Need to file a Workers' Compensation claim?

We make the process easy and stress free.

At Great American, we understand that filing a claim can be stressful. That's why we give you multiple ways to report your claim.

Before reporting your claim, please have ready:

- Your policy number
- Complete and accurate information regarding the claim.

Report Online

To use the app, you will first need to register on the Great American Insured Portal

https://insuredportal.gaig.com

1. **Click the Request Access link**
2. **Complete the Policyholder Registration form**
3. **Confirm the Insured Portal system generated "Identity Verification" email**

Preregistration Required

Call our reporting center

877-836-1555

We support employers' return to work plans, and make every effort to assist you with yours. Please report a claim as soon as you are aware of it. We are available 24 hours a day, seven days a week!

Thank you for choosing Great American Insurance Group!

Great American Insurance Group, 301 E. Fourth St., Cincinnati, OH 45202. Policies are underwritten by Great American Insurance Company, Great American Assurance Company, Great American Alliance Insurance Company, Great American Insurance Company of New York, Great American Security Insurance Company and Great American Spirit Insurance Company, authorized insurers in all 50 states and DC. The Great American Insurance Group eagle logo and the word marks Great American® and Great American Insurance Group® are registered service marks of Great American Insurance Company. © 2020 Great American Insurance Company. All rights reserved. 4642-ALT-1 (5/20)

Accident Information:

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

Employee Information:

- Name, physical home address, county, and home phone
- Date of birth, Social Security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

Medical Provider Information:

- Name of clinic/doctor's office where employee was treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

After you report a claim, the Claim Reporting Center:

- Assigns your claim to an Alternative Markets Claim professional who will contact you and your employee to acknowledge the claim and initiate the process.
- Provides you with a copy of the First Report of Injury.
- Sends this report directly to the state either by mail or electronic submission, based on your state's requirements.

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

REPORT OF INJURY

P.O. Box 58
Jefferson City, MO 65102-0058

(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*	CARRIER ADMINISTRATOR CLAIM NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER
	INSURED REPORT NUMBER	
	EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)*	LOCATION #
SIC CODE / EMPLOYER FEIN		PHONE #

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*	POLICY PERIOD ___ to ___	CLAIMS ADMINISTRATOR *(NAME, ADDRESS & PHONE NO.)*
	CHECK IF APPROPRIATE ☐ SELF INSURANCE	
CARRIER FEIN	INSURANCE POLICY NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)*	DATE OF BIRTH	SOCIAL SECURITY #	DATE HIRED	STATE OF HIRE
ADDRESS *(INCLUDE ZIP)*	SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS ☐ UNMARRIED SINGLE DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION JOB TITLE	
			EMPLOYMENT STATUS	
PHONE #	# OF DEPENDENTS		NCCI CLASS CODE	

WAGE

RATE PER ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER	# OF DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME PHONE NUMBER	TYPE OF INJURY ILLNESS	PART OF BODY AFFECTED
DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.	CAUSE OF INJURY CODE

DATE RETURN TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

TREAT-MENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*	HOSPITAL *(NAME & ADDRESS)*	INITIAL TREATMENT ☐ 0 - NO MEDICAL TREATMENT ☐ 1 – MINOR: BY EMPLOYER ☐ 2 – MINOR CLINIC HOSPITAL ☐ 3 – EMERGENCY CASE ☐ 4 – HOSPITALIZED > 24 HOURS ☐ 5 – FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

NOTE: This form constitutes the detailed report of injury required by §287.380, RSMo, and rules applicable thereto. An injury that requires immediate first aid, but does not result in further medical treatment or lost time from work, need not be reported to the Division. Employers should report all injuries to their workers' compensation insurance carrier or third-party administrator (TPA) within five days of the date of the injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. See §287.380, RSMo. If the employer has been granted self-insurance authority by the Division pursuant to §287.280, RSMo, and rules applicable thereto, please report all injuries to your TPA or Service Company to enable them to file this report with the Division.

