



Midlands Claim Administrators, Inc.
P.O.Box 238808 • Oklahoma City, OK 73123
Phone 866-264-2805 • Fax 888-799-5628

Midlands Claim Administrator's, Inc.

Midlands is committed to providing the most efficient and cost effective claims administration services in the market today. We have numerous resources available to ensure that we are able to fulfill these promises.

When you have an employee that is involved in a work related accident, we are available by phone, facsimile, or email. Midlands has a dedicated staff of adjusters and nurse case managers that can assist you in getting your injured employees the care that they need in a timely manner. In addition, Midlands will thoroughly investigate your claims and ensure that all costs associated with these claims are appropriate. Upon completion of the investigation, all related costs will be paid in a timely manner which means usually within 7-10 days.

For your convenience, the following is a list of contact information:

Claims Administration

Louis Pippin
Vice President of Claims
Phone 866-264-2805, Facsimile 405-767-1212
lpippin@midman.com

Pat Brooks
Claim Supervisor
Phone 866-264-2805, Facsimile 405-767-1212
pbrooks@midman.com

Deborah Reichert
Notice of Injury Center
Phone 888-799-6642, Facsimile 888-799-5628
dreichert@midman.com

Case Management Services

Deborah Storey
Department Manager
Phone 877-340-7772, Facsimile 405-767-1212
dstorey@midman.com

Kelly Rakestraw
Nurse Case Manager
Phone 877-340-7772, Facsimile 405-767-1212
krakestraw@midman.com

I look forward to working with you and please call with any questions or concerns.

Sincerely,

Louis Pippin
Vice President of Claims



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TRANSMITTAL SHEET FOR ON-THE-JOB INJURY INFORMATION

Date of Transmittal:	
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The attached information is provided as notice/follow-up of an on-the-job injury.

Policy Number:	
Employer:	
Employee:	
Contact Name & Phone Number:	
Contact Fax Number:	

IN ORDER TO PROCESS A NEW CLAIM, PLEASE INCLUDE THE FOLLOWING FORMS :

- Employer's Report of Injury
- Employee's First Report of Accident/Injury
(completed and signed by the employee)
- Employee Information Sheet
- Authorization for Release of Medical Records

IF THE EMPLOYEE WILL LOSE TIME BEYOND THE ELIMINATION PERIOD OF THE POLICY:

- Employer's Report of Disability Request For Wage Benefit Reimbursement
- Wage History

Fraud Warning:

"It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and / or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

WHEN COMPLETED PLEASE FAX TO:

Midlands Claims Administrators
(888) 799-5628



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Policy # **EMPLOYERS REPORT OF INJURY**

Name of injured employee (Last, First, MI)		Sex F M	Date of Injury	Time of Injury Am Pm	Date Lost Time Began (M-D-Y-)	Expected Return to work date
Social Security #	Home Phone ()	Birth Date (M-D-Y-)	Part of body Injured		Type of Injury (i.e. Strain, Sprain, Fatality etc.)	
Does this employee speak English? If No, specify Language			Cause of Injury (Fall, Tool, Machine, etc.)			
Mailing address Street or P.O. Box City State Zip County			How & Why the Injury/Illness Occurred			
Marital Status? Married Widowed Separated Single Divorced			Address of Location where Injury or Exposure Occurred. Mailing address Street or P.O. Box City State Zip County			
Number of dependant Children		Spouses Name		Worksite Location (IE. Stairs, Dock etc...)		
Injured Taken to:		Phone Number		Name of any witnesses		
Doctor's Mailing Address City State Zip			Was the employee doing his regular job at the time of Injury/Exposure?			
			Supervisor's Name and phone #			

Personnel Information

Date of Hire (M-D-Y)	Was employee hired or recruited in Texas	Length of service in current position Years Months	Length of service in occupation Years Months
Occupation of Injured Worker	Applicable Classification code From Policy (4 digit code)		

Contact Information

Name & Title of person completing this form		Name of employer (Including DBA)	
Employer mailing address	Phone Number	Business location (if different from mailing address)	
City	State Zip	City	State Zip

