discrimination)

75B. Qualified handicapped person; discrimination against exercising rights under this chapter.

1. Any employee who has sustained a work-related injury and is capable of performing the essential functions of a particular job, or who would be capable of performing the essential functions of such job with reasonable accommodations, shall be deemed to be a qualified handicapped person under the provisions of Chapter 151B.

2. No employer or duly authorized agent or an employer shall discharge, refuse to hire or in any other manner discriminate against an employee because the employee has exercised a right afforded by this chapter, or who has testified or in any manner cooperated with an injury or proceeding pursuant to this chapter, unless the employee knowingly participated in a fraudulent proceeding. Any person claiming to be aggrieved by a violation of this section may initiate proceedings in the superior court department of the trial court for the county in which the alleged violation occurred. An employer found to have violated this paragraph shall be exclusively liable to pay to the employee lost wages, shall grant the employee suitable employment, and shall reimburse such reasonable attorney fees incurred in the protection of rights granted as shall be determined by the court. The court may grant whatever equitable relief it deems necessary to protect rights granted by this section.

3. In the event that any right set forth in this section is inconsistent with an applicable collective bargaining agreement, such prevail. An employee may not otherwise waive rights granted by this section.

X. Rehabilitation

The purpose of this section of the Workers' Compensation Act is restoration of the insured employee to suitable employment to the maximum extent practicable consistent with the priorities listed in Section (30E - 3011) of the Workers' Compensation Act. To further that purpose, it is the shared responsibility of all parties involved to cooperate in developing a rehabilitation process designed to promote re-employment at a level of earning commensurate with the employee's ability to perform under present conditions consistent with the priorities of Section (30E - 3011) of the Massachusetts Workers' Compensation Act.

(30E - 3011) - Semi-mandatory. The stated policy of the Act is to encourage and assist in the development of voluntary agreements to provide and utilize vocational rehabilitation services when necessary to return employees to suitable gainful employment. The law requires the injured employee to meet with the Office of Education and Rehabilitation for an initial screening. If the Office determines that the services are warranted, it will work with the employer and employee in developing a program. If no program is agreed upon by employer and employee, the Office may develop a program and notify the employer/insurer. If the insurer refuses (or fails) to provide the program, the Office may do so from a trust fund. Upon successful completion, the insurer may be assessed two (2) times the cost of the program.

The employer is responsible for the cost of the program including board, travel and lodging. Programs are limited to 104 weeks. Parties must agree on the provider.

Benefits may be reduced or suspended for refusal to cooperate.

Retraining may be allowed within any of the following categories. Where needed, a vocational or medical rehabilitation expert will be assigned.

1. Former Job - Return of the employee to his pre-injury job with same employer.

2. Modified Job - Return of the employee to his pre-injury job with the same employer. The tasks or the work place may be modified and the employee retrained if necessary to achieve this return.

3. New Job - Return to employment with the pre-injury employer in a different position. The employee may be retrained if necessary.

4. On-The-Job-Training With Pre-Injury Employer - Return to employment with the pre-injury employer for on-the-job-training.

5. New Employer - Employment with a new employer, retraining may be allowed if necessary.

6. On-The-Job-Training With A New Employer

7. Career Retraining - A goal-oriented period of formal retraining, which is designed to lead to employment in another career field.

XI. Workers' Compensation Department of Industrial Accidents Offices

The Department of Industrial Accidents has its central office at:
1 Congress Street, Suite 100, Boston, MA 02114-2017

DIA LOCATIONS

Boston	1 Congress Street, Suite 100 Boston, MA 02114
Fall River	1 Father DeValles Blvd., 3rd Fl Fall River, MA 02723
Lawrence	354 Merrimack Street, Bldg. 1, Suite 230 Lawrence, MA 01843
Springfield	436 Dwight Street, Room 105 Springfield, MA 01103
Worcester	340 Main Street Worcester, MA 01609

XII. Sample Forms for Employer's Use

101 Employer's First Report of Injury (LTW Cases)
118 Employer's First Report of Injury (Medical Only) or (Incident Only)
117 Wage Statement

See samples included in this claims kit.