PRINT QUALITY: All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division MUST be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

Data Element Dictionary for Hard Copy Report of Injury

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Employer (Name & Address)	The name of the employer where the employee was employed at the time of the injury.	This is the name the employer does business under followed by the FULL address including mailing address, city, state and zip code.	M
Industry Code	The code which represents the nature of the employer's business which is contained in the North American Industry Classification System Manual published by the Federal Office of Management and Budget. See implementation note below: The industry code selected should represent the primary nature of the employer's business. If the employer is assigned multiple industry codes, use the code that relates to the specific business operation for which the employee was employed at the time of the injury. The data element may contain an SIC code or NAICS Code. SIC code will be identified with the characters 'SC' as the last two characters of the data element. If SC is not present, the code is presumed to be NAICS.	This is the Standard Industrial Classification Code for the employer. SIC/NAICS codes can be found at www.census.gov/epcd/www/naics.html	M
Employer FEIN	The FEIN of the employer where the employee was employed at the time of the injury.	Must be the primary FEIN for the Employer listed above.	M
Report Purpose Code (RPC)	Defines the specific purpose of the report being filed with the state of Missouri. 00 = Original FROI 02=Change CO=Correction AQ=Acquired Report of Injury AU=Acquired Unallocated Report of Injury	The Report of Injury that the employer is required to file with the Division of Workers' Compensation (Division) through the insurance carrier or third party administrator (TPA).	M
Claims Administrator's Number	Identifies a specific claim within a claim administrator's claims processing system.	Number used by the organization adjusting the claim (insurance company, third party administrator, etc.).	M
Jurisdiction	The governing body or territory whose statute applies.	This must always be Missouri.	M
Jurisdiction Claim Number		The injury number assigned by the Division upon receipt of the First Report of Injury with all mandatory information provided. The reporting entity is to leave this field blank.	

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Insured Report Number	A number used by the insured to identify a specific claim.		O
Employer's Location Address	List the physical address of where the employee sustained the accident or illness if that location is different from where the employer wishes to have correspondence sent.		O
Insured Location Number	A code defined by the insurer/employer, which is used to identify the employer's location of the accident.		O
Phone Number	List a phone number of the employer location where the employee worked at the time of the accident.		O
Carrier (insurer) Name & Address	The name and mailing address of the carrier or self-insured entity assuming the employer's financial responsibility for the workers' compensation claim.	If the employer is **individually** self-insured, the **individual** self-insured employer's name and mailing address would be indicated in this field. The FEIN and Name must match. **If the employer is self-insured by a trust, the trust's name would be submitted in this field.**	M
Carrier (insurer) FEIN Number	The FEIN of the carrier or self-insured assuming the employer's financial responsibility for the workers' compensation claim(s).		M
Carrier Policy Number	The number assigned to the contract/policy for the employer or association group.	A number assigned by the **insurance company, *(Not a number assigned by a TPA)*** for the specific workers' compensation policy for that employer. Not a required field for Division approved self-insureds.	M
Policy Period	List the effective and expiration dates of the contract/policy.	The date that the policy became effective and the date the policy expires or is no longer in effect. No date is required in this field if the injury falls within the Division approved self-insurer's self-insurance period.	M
Self-Insured Indicator	An indicator that identifies the employer as one who is authorized by the state of Missouri to retain the risks arising from their operations and bears the financial responsibility. Y=Yes, N=No	Condition – Must indicate Y(Yes) ONLY for an individual employer or a member of a self-insured trust authorized by the Missouri Division of Workers' Compensation to self-insure under § 287.280, RSMo. It does not include uninsured employers or employers under deductible insurance policies.	C
Claim Administrator (TPA) Name & Address	The name and mailing address of the Third Party Administrator (TPA), independent administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	Name and mailing address of the Third Party Administrator (TPA), independent adjuster, contracted to adjust the claim and phone number of the office adjusting the claim. If there is not a TPA, independent adjuster/administrator, contracted to adjust the claim please leave blank.	C