X _____
 Signature & Title of person completing this form

Date _____



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EMPLOYEE'S FIRST REPORT OF ACCIDENT/INJURY
ALL ACCIDENTS, NO MATTER HOW SMALL OR SLIGHT MUST BE REPORTED
PLEASE WRITE LEGIBLY
ANSWER ALL QUESTIONS

Name of Employer (including dba) _____ Policy No. _____

_____ Date of Injury

NAME OF INJURED EMPLOYEE _____
 (FIRST NAME) (MIDDLE NAME) (LAST NAME)

TITLE _____ JOB DESCRIPTION _____

HOME ADDRESS _____
 (STREET & HOUSE NUMBER) (CITY) (STATE) (ZIP) (AREA CODE) (PHONE NUMBER)

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____ NAME OF SUPERVISOR _____

WAS MEDICAL ATTENTION RECEIVED? _____ NAME OF DOCTOR OR CLINIC _____

1. WHAT TIME DID INJURY OCCUR? _____ AM/PM (CIRCLE ONE)

2. HOW DID ACCIDENT OCCUR? _____

3. WHAT ACTIVITY WERE YOU DOING WHEN INJURED? _____

4. WHAT PART OF YOUR BODY WAS HURT? _____

5. DESCRIBE THE INJURY. (EXAMPLE: CUT, BRUISES, BROKEN BONE, ETC.) _____

6. WHAT OBJECT OR ITEM DIRECTLY CAUSED THE INJURY? _____

7. HOW MANY DAYS DID YOU MISS FROM WORK, IF ANY? _____ LAST DAY WORKED? _____

8. IF NOT RETURNED TO WORK, HOW LONG DID THE DOCTOR SAY THAT YOU WILL BE OFF WORK? _____

9. HAVE YOU EVER HAD SIMILAR INJURY? _____ IF YES, EXPLAIN & WHEN? _____

10. DID THIS ACCIDENT HAPPEN BECAUSE YOU FAILED TO USE OR WEAR EQUIPMENT PROVIDED TO HELP YOU DO THE TASK SAFELY? YES OR NO (CIRCLE ONE)

11. LIST NAMES OF ALL WITNESSES TO THE ACCIDENT: _____

12. ON THE NEXT PAGE, WRITE YOUR DETAILED DESCRIPTION OF ALL FACTS INVOLVED IN THIS ACCIDENT.



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EMPLOYEE INFORMATION SHEET

The following will explain your responsibilities under the company job injury benefit plan. You must comply with the guidelines of the company plan EXACTLY. Failure to follow these guidelines and directions will result in a delay, denial or stoppage of payment of medical bills and/or job-injury payments that may be provided to you under the company plan.

1. Your employer is a NON-SUBSCRIBER to the Texas Workers' Compensation Act. We do not carry Workers' Compensation Insurance on our employees who work in a Texas facility.
2. Any injury you sustain while directly performing your job duties must be reported immediately to your supervisor or manager. Do not wait until the end of your shift, the end of the day, or tomorrow to report the incident. Immediately means directly following the mishap. Failure to report may void benefits.
3. Following your verbal report to your supervisor, you must complete a written report on the "EMPLOYEE'S FIRST REPORT OF ACCIDENTAL INJURY" form and submit it to your supervisor within 48 HOURS following the mishap. Failure to report may void benefits.
4. Your supervisor/manager and you will make a determination regarding when, and if, a trip to the doctor is necessary. If the incident is a seemingly minor one, you have exercised your reporting duty. Sometimes, injury soreness works itself out with no problem. And, sometimes a minor problem progresses into greater problems.
5. For injuries requiring prompt medical attention, you will be taken to a medical clinic or hospital for treatment. If this initial visit is to a medical provider other than the normal company approved physician, you must go to the approved physician to submit to a urinalysis drug screen and follow-up care. The approved physician will assume control of medical care and management of your injury problems. He/she may refer you to specialists, if deemed advisable. Medical care and treatment by doctors not approved is only acceptable under the company injury benefit plan for emergency treatment immediately following an injury to stabilize your condition, relieve pain, or stop bleeding.