XIII. Return-to-Work Program (Full/Light Duty)

The purpose of the Massachusetts Workers' Compensation Act is to assist an injured employee after a work-related injury has occurred.

In most cases, return to work is accomplished in a timely fashion.

As a self insured business, you have accepted a greater amount of responsibility and have shown a desire to better control the Workers' Compensation exposure to your company.

One way to control the costs of Workers' Compensation is to participate in Return-to-Work programs for full and light-duty capacities.

As your claims administrator, we will be working with you and other "team" members to accomplish this goal, i.e., Return-to-Work.

Other "team" members include such people as vocational and medical rehabilitation specialists, physicians, adjusters, defense counsel, and loss control representatives.

As a team, we will be working together to place an injured employee back to work. Light-duty positions will be needed along with job descriptions.

XIV. Cove Risk Services, LLC's Duties

1. Immediate telephone contact with the employer to confirm compensability, compensable lost-time, review an action plan, i.e., adjuster assigned, or denial of claim.

2. Follow-up by telephone with the employer to review the status of each lost-time case.

3. Immediate telephone contact with the injured employee to review benefits and needed documentation, such as medical authorization, attending physician information, utilization review program.

4. File Form 101 with the DIA on claims with 5 or more days of disability.

5. Where allowable, weekly telephone contact with the employee to review progress.

6. Telephone and written contact with the attending physicians to review treatment and progress.

7. Coordinate ergonomic specialists to meet with the employer and employee when a complete change of job duties is required or gradual return-to-work via light duty to full duty.

8. Coordinate any needed state service agencies such as rehabilitation specialists.

9. Request job description for new or light-duty positions.

10. Medical file reviews by physicians who will be contacting the attending physicians, physical examination physicians and at times, the employer.

11. Request the employer to allow the employee to return to light-duty work.

12. Review loss runs with member.

XV. Employer Duties

1. Prompt reporting of all lost-time cases or those cases that go from a medical-only status to a lost-time status.

2. Full cooperation with the adjusters and specialists assigned to handle lost-time cases.

3. Preparation of light duty job descriptions.

4. Promote full duty Return-to-Work of all injured employees.

5. Where allowable, contact the injured employee on a weekly or bi-weekly basis to show concern.

6. Allow employees who return to work to take the needed time off to seek follow-up medical attention.

7. Transit information to the claims department on any cases that could benefit from surveillance.

8. Encourage employees to return to work as soon as possible within the restrictions diagnosed by the attending physicians.

9. Attend rehabilitation meetings where the employer's input is needed.

10. Attend pre-planned claims presentations.

The Return-to-Work program is designed to minimize the loss dollars spent by returning the employee to work as quickly as possible. Hopefully, the position will be with his original employer.

With the employer's cooperation, this can be accomplished.

Without the employer's cooperation, the exposure increases.

When there is no job to which an employee can return, the claims department must try to obtain a reduced earning capacity at the Department of Industrial Accidents and work with vocational specialists to find the employee a job. All of this takes time and costs extra loss/expense dollars, which increase the loss history of the employer and group as a whole.

Only as a coordinated team can we maintain a successful Return-to-Work program.

XVI. Claims/Employer Meetings

As your claims administrator, Cove Risk Services, LLC will provide claims and loss control liaisons to review particular cases.

Many such cases can be handled over the phone, but where a more in-depth meeting is needed, appointments can be scheduled.

XVII. Settlement Authority

Section 74 ("Lump Sums - Consent of Employer") (applicable to pending claims).

If the employer is an experience-modification insured (The Industrial Accident Board presently has taken the position that this includes employers whose workers' compensation premiums exceed $2,500), the permission of the employer must be obtained in writing before a lump-sum settlement can be approved. As this is applicable to pending cases, all matters which are presently scheduled for lump sum are subjected to this provision; and the employers must be contacted and approval secured. This does not apply to claims that are no longer factored into the employer's experience modification ratings.