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Claim Administrator (TPA) FEIN Number	The FEIN of the Third Party Administrator (TPA), independent adjuster/administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	FEIN number for the company hired as a TPA. Note: If there is no Third Party Administrator, please leave blank.	C
Agent Name & Code Number	List the name and code number of the carrier or claim administrator agent who administers the workers' compensation claims for the employer.		O
Employee Name	The injured worker's legally recognized name which is used on legal documents, employment, Social Security, banking, records, etc.	Name to include last, first and middle initial.	M
Employee Date of Birth	The date the injured worker was born.	Must be a valid date.	M
Social Security Number	A number assigned by the Social Security Administration used to identify the employee.	If a SSN is not available please call 573-526-3542.	M
Date of Hire	The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.	Must be valid date.	O
State of Hire	List the state where the employer hired the employee.		O
Employee Address	The mailing address used by the injured worker.	The address should not be listed as unknown. Please include the last known address provided by the injured worker that is on file with the employer.	M
Employee Phone	A telephone number where the injured worker can be reached.	This is an optional field, although if the employer or insurance company has this information, **please** report it to the Division. This will improve communication between the parties. This will be a numeric field only *5736367777.*	O
Gender Code	The code which indicates the sex of the employee. Gender of employee F=Female M=Male U=Unknown		M
Number of Dependents	The number of dependents as defined by the administrating jurisdiction.	Spouse, minor children or others if known. Required if date of death is entered. Numeric field 0-9.	C
Marital Status Code	The code, which indicates the marital status of the employee. U = Widowed, divorced, single, unmarried, M = Married, S = Separated, K = Unknown		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Occupational/ Job Title or Description	Identifies the primary occupation of the employee at the time of the accident or injurious exposure.		O
Employment Status Code	Indicate the employee's primary work code status at the time of the injury with the covered employer.		O
NCCI Class Code	A code, which, corresponds to the primary occupation in which the employee was engaged at the time of the accident/injury or injurious exposure.	MO uses NCCI codes.	M
Wage	The reported employee's pre-injury wage for the wage period. Implementation Note: This amount may include commission, piecework earnings, and other forms of income converted to a normal scheduled work week, plus the estimated value of lodging, food, laundry and other payments in kind; and concurrent employment earnings, as prejurisdictional requirement.	"Gross Wages" includes, in addition to money paid by the employer for services rendered by the employee, the reasonable value of board, rent, housing, lodging or similar advance by the employer, except if it continues to be provided to the employee for the period of disability, it is not included in calculating the average weekly wage. "Wages" also includes gratuity received in the course of employment from individuals other than the employer that are reported for income tax purposes. "Wages" does not include fringe benefits such as retirement, pension, health and welfare, life insurance, training, Social Security or other employee or dependent benefit plan provided by the employer. **Please See Special Notes #1**	M
Wage Period	A code indicating the time period during which the wage was earned.	Please use the weekly wage rate paid to the employee.	M
Number of Days Worked	The number of the employee's regularly scheduled workdays per week.		O
Full Wages Paid for the Date of Injury Indicator	Indicates whether full wages for the date of the accident/injury or illness were paid by the employer.		O
Salary Continued Indicator	The employer has paid or is paying the employee's salary in lieu of compensation during an absence caused by a work-related injury.	Did the employer continue to pay salary to the employee after the injury? N=No Y=Yes	O
Time Employee Began Work	Time at which the employee began work on the day of the accident/injury or illness.		O
Date of Injury/Illness	For traumatic injury, the date on which the accident occurred. For occupational disease or cumulative injury, the date of injury is the date of last injurious exposure to the cause or substance creating the condition, unless otherwise defined by statute.	Date that injury/illness occurred or became known to employee; whichever is later.	M

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Time of Occurrence	The time at which the accident occurred.	To the extent that the time of the occurrence of the accident/injury is available, you should provide it to the Division. Please indicate a.m. or p.m.	O
Date Last Day Worked	The last paid workday prior to the initial date of disability as defined by jurisdiction.	Must be valid date.	O
Date Employer Notified	The date that the injury was reported to a representative of the employer.		M
Date Disability Began	The first day on which the employee originally lost time from work due to the occupational injury or disease or as otherwise defined by jurisdiction.	**Date of disability must be greater than Date of Injury.** First date employee starts losing time from work after the date of injury. This is the day after the date of injury or the first day of work missed, if later. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days. **Please See Special Notes #2**	C
Contact Name & Phone Number	List the name and phone number for a representative of the employer.		C
Type of Injury/Illness	List the type of injury/illness sustained by the employee.		O
Part of Body Affected	List the part of body to which the employee sustained injury.		O
Employer Premises Indicator	An indicator to denote whether the accident occurred at the employer's address provided.	If the injury/illness occurred on the employer's property indicate "YES." If it occurred elsewhere indicate "NO."	M
Type of Injury/Illness Code	The code, which corresponds to the nature of the injury sustained by the employee.	Choose from the list of code numbers, which corresponds with the nature of the injury. A list of codes with description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx **Please See Special Notes #2**	M
Part of Body Affected Code	The code, which corresponds to the part of the body to which the employee sustained injury.	Choose from the list of code numbers, which corresponds with the part of body injured. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx	M