6. You must remain cooperative in investigating and documenting the injury incident. Unless the injury causes serious physical incapacity, you shall return to your supervisor and assist him/her in fulfilling obligations to complete various forms. The "Employee's First Report of Accident Injury" is for you to list information concerning yourself, and to express your thoughts and views regarding the injury incident. The other forms are required documents that your supervisor must complete following each injury. The supervisor is directed to complete the written investigation and necessary paperwork as soon after the injury as possible. This is designed to aid our collection of information and statistical facts while they are fresh in the minds of those persons having knowledge about your incident. In the event you are not able to return to your supervisor to complete the necessary paperwork, your supervisor will come to your home, hospital room, or work with you at the first available opportunity to accomplish the reporting task.
7. You must follow the doctor's orders and instructions regarding care, treatment, return-to-work and all appointment scheduling.
8. It shall be your responsibility to stay in communication with your supervisor regarding doctor appointments and doctor statements about your condition, including return-to-work (or no-duty) status. Prior to each doctor's visit you shall advise your supervisor of the appointment. Telephone calls are sufficient to advise your supervisor of these scheduled appointments. Following each visit to the doctor you shall let your supervisor know the findings and outcome of the doctor's examination. You must deliver the doctor's written statement slip to your supervisor to keep him/her adequately informed of your condition and situation. Also, the doctor's statement slip will be included in your injury incident file as part of your records. Acceptance of benefits under your employer's Occupational Injury Benefit Program (the Plan) constitutes acceptance of all terms and conditions of that Plan.

Employee Signature _____

Date _____

Signature of translator, if translated



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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request and authorize any physician, hospital or health-care provider who has provided treatment to me to furnish to MIDLANDS CLAIM ADMINISTRATORS, P.O. Box 238808, Oklahoma City, Oklahoma 73123, or its designated representative, any and all information and medical records you have concerning my care and treatment.

The matters to be released pursuant to this authorization include any and all records and information concerning my care and treatment, including but not limited to records of any illness, injury, medical histories, consultations, examinations, prescriptions, diagnoses, tests, reports or treatments, including copies of all hospital records, medical records or doctors' office records in your possession.

The release of the matters listed above is being authorized for purposes of investigation of a work related injury and/or to advise a treating physician (of a work related injury) about medical history issues. Acceptance of benefits under your employer's Occupational Injury Benefit Program (the Plan) constitutes acceptance of all terms and conditions of that Plan.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

Date: _____ Signature: _____

Print Name

The signature of witnesses is not required for the validity of This document, but are to be provided if reasonably available.

Witness to Signature

Witness to Signature



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CALCULATION OF DISABILITY BENEFITS AND INSTRUCTIONS FOR COMPLETING WAGE HISTORY

Start the Wage History form by using the last full pay period before the injury as week one. Use gross pay figures. Complete the remainder of the form going back for a total of seventeen weeks. Add the gross pay figures and divide by seventeen to get the average weekly wage. Multiply the average weekly wage by 75% to calculate the weekly indemnity benefit. This is the amount you will use as a gross pay figure as the benefits are taxable and reportable as income. The maximum weekly indemnity benefit is the amount found on the Employer's Primary Indemnity Coverage Declarations page under section 4. Limits of Coverage and e. Weekly Indemnity.

When filing for reimbursement under the policy, you will need to provide a copy of the check paying the employee's disability wages as well as a copy of the off work slip from the doctor. Provide a copy of the completed Wage History with the first submission for reimbursement and the Employer's Report of Disability/Request for Wage Benefits Reimbursement covering the pay period involved.

These are guidelines based on the reimbursement provided by your policy. You will need to check your policy for specifics regarding the elimination period and maximum weekly indemnity benefits.



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WAGE HISTORY

Please use the following form to report salary/wage history for your injured employee.