XVIII. Defense Counsel

As required under the Workers' Compensation Act, Cove Risk Services, LLC must appoint a local defense counsel.

The following firm has been designated as defense counsel for your self-insured group.

Curtin, Murphy & O'Reilly
31 St. James Avenue
Boston, MA 02116
Telephone: (617) 574-1700

XIX. Medical Only Cases

A permanent record of all work-related incidents, regardless of whether a Form 118 is required, should be maintained. It is also recommended that a record of such incidents be maintained in a separate workers' compensation file in chronological order.

A Form 118 should only be sent to Cove Risk Services, LLC.

XX. Double Compensation Exposure (Sec. 152/28)

Willful misconduct of employer; defense reimbursement of insurer; employment of minor; mentally handicapped persons; injuries at sheltered workshops.

If employee is injured by reason of the serious and willful misconduct of an employer or of any person regularly entrusted with and exercising the power of superintendence, the amounts of compensation hereinafter provided shall be doubled. In case the employer is insured, he shall repay to the insurer the extra compensation paid to the employee. If a claim is made under this section, and the employer is insured, the employer may appear and defend against such claim only. The employment of any minor, known to be such, in violation of any provision, of Sections 60 to 74, inclusive or of Section 104 of Chapter 149 shall constitute serious and willful misconduct under this section.

As used in this section the term "minor" shall include mentally handicapped persons 18 years of age or older unless:

1. the employment takes place in a sheltered workshop which holds either a license from the Department of Developmental Services or accreditation from the Commission on Accreditation of Rehabilitation Facilities; and

2. a professional vocational specialist evaluates the employee at the employment site, for the specific job performed and such evaluation determines in writing the employee is appropriate for and capable of such employment; and

3. the employee has agreed in writing to the written rehabilitation plan or to an accurate verbal description of such written plan.

The Division of Administration shall keep statistical records on injuries that occur at sheltered workshops. If there appears to be a pattern of such injuries at a particular sheltered workshop, the Office of Claims Administration shall notify the Department of Mental Retardation and such department shall take whatever action it deems appropriate.

XXI. Serious Loss Reporting/Excess Reporting

A serious loss is defined as any loss that has an incurred exposure (paid and outstanding reserves of $50,000 or higher). Cove Risk Services, LLC will provide serious loss information to the Board of Trustees on a quarterly basis. Each individual case will have a serious loss report and serious loss report outline, with excess reporting information.

XXII. Conclusion

The claims procedures outlined in this manual are to be viewed only as a guideline and are not to be construed as a substitute for actual legislation and/or court decisions. It is not intended to abrogate an employer's responsibility under applicable state and/or federal safety laws.

Most of the claims administration policy is standard to all workers' compensation programs in the state of Massachusetts. Workers' Compensation is highly regulated, and regulations specify in-depth the type of claim reporting which must be done and the forms which must be used.

The claims administration procedures are written for the benefits of the members of your self-insurance group, to be used as a reference manual. Items such as the type of forms, which must be completed and the time frames for various filings have been discussed.

The purpose of a claims administration policy is to ensure correct and timely payment of employees' claims, and to satisfy Massachusetts W.C. Regulations; Chapter 152.

Claims Forms

Massachusetts Retail Merchants Workers' Compensation Group, Inc.
Massachusetts Care Self-Insurance Group, Inc.
Massachusetts Healthcare Self-Insurance Group, Inc.
Massachusetts Manufacturing Self-Insurance Group, Inc.
Massachusetts Trade Self-Insurance Group, Inc.

CLAIMS SHOULD BE FILED ON-LINE ON OUR WEBSITE

(Browsers: Google Chrome, Firefox or Internet Explorer version 10 or newer.)

Please refer to page 3 of this booklet for detailed reporting instructions.

www.coverisk.com

For questions regarding claims reporting or claims status call:

Claims Office	1-800-790-8877 1-781-843-0005
Claims Fax:	1-800-382-8891*

* Please note: For your convenience, the fax line is available
24 hours a day, 7 days per week

CoveRisk
Services, LLC

P.O. Box 859222-9222 / Braintree, MA 02185
(781) 843-0005 / 800-790-8877 / Fax (800) 382-8891

Please check your group from the list below.