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Zip Code of the Location Where Accident or Illness Exposure Occurred	The zip (postal code) that corresponds to the location where the injury occurred.	The code is required to assist with docket setting if needed.	M
All Equipment Using	List all the equipment; materials or chemicals the employee was using at the time of the accident/injury or illness exposure occurred.		O
Specific Activity Engaged In	Describe the specific activity that the employee was doing at the time the accident/injury or illness exposure occurred.		O
Work Process Engaged In	Describe the work process the employee was doing when the accident/injury or illness exposure occurred.		O
How the Injury or Illness Occurred	A free form description of how the accident occurred and the resulting injuries.	Describe how the injury/illness occurred. Please include the events that led to the injury/illness and any objects or substances that directly injured the employee or made the employee ill. Maximum of 150 characters, including spaces. *For example: Employee was on ladder putting away product, fell on chemical barrel breaking lower arm; arm lacerations; exposed to chemical liquid and fumes (141 characters).*	M
Cause of Injury Code	The code which corresponds to the cause of injury.	Choose from the list of code numbers, which corresponds with the cause of the injury. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx (Struck by, fell, auto accident, exposure, etc.)	M
Date Returned to Work	The first date on which the employee returned to work following the injury.	Must be a valid date. Must be entered if employee lost days of work and returned to work before first report of injury is filed.	C
Employee Date of Death	The date the injured worker died.	Must be a valid date.	C
Safeguards	Indicate whether safeguards or safety equipment was provided by checking "Yes" or "No."		O
Were They Used	Indicate whether the safeguards or safety equipment was used by the employee by checking "Yes" or "No."		O
Physician/Health Care Provider	List the name and address of the physician or health care provider who provided initial medical treatment to the injured employee after the accident/injury or illness.		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Hospital	List the name and address of the hospital where the employee received initial medical treatment.		O
Initial Treatment	A code used to identify the extent of medical treatment received by the employee immediately following the accident. 0= No medical treatment 1= Minor on-site remedies by employer medical staff 2= Minor clinic/hospital medical remedies and diagnostic testing 3= Emergency evaluation, diagnostic testing, and medical procedures 4= Hospitalization > 24 hours 5= Future major medical/lost time anticipated	First Aid includes the administration of immediate and temporary medical aid to the employee that a lay person may provide, such as the application of Band-Aid to treat a minor scratch or the removal of a splinter that would not result in the need for a referral to a doctor or other health care professional for additional medical treatment or would not result in further lost-time from work. The on-site company nurse or physician may be the individual that provides the first aid. If the company nurse or physician provides service beyond first aid, then the injury must be reported even if the treatment occurs on-site. **Please see Special Notes #2**	M
Witness	List the name and address of all witnesses who were present when the employee sustained the accident/injury or illness.		O
Date Reported to Claims Administrator	The date the claim administrator who is processing the claim received notice of the loss or occurrence.		M
Date Prepared	List the date that the representative for the claims administrator prepared this report of injury.		O
Preparer's Name and Title	List the name and title of the claims administrator's representative who prepared this report of injury.		C
Phone Number	List the phone number of the representative preparing this report of injury.		C

M – Mandatory – Cases missing mandatory information will NOT be accepted by the Missouri Division of Workers' Compensation system.

C – Conditional – Data Elements with Conditional fields indicate a value is required based on another Data Element or pre-existing condition.

Examples: When a death case is reported then the death date would be required.
If the employee has returned to work prior to the report being filed, the date of return to work would be entered.

O – Optional – Data Elements identified as Optional may be entered but are not required.

Special Notes

1) Wage Instructions

A) Missouri Notes: Report the wage information as the average weekly wage (AWW) of the employee. These rules apply for calculating the average weekly wage.