To complete this wage history form, begin with week 1, using earnings for the week preceding the date of injury and counting back 17 weeks. If the employee has not been employed 17 weeks, use the salary of an employee performing the same or similar function. PLEASE NOTE NAME OF EMPLOYEE, THE APPROPRIATE LOCATION, IF YOU ARE USING A SAME OR SIMILAR EMPLOYEE'S WAGE HISTORY.

EMPLOYER NAMED _____ TODAY'S DATE _____

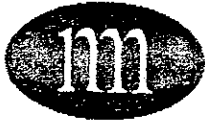
INJURED EMPLOYEE _____ DATE OF INJURY _____

SAME OR SIMILAR EMPLOYEE (name) _____

WEEK	DATE FROM	DATE TO	# DAYS WORKED	TOTAL HOURS	GROSS PAID
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					

TOTAL PAY
DIVIDED BY 17 WEEKS = _____

AVERAGE WEEKLY WAGE
=====



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EMPLOYER'S REPORT OF DISABILITY REQUEST FOR WAGE BENEFIT REIMBURSEMENT

Employee

Name of injured employee	Sex M F	Date of Injury	Date Lost Time Began
Social Security #	Home Phone ()		

Employer

Employer	Policy #	Claim #
Employer's mailing address	City	State Zip

Reporting Period

This report Covers	Has employee returned to work	Estimated return to work date
From To	Y N	

COPIES OF PAYROLL CHECKS MUST BE ATTACHED
AS WELL AS DISABILITY CERTIFICATION FROM A
HEALTHCARE PROVIDER.

Additional Comments:

X _____
Signature and title of person completing form

Date _____



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EMPLEADO HOJA DE LA INFORMACIÓN

La voluntad siguiente explica sus responsabilidades debajo de plan de ventaja de lesión del trabajo de la compañía. Usted debe conformarse con las pautas del plan de la compañía EXACTAMENTE. La falta de seguir estas pautas y direcciones da lugar a retrasa, la negación o la parada del pago de cuentas médicas y/o pagos de trabajo-lesio'n que se pueden proporcionarle bajo plan de la compañía.

1. Su el patrón es un NON-SUBSCRIBER al acto de la remuneración de los trabajadores de Tejas. No lleve el seguro de la remuneración de los trabajadores en nuestros empleados que trabajen en un Tejas facilidad.
2. Cualesquiera lesión que usted sostiene mientras que directamente la ejecución de sus deberes del trabajo debe ser divulgada inmediatamente a su supervisor o encargado. No espere hasta el final de su cambie de puesto, el final del día, o divulgar mañana el incidente. Inmediatamente medios que siguen directamente la desgracia. La falta de divulgar puede anular ventajas.
3. Siguiendo su informe verbal a su supervisor, usted debe terminar un informe escrito encendido el PRIMER INFORME "del EMPLEADO la forma de LESIÓN de ACCIDENTAL" y la somete a su supervisor que sigue cuanto antes la desgracia. La falta de divulgar puede ventajas vacías.
4. Su supervisor/manager y usted harán una determinación en relación con a cuando, y si, un viaje al doctor es necesario. Si el incidente es a el aparentemente de menor importancia, usted ha ejercitado su deber de divulgación. A veces, lesión el dolor se trabaja hacia fuera sin problema. Y, a veces un problema de menor importancia progresa en mayores problemas.
5. Para lesiones que requieren la atención médica pronto, le llevarán a a clínica u hospital médica para el tratamiento. Si esta visita inicial está a a abastecedor médico con excepción del médico aprobado compañía normal, usted debe ir al médico aprobado a someter a una pantalla y a una carta recordativa de la droga del urinalysis cuidado. El médico aprobado asumirá control de la asistencia médica y gerencia de sus problemas de lesión. He/she puede referirle a los especialistas, si juzgado recomendable. La asistencia médica y el tratamiento de los doctores no aprobados está solamente aceptable bajo plan de ventaja de lesión de la compañía para el tratamiento de la emergencia inmediatamente después de lesión para estabilizar su condición, releve el dolor, o pare el sangrar.