❏ Massachusetts Retail Merchants Workers' Compensation Group, Inc.
❏ Massachusetts Care Self-Insurance Group, Inc. (nursing homes)
❏ Massachusetts Healthcare Self-Insurance Group, Inc. (hospitals)
❏ Massachusetts Manufacturing Self-Insurance Group, Inc.
❏ Massachusetts Trade Self-Insurance Group, Inc.

P.O. Box 859222-9222 / Braintree, MA 02185
(781) 843-0005 / 800-790-8877 / Fax (800) 382-8891

Supervisor's Investigative Report

This is a follow-up report used to indentify and correct conditions or practices which have led to an employee work-related incident.

Employer's Name: _____

I. GENERAL INFORMATION

Employee Name _____ Department _____

Supervisor Completing This Form _____ Date of Incident _____ Date Supervisor Notified _____

II. INTERVIEW WITH FIRST PERSON NOTIFIED OF INCIDENT

Name of Person _____ Date Person was Notified _____

III. INTERVIEW EACH WITNESS (Name and Statement)

_____
_____
_____

IV. WHERE DID THE INCIDENT OCCUR?

_____
_____
_____

V. DESCRIBE WHAT HAPPENED AND THE REASON(S) INCIDENT OCCURRED

_____
_____
_____

VI. WHAT ACTION WAS TAKEN TO PREVENT A RECURRENCE?

_____
_____
_____

VII. SIGNATURE

Signature of Supervisor Completing Form _____ Date Completed _____

Signature of Safety Officer _____ Date Reviewed by Safety Committee _____

VIII. IMPORTANT

If equipment or machinery was the cause of the incident, please advise the claims department of any service contracts.

FORM 101

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 101
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA USE ONLY

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

THIS FORM MUST BE FILED BY THE *EMPLOYER* IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.

***INSTRUCTIONS AND CODES ON THE REVERSE SIDE* - Please Print Legibly or Type - Unreadable forms will be returned.**

EMPLOYEE

1. Employee's Name (Last, First, MI):	2. Home Telephone Number:	3. Social Security Number*:	4. Sex: ☐ M ☐ F
5. Home Address (No., Street, City, State & Zip Code):	5a. Native Language Code: _____ Other:_____	6. Marital Status: ☐ M ☐ S	7. No. of Dependents:
8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):	10. Average Weekly Wage: $ ☐ Estimated ☐ Actual	

EMPLOYER

11. Employer's Name:	12. Federal Tax I.D. Number:
13. Employer's Address (No., Street, City, State & Zip Code):	14. Employer's Telephone Number:
	15. Industry Code (See Reverse Side):
16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR): P.O. Box 859222-9222 Braintree, MA 02185 (1-800-790-8877)	17. W.C. Policy Number:
18. Self-Insured? ☐ Yes ☐ No If Yes, Self-Insurer Number:	19. Business Type : ☐ Service ☐ Wholesale ☐ Mfg. ☐ Retail ☐ Other _____

INJURY INFORMATION

20. DATE OF INJURY (mm/dd/yyyy):	**20a. Insurer's Case/Claim File No.:**
21. Was Employee Injured on Employer's Premises? ☐ Yes ☐ No	22. Location of Injury if not on Employer's Premises:
23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	**24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):**
25. If Employee has Died, Date of Death (mm/dd/yyyy):	26. Source of Injury (Chemicals, Machinery, etc.):
27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:	

28. Person to Whom Injury was Reported (list position):	29. Date Reported (mm/dd/yyyy):	30. Date Reported as work related (mm/dd/yyyy):
31. Injury Code(s) / Body Part Code(s) a. to body part a. b. to body part b. c. to body part c.	32. Witness(es) to Injury - Give Full Name(s), if none state as such:	
33. Has Employee Returned to Work? ☐ Yes ☐ No	34. Date Employee Returned to Work(mm/dd/yyyy):	
35. Employee's Regular Occupation:	36. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No	

PREPARER

37. PREPARER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):	38. PREPARER'S Title:	
39. PREPARER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):	40. Date Prepared (mm/dd/yyyy):	40a. PREPARER'S e-mail address:

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report. Form 101 - Revised 7/2010 - Reproduce as needed.