1) If the employee's wage is fixed by the year, the AWW is the yearly wage divided by 52;

2) If the employee's wage is fixed by the month, the AWW is the monthly wage multiplied by 12 and divided by 52;

3) If the employee's wage is fixed by the week, that amount is the AWW;

4) If the employee's wages are fixed by the day, hour or output, the numerator is the actual gross wages earned by the employee in the last thirteen calendar weeks immediately preceding the week in which the injury occurred; and the denominator is 13 to calculate the AWW.

i) The formula is: Actual gross wages earned in prior 13 weeks/13=AWW. *For example, the employee's hourly wage is $9.00/hour. The overtime rate is $13.50/hour. The employee works 40 hours per week at $9.00 an hour plus occasional overtime. Employee worked overtime of 44 hours in the 13-week period immediately preceding the week of the injury. The employer has employed the employee for 2 years.*

The gross wages are $9.00 X 40 hours X 13 weeks = $4,680. You also need to include the overtime 44 hours. Therefore, $13.50 X 44 hours = $594. The total wages are $4,680 plus $594 = $5,274. The AWW is $5,274/13=$405.69.

ii) If the employee misses nonconsecutive workdays during the 13-week period in multiples of 5 those days shall be subtracted from the denominator. *For example: if the employee misses 5 days, one week is subtracted from 13 and the denominator becomes 12; if the employee misses 10 days, two weeks are subtracted from 13 and the denominator becomes 11; and so on.*

iii) Partial weeks of time missed by the employee do not count to change the denominator. *For example: if the employee misses 4 days, the denominator is 13; if the employee misses 6 days, one week is subtracted from 13 and the denominator becomes 12; and so on.*

iv) If the employee works less than 13 weeks but more than 2 weeks, the AWW is the same formula with the numerator as the gross wages calculated for the number of weeks of employment and the denominator is the number of weeks of employment. *For example, the employee worked for the employer 8 weeks prior to the week of the injury. The employee was paid $9.00 per hour and worked 40 hours per week. The employee worked 13 hours of overtime. The overtime rate is $13.50. The gross wages are $9.00 X 40 hours X 8 weeks plus $13.50 X 13 hours = $3,055.50. The AWW is $3,055.50/8=$381.94.*

5) If the employee works less than two weeks the AWW shall be equivalent to the AWW for the same or similar employment. However, if the employer has agreed to a certain hourly wage, then the hourly wage agreed upon multiplied by the number of weekly hours scheduled shall be the employee's AWW.

B) **When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.**

C) When Initial Treatment Code is reported as equal to 00, 01 or 02, the case will be considered as a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed. When the Initial Treatment Code is reported as equal to 03, 04 or 05, the case will be considered as an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

2) **Initial Treatment Code, Date Disability Began and Date Returned to Work:**

A) When Initial Treatment Code is reported as 00, 01 or 02, the case will be considered a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed.

B) When the Initial Treatment Code is reported as 03, 04 or 05, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

1) When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

C) The following are examples of First Aid treatment:

a) Use of non-prescription medication at non-prescription strength.

b) Cleaning, flushing or soaking wounds on the surface of the skin.

c) Using wound coverings such as bandages, Band-Aids, gauze pads, etc. or using butterfly bandages or Steri-Strips. (Other wound closing devises such as sutures, staples, glues, etc. are considered medical treatment.)

d) Use of any non-rigid means of support such as an elastic bandage, wrap, or non-rigid belt. (The use of devices with rigid stays or other systems designed to immobilize body parts is considered medical treatment.)

e) Use of temporary immobilization devices (e.g., splints, slings, neck collars, etc.) while transporting an accident victim.

f) Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs, or other simple means.

g) Use of finger guards.

h) Drinking of fluids for relief of heat stress.

3) **Mesothelioma Liability: Several changes to the Workers' Compensation Law went into effect January 1, 2014. Pursuant to §287.200.4, RSMo, employers may elect to accept mesothelioma liability in one of the following ways:**

a. Insuring their liability by purchasing a workers' compensation policy;

b. Meeting the requirements of the Division of Workers' Compensation to qualify as a self-insurer;

c. Joining a Group Insurance Pool that complies with §287.223. (An employer may become a member of the Missouri Mesothelioma Risk Management Fund);

d. Rejecting *mesothelioma* liability under the Missouri Workers' Compensation Law.

Please note that if an employer has rejected *mesothelioma* liability coverage under the Workers' Compensation Law, the exclusive remedy provision of the Workers' Compensation Law, §287.120, RSMo, does not apply.