6. Usted debe seguir siendo cooperativo en investigar y la documentación de lesión incidente. A menos que lesión cause incapacidad física seria, usted vuelva a su supervisor y asista a him/her en obligaciones satisficentes a llene el formulario varios.El primer informe "del empleado de lesión del accidente" es para usted para enumerar la información referente a se, y para expresar sus pensamientos y opiniones con respecto al incidente de lesión.Se requieren las otras formas documentos que su supervisor debe terminar el siguiente de cada lesión. ordenan al supervisor terminar la investigación escrita y necesario papeleo tan pronto después de lesión como sea posible.Esto se diseña para ayudar nuestra colección de información y hechos estadísticos mientras que están frescos en mentes de esas personas que tienen conocimiento sobre su incidente.En el acontecimiento usted no pueda volver a su supervisor para terminar el papeleo necesario, su supervisor vendrá a su hogar, sitio del hospital, o trabajo con usted en primera oportunidad disponible de lograr la tarea de divulgación.
7. Usted debe seguir las pedidos y las instrucciones del doctor con respecto a cuidado, el tratamiento, volver-a-trabaja y todo el programar de la cita.
8. Será su responsabilidad permanecer en la comunicación con su supervisor con respecto citas del doctor y a declaraciones del doctor sobre su la condición, incluyendo volver-a-trabaja (o ninguno-deber) estado.Antes de cada uno la visita del doctor usted aconsejará a su supervisor de la cita.Teléfono las llamadas son suficientes aconsejar a su supervisor de éstos programar citas.Después de cada visita al doctor usted dejará a su supervisor sepa los resultados y el resultado de la examinación del doctor.Usted debe entregar el resbalón escrito de la declaración del doctor a su supervisor a la subsistencia him/her informado adecuadamente su condición y situación.También, el doctor el resbalón de la declaración será incluido en su archivo del incidente de lesión como parte de su expedientes. Aceptación de ventajas bajo su lesión ocupacional de los employer's El programa de ventaja (el plan) constituye la aceptación de todos los términos y condiciones de ese plan.

Observe por favor la advertencia del fraude debajo:

"es un crimen para proporcionar falso o información engañosa a un asegurador con el fin de defraudar el asegurador o cualquier otra persona. Las penas incluyen el encarcelamiento y/o multas. Además, un asegurador puede negar ventajas de seguro si información falsa relacionado materialmente con una demanda fue proporcionado por el aspirante."

Empleado de la firma _____

Fecha _____

Firma del traductor, si está traducido _____



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AUTORIZACIÓN PARA EL LANZAMIENTO DE EXPEDIENTES MÉDICOS

Solicito y autorizo por este medio a cualquier médico, hospital o abastecedor del salud-cuidado que me ha proporcionado el tratamiento para equipar a MIDLANDS CLAIM ADMINISTRATORS, P.O. Box 238808, Oklahoma City, Oklahoma 73123, o su representante señalado, y toda la información y expedientes médicos que usted tiene respecto a mi cuidado y tratamiento.

Las materias que se lanzarán conforme a esta autorización incluya cualesquiera y todos los expedientes e información referente mi cuidado y tratamiento, incluyendo pero no limitado a los expedientes de cualquier enfermedad, lesión, historiales médicos, consultas, exámenes, prescripciones, diagnósticos, pruebas, informes o tratamientos, incluyendo las copias de todos los expedientes del hospital, expedientes médicos o expedientes de la oficina de los doctores en su posesión.

El lanzamiento de las materias enumeradas arriba está autorizado para los propósitos de la investigación de un trabajo relacionado lesión y/o con un médico que trata (de lesión relacionada del trabajo) sobre historial médico ediciones. Aceptación de ventajas bajo su lesión ocupacional de los employer's El programa de ventaja (el plan) constituye la aceptación de todos los términos y condiciones de ese plan.

Una copia de esta autorización es acordado por el infrascrito tener el mismo efecto y fuerza que una original.

Fecha: _____

Firma: _____

Nombre De la Impresión

La firma de testigos no se requiere para la validez de este documento, pero debe ser proporcionado si razonablemente disponible.

Testigo a la firma

Testigo a la firma