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

FILING INSTRUCTIONS

1. WHEN TO FILE: File this form within 7 calendar days, not including Sundays and legal holidays, of receipt of notice of any injury alleged to have arisen out of and in the course of employment, which totally or partially incapacitates an employee for a period of 5 or more calendar days from earning wages. This form is not an admission of liability, but must be filed even though the Employer may believe that the Employee is not injured, or that the Employee is not entitled to benefits under M.G.L. Chapter 152.
2. WHERE TO FILE: This form should be mailed to the Department of Industrial Accidents at the address shown on the front of the form. Copies must also be provided to the Employee and to the Employer's Workers' Compensation insurer.
3. PENALTIES: Failure to report injuries on this form may result in a fine of $100.00 in accordance with M.G.L. Chapter 152, Section 6.
4. EMPLOYER'S NAME & SIGNATURE IN BOXES 37 & 39: This form must be filed by the employer or an authorized agent/representative of the employer.

NATIVE LANGUAGE CODES

1 – English / 2 – Portuguese / 3 – Haitian Creole / 4 – Spanish / 5 – Chinese / 6 – Vietnamese / 7 – Cape Verdean / 9 – Other

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production - Crops
02 Agriculture Production - Livestock
07 Agricultural Services
08 Forestry
09 Fishing, Hunting and Trapping

Mining
10 Metal Mining
12 Coal Mining
13 Oil and Natural Gas
14 Nonmetallic Minerals, Except Fuels

Construction
15 General Building Contractors
16 Heavy Construction, Ex. Building
17 Special Trade Contractors

Manufacturing
20 Food and Kindred Products
21 Tobacco Products
22 Textile Mill Products
23 Apparel and Other Textile Products
24 Lumber and Wood Products
25 Furniture and Fixtures
26 Paper and Allied Products
27 Printing and Publishing
28 Chemicals and Allied Products
29 Petroleum and Coal Products
30 Rubber and Misc. Plastic Products
31 Leather and Leather Products
32 Stone, Clay and Glass Products
33 Primary Metal Industries
34 Fabricated Metal Products
35 Industrial Machinery and Equipment
36 Electronic and Other Electrical Equipment
37 Transportation Equipment
38 Instruments and Related Products
39 Miscellaneous Manufacturing Industries

Transportation and Public Utilities
40 Railroad Transportation
41 Local and Interurban Passenger Transit
42 Trucking and Warehousing
43 U.S. Postal Service
44 Water Transportation
45 Transportation by Air
46 Pipelines, Except Natural Gas
47 Transportation Services
48 Communications
49 Electric, Gas and Sanitary Services

Wholesale Trade
50 Wholesale Trade - Durable Goods
51 Wholesale Trade - Non-durable Goods

Retail Trade
52 Building Materials and Garden Supplies
53 General Merchandizing
54 Food Stores
55 Automotive Dealers and Service Stations
56 Apparel and Accessory Stores
57 Furniture and Home Furnishing Stores
58 Eating and Drinking Establishments
59 Miscellaneous Retail

Finance, Insurance and Real Estate
60 Depository Institutions
61 Non-depository Institutions
62 Security and Commodity Brokers
63 Insurance Carriers
64 Insurance Agents, Brokers and Service
65 Real Estate
67 Holding and Other Investment Officers

Services
70 Hotels and Other Lodging Places
72 Personal Services
73 Business Services
75 Auto Repair Services and Parking
76 Miscellaneous Repair Services
78 Motion Pictures
79 Amusements and Recreation Services
80 Health Services
81 Legal Services
82 Educational Services
83 Social Services
84 Museums, Botanical, Zoological Gardens
86 Membership Organizations
87 Engineering and Management Services
88 Private Households
89 Services, NEC