4) **Occupational diseases:** Occupational diseases due to toxic exposure have been defined effective January 1, 2014. The "occupational diseases due to toxic exposure" includes the following: asbestosis, berylliosis, coal worker's pneumoconiosis, bronchiolitis obliterans, silicosis, silicotuberculosis, manganism, acute myelogenous leukemia and myelodysplastic syndrome. The reporting requirements relating to other occupational diseases such as carpal tunnel syndrome, etc. remains the same.

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

REPORT OF INJURY

P.O. Box 58
Jefferson City, MO 65102-0058

(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*	CARRIER ADMINISTRATOR CLAIM NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER
	INSURED REPORT NUMBER	
	EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)*	LOCATION #
SIC CODE / EMPLOYER FEIN		PHONE #

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*	POLICY PERIOD to	CLAIMS ADMINISTRATOR *(NAME, ADDRESS & PHONE NO.)*
	CHECK IF APPROPRIATE ☐ SELF INSURANCE	
CARRIER FEIN	INSURANCE POLICY NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)*	DATE OF BIRTH	SOCIAL SECURITY #	DATE HIRED	STATE OF HIRE
ADDRESS *(INCLUDE ZIP)*	SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS ☐ UNMARRIED SINGLE DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION JOB TITLE	
			EMPLOYMENT STATUS	
PHONE #	# OF DEPENDENTS		NCCI CLASS CODE	

WAGE

RATE PER ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER	# OF DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME PHONE NUMBER	TYPE OF INJURY ILLNESS	PART OF BODY AFFECTED
DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.	CAUSE OF INJURY CODE

DATE RETURN TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*	HOSPITAL *(NAME & ADDRESS)*	INITIAL TREATMENT ☐ 0 - NO MEDICAL TREATMENT ☐ 1 – MINOR: BY EMPLOYER ☐ 2 – MINOR CLINIC HOSPITAL ☐ 3 – EMERGENCY CASE ☐ 4 – HOSPITALIZED > 24 HOURS ☐ 5 – FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

NOTE: This form constitutes the detailed report of injury required by §287.380, RSMo, and rules applicable thereto. An injury that requires immediate first aid, but does not result in further medical treatment or lost time from work, need not be reported to the Division. Employers should report all injuries to their workers' compensation insurance carrier or third-party administrator (TPA) within five days of the date of the injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. See §287.380, RSMo. If the employer has been granted self-insurance authority by the Division pursuant to §287.280, RSMo, and rules applicable thereto, please report all injuries to your TPA or Service Company to enable them to file this report with the Division.

PRINT QUALITY: All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division MUST be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

Data Element Dictionary for Hard Copy Report of Injury

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Employer (Name & Address)	The name of the employer where the employee was employed at the time of the injury.	This is the name the employer does business under followed by the FULL address including mailing address, city, state and zip code.	M
Industry Code	The code which represents the nature of the employer's business which is contained in the North American Industry Classification System Manual published by the Federal Office of Management and Budget. See implementation note below: The industry code selected should represent the primary nature of the employer's business. If the employer is assigned multiple industry codes, use the code that relates to the specific business operation for which the employee was employed at the time of the injury. The data element may contain an SIC code or NAICS Code. SIC code will be identified with the characters 'SC' as the last two characters of the data element. If SC is not present, the code is presumed to be NAICS.	This is the Standard Industrial Classification Code for the employer. SIC/NAICS codes can be found at www.census.gov/epcd/www/naics.html	M
Employer FEIN	The FEIN of the employer where the employee was employed at the time of the injury.	Must be the primary FEIN for the Employer listed above.	M
Report Purpose Code (RPC)	Defines the specific purpose of the report being filed with the state of Missouri. 00 = Original FROI 02=Change CO=Correction AQ=Acquired Report of Injury AU=Acquired Unallocated Report of Injury	The Report of Injury that the employer is required to file with the Division of Workers' Compensation (Division) through the insurance carrier or third party administrator (TPA).	M
Claims Administrator's Number	Identifies a specific claim within a claim administrator's claims processing system.	Number used by the organization adjusting the claim (insurance company, third party administrator, etc.).	M
Jurisdiction	The governing body or territory whose statute applies.	This must always be Missouri.	M
Jurisdiction Claim Number		The injury number assigned by the Division upon receipt of the First Report of Injury with all mandatory information provided. The reporting entity is to leave this field blank.	