Public Administration
91 Executive, Legislative and Garden
92 Justice, Public Order, and Safety
93 Finance, Taxation, and Monetary Benefits
94 Administration of Human Services
95 Environmental Quality and Housing
96 Administration of Economic Program
97 National Security and International Affairs

Non-classifiable Establishments
99 Non-classifiable Establishments

NATURE OF INJURY OR ILLNESS CODES

100 Amputation or Erucloation
110 Asphyxia or Strangulation Etc.
120 Burns (Heat)
130 Burns (Chemical)
140 Concussion
160 Contusion, Crushing, Bruise
170 Cut, Laceration, Puncture
190 Dislocation
200 Electric Shock, Electrocution
210 Fracture
250 Hernia, Rupture
300 Scratches, Abrasions
310 Sprains, Strains
400 Multiple Injuries
900 No Injury
950 Damage to Prosthetic Devices
995 No Other Injury, NEC**
999 Non-classifiable

Infective or Parasitic Disease
150 Infective or Parasitic Disease, UNS*
151 Amebiasis
152 Anthrax
153 Brucellosis
154 Conjunctivitis and Opthalmia
156 Tetanus
157 Tuberculosis
159 Other Infective or Parasitic Diseases

Dermatitis
180 Dermatitis, UNS*
183 Primary Infections of the Skin
184 Other Skin Conditions
185 Dermatitis, Allergenic or Contact
189 Skin Condition, NEC**

Poisoning Systemic
270 Poisoning, Systemic, UNS*
271 Due to Toxic Materials other than Lead
272 Diseases of the Blood and Blood Forming Organs
273 Upper Respiratory Conditions
274 Influenza, Pneumonia, Etc.
276 Other Diseases of the Gastro-Intestinal Tract
278 Effects of Lead
279 Other Toxic Effects of One System Only

Respiratory Systems, Conditions of
570 Respiratory Systems, Conditions of
571 Upper Respiratory
572 Asthma, Influenza, Pneumonia

Pneumoconiosis
280 Pneumoconiosis
281 Aluminosis
282 Anthracosis
283 Asbestosis
284 Byssinosis
285 Siderosis
286 Silicosis
287 Other Pneumoconioses
289 Pneumoconiosis and Tuberculosis

Nervous System, Conditions of
560 Nervous System, Conditions of - NEC**
561 Diseases of the Central Nervous System
562 Diseases of the Nerves and Peripheral Ganglia

Neoplasm Tumor
550 Neoplasm Tumor, UNS*
551 Malignant
552 Benign

Radiation Effects
290 Radiation Effects, UNS*
291 Non-Ionizing Radiation
292 Microwaves
293 Ionizing Radiation - X-Ray
294 Ionizing Radiation - Isotopes
295 Welder's Flash

Other
265 Carpal Tunnel Syndrome
510 Cardiovascular and Other Conditions of the Circulatory System
520 Complications Peculiar to Medical Care
500 Effects of Changes in Atmospheric Pressure
240 Effects of Environmental Heat
220 Effects of Exposure to Low Temperature
530 Eye, other Diseases of the Eye
230 Hearing Loss or Impairment
991 Heart Condition ,Excludes Heart Attack
320 Hemorrhoids
330 Hepatitis, Serum and Infective
275 Hepatitis, Toxic
260 Inflammation of Joints, Etc.
540 Mental Disorders
900 No Illness
999 Non-classifiable
990 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s), UNS*
140 Face, UNS*
141 Jaw, Chin
144 Mouth and Throat (vocal chords, larynx)
146 Nose
148 Face, Multiple Parts
149 Face, NEC**
150 Scalp
160 Skull
198 Head Multiple
200 Neck & Cervical Vertebrae

UPPER EXTREMITIES
300 Upper Extremities, NEC**
310 Arm(s), UNS*
311 Upper Arm
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s), Not Wrists or Fingers
340 Finger(s)
398 Upper Extremities, Multiple
400 Trunk, UNS*
410 Abdomen, Internal Organs, Inguinal Hernia
420 Back
430 Chest, Ribs, Breastbone, Internal Organs
440 Hip(s)..,Pelvis, Organs and Buttocks
450 Shoulder(s)
498 Trunk, Multiple

LOWER EXTREMITIES
500 Lower Extremities
510 Leg(s), UNS*
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet, Not Ankle
540 Toe(s)
598 Lower Extremities, Multiple
700 MULTIPLE PARTS
Applies when more than one major body part as been effected such as an arm and a leg
999 NON-CLASSIFIABLE - Insufficient information to identify part of body effected. Includes damage to prosthetic devises.

***UNS - UNSPECIFIED** ****NEC - NOT ELSEWHERE CLASSIFIED**

Claim #:
Caption:

Authorization to Disclose Health Information

Patient Name: _____
Date of Birth: _____ Social Security Number: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.

2. The individuals or organizations listed on page two are authorized to make disclosure.

3. The type and amount of information to be used or disclosed is as follows:
   medical records, office notes, hospital records, pharmaceutical records, x-ray films, MRI films, CAT scans, other radiological films and medical bills concerning my medical treatment arising out of or prior to the date of accident.

Your signature must appear on the line next to the below listed items for the following types of health information to be released. Your initials and signature must also appear at the bottom of both pages respectively.

HIV/AIDS related information and/or records _____
Mental Health information and/or records _____
Drug/Alcohol diagnosis and treatment information _____
Pregnancy/Family Planning related information _____
Physical/Sexual Abuse related information and/or records _____
Sexually Transmitted Disease related information and/or records _____

4. This information may be disclosed to and used by the following individual or organization:

Cove Risk Services, LLC
P.O. Box 859222-9222
Braintree, MA 02185
1-800-790-8877 or 1-781-843-0005
(FAX) 1-800-382-8891

for the purpose of a legal workers' compensation claim.

5. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the person or entity I authorized to release my information. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the closure of my pending Workers' Compensation Claim or one year from the date signed, whichever is later.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

7. I authorize Cove Risk Services, LLC, its agents or assigns to communicate or correspond with my treating doctors for purposes of medical history, diagnosis, treatment, degree of disability, ability to return to work or permanency.

8. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient Initials: _____
Date: _____

Claim #:
Caption:

Authorization to Disclose Health Information (continued)

Name and Address of Medical Provider: _____

Name and Address of Medical Provider: _____

Name and Address of Medical Provider: _____

Name and Address of Medical Provider: _____

Name and Address of Medical Provider: _____

Name and Address of Medical Provider: _____

Name and Address of Medical Provider: _____

Name and Address of Medical Provider: _____

Name and Address of Medical Provider: _____

Name and Address of Medical Provider: _____

Signature of Patient: _____
Date: _____

Please check your group from the list below.

❑ Massachusetts Retail Merchants Workers' Compensation Group, Inc.
❑ Massachusetts Care Self-Insurance Group, Inc. (nursing homes)
❑ Massachusetts Healthcare Self-Insurance Group, Inc. (hospitals)
❑ Massachusetts Manufacturing Self-Insurance Group, Inc.
❑ Massachusetts Trade Self-Insurance Group, Inc.

Form 117

P.O. Box 859222-9222 / Braintree, MA 02185
(781) 843-0005 / 800-790-8877 / Fax (800) 382-8891

AVERAGE WEEKLY WAGE COMPUTATION SCHEDULE

PLEASE PRINT OR TYPE: Date: (MM/DD/YY):

Employer Name and Address		Insurer Case File Number
Employee Name	Children Under 18 Years Old	Dependents Other Than Children
Date of Injury (MM/DD/YY) / /	First Date of Disability (MM/DD/YY): / /	Date Employed (MM/DD/YY): / /

Has Employee been certified by U.S. Veterans Administration for any type of disability? Yes ☐ No ☐

Indicate only those wages earned by the injured employee during the 52-week period immediately preceding the accident. If the injured employee has worked less than 52 weeks, report wages for the time worked and, for the remaining weeks on this schedule, substitute wages of a fellow employee in the same class of employment who has worked for one year or more.

Week No.	Year: Week Ending Month	Day	Gross Amount Paid Including Overtime	No. of Meals Per Week	Week No.	Year: Week Ending Month	Day	Gross Amount Paid Including Overtime	No. of Meals Per Week	Week No.	Year: Week Ending Month	Day	Gross Amount Paid Including Overtime	No. of Meals Per Week
1					19					37				
2					20					38				
3					21					39				
4					22					40				
5					23					41				
6					24					42				
7					25					43				
8					26					44				
9					27					45				
10					28					46				
11					29					47				
12					30					48				
13					31					49				
14					32					50				
15					33					51				
16					34					52				
17					35					TOTAL				
18					36					AVERAGE				

Was Room Furnished To Employee? Yes ☐ No ☐	If Tips or Other Benefits Were Earned, Describe and State Value Per Week:

Comments
Average Weekly Wage computed above is based on _____ weeks wage data.

THIS IS A TRUE COPY OF PAYROLL RECORD OF THE ABOVE NAMED EMPLOYEE OR OF A FELLOW EMPLOYEE IN THE SAME CLASS OF EMPLOYMENT

Name of Fellow Employee	Employer Preparer's Signature	Preparer's Title

FORM 118

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

EMPLOYER'S NOTIFICATION TO INSURER OF MEDICAL ONLY INJURIES

If An Injury Has Resulted in 5 or more Lost Work Days,
File "Employer's First Report of Injury", Form 101

DO NOT File This Form With The Department of Industrial Accidents

PLEASE PRINT OR TYPE:

EMPLOYEE

1. Employee Name (Last, First MI)		2. Home Telephone ( ) -	3. Social Security Number* - -
4. Home Address (No. & Street, City, State, Zip Code)		5. Marital Status ☐ Single ☐ Married	6. No. of Dependents
7. Date of Hire (MM/DD/YY): / /	8. Date of Birth (MM/DD/YY) / /	9. Sex ☐ Male ☐ Female	10. Hourly Wage
11. Piece or Hourly Worker? ☐ Piece ☐ Hourly	12. Hours Worked Per Day	13. Days Worked Per Week	14. Avg. 52-Week Wage: $ _____ ☐ Estimated or ☐ Actual

EMPLOYER

15. Employer Name	16. Employer Self-Insured? ☐ Yes ☐ No	17. Federal Tax ID -
18. Employer Address (No. & Street, City, State, Zip Code)	19. Employer Telephone ( ) -	20. Industry Code
21. Insurance Carrier: Name and Address of Branch Responsible for This Case (Not Local Agent or Adjuster)		
22. Worker's Compensation Policy Number	23. OSHA Case File Number (if applicable)	

INJURY INFORMATION

24. Date of Injury (MM/DD/YY): / /	25. Time of Injury ☐ A.M. ☐ P.M.	26. Source of Injury (e.g., Machine, Tool, Substance, etc.)	
27. Address Where Injury Occurred		28. On Employer's Premises? ☐ Yes ☐ No	29. Employer Location Code
30. Regular Occupation		31. Regular Occupation When Injured? ☐ Yes ☐ No	
32. To Whom Was Injury Reported?			33. Date Reported (MM/DD/YY): / /
34. Nature of Injury(ies) (Burn, Fracture, Cut, etc.)			
35. Injured Body Part(s) Description (Arm, Leg, Back, etc.)			
36. Physician Name and Address			
37. Hospital Name and Address			
38. Describe How Injury Occurred (e.g., Struck by__, Fell from__, Exposed to...)			
39. If Employee Has Returned to Work Date of Return (MM/DD/YY): / /		40. Returned to Regular Occupation? ☐ Yes ☐ No	

41. Preparer's Name (Please Print or Type)	42. Preparer's Title
43. Preparer's Signature	44. Date Prepared (MM/DD/YY):

*Disclosing Social Security Number is voluntary.

P.O. Box 859222-9222
Braintree, MA 02185

800-790-8877
FAX 800-382-8891

www.coverisk.com

MA 7 2016