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Insured Report Number	A number used by the insured to identify a specific claim.		O
Employer's Location Address	List the physical address of where the employee sustained the accident or illness if that location is different from where the employer wishes to have correspondence sent.		O
Insured Location Number	A code defined by the insurer/employer, which is used to identify the employer's location of the accident.		O
Phone Number	List a phone number of the employer location where the employee worked at the time of the accident.		O
Carrier (insurer) Name & Address	The name and mailing address of the carrier or self-insured entity assuming the employer's financial responsibility for the workers' compensation claim.	If the employer is **individually** self-insured, the **individual** self-insured employer's name and mailing address would be indicated in this field. The FEIN and Name must match. **If the employer is self-insured by a trust, the trust's name would be submitted in this field.**	M
Carrier (insurer) FEIN Number	The FEIN of the carrier or self-insured assuming the employer's financial responsibility for the workers' compensation claim(s).		M
Carrier Policy Number	The number assigned to the contract/policy for the employer or association group.	A number assigned by the **insurance company, *(Not a number assigned by a TPA)*** for the specific workers' compensation policy for that employer. Not a required field for Division approved self-insureds.	M
Policy Period	List the effective and expiration dates of the contract/policy.	The date that the policy became effective and the date the policy expires or is no longer in effect. No date is required in this field if the injury falls within the Division approved self-insurer's self-insurance period.	M
Self-Insured Indicator	An indicator that identifies the employer as one who is authorized by the state of Missouri to retain the risks arising from their operations and bears the financial responsibility. Y=Yes, N=No	Condition – Must indicate Y(Yes) ONLY for an individual employer or a member of a self-insured trust authorized by the Missouri Division of Workers' Compensation to self-insure under § 287.280, RSMo. It does not include uninsured employers or employers under deductible insurance policies.	C
Claim Administrator (TPA) Name & Address	The name and mailing address of the Third Party Administrator (TPA), independent administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	Name and mailing address of the Third Party Administrator (TPA), independent adjuster, contracted to adjust the claim and phone number of the office adjusting the claim. If there is not a TPA, independent adjuster/administrator, contracted to adjust the claim please leave blank.	C

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Claim Administrator (TPA) FEIN Number	The FEIN of the Third Party Administrator (TPA), independent adjuster/administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	FEIN number for the company hired as a TPA. Note: If there is no Third Party Administrator, please leave blank.	C
Agent Name & Code Number	List the name and code number of the carrier or claim administrator agent who administers the workers' compensation claims for the employer.		O
Employee Name	The injured worker's legally recognized name which is used on legal documents, employment, Social Security, banking, records, etc.	Name to include last, first and middle initial.	M
Employee Date of Birth	The date the injured worker was born.	Must be a valid date.	M
Social Security Number	A number assigned by the Social Security Administration used to identify the employee.	If a SSN is not available please call 573-526-3542.	M
Date of Hire	The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.	Must be valid date.	O
State of Hire	List the state where the employer hired the employee.		O
Employee Address	The mailing address used by the injured worker.	The address should not be listed as unknown. Please include the last known address provided by the injured worker that is on file with the employer.	M
Employee Phone	A telephone number where the injured worker can be reached.	This is an optional field, although if the employer or insurance company has this information, **please** report it to the Division. This will improve communication between the parties. This will be a numeric field only *5736367777.*	O
Gender Code	The code which indicates the sex of the employee. Gender of employee F=Female M=Male U=Unknown		M
Number of Dependents	The number of dependents as defined by the administrating jurisdiction.	Spouse, minor children or others if known. Required if date of death is entered. Numeric field 0-9.	C
Marital Status Code	The code, which indicates the marital status of the employee. U = Widowed, divorced, single, unmarried, M = Married, S = Separated, K = Unknown		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Occupational/ Job Title or Description	Identifies the primary occupation of the employee at the time of the accident or injurious exposure.		O
Employment Status Code	Indicate the employee's primary work code status at the time of the injury with the covered employer.		O
NCCI Class Code	A code, which, corresponds to the primary occupation in which the employee was engaged at the time of the accident/injury or injurious exposure.	MO uses NCCI codes.	M
Wage	The reported employee's pre-injury wage for the wage period. Implementation Note: This amount may include commission, piecework earnings, and other forms of income converted to a normal scheduled work week, plus the estimated value of lodging, food, laundry and other payments in kind; and concurrent employment earnings, as prejurisdictional requirement.	"Gross Wages" includes, in addition to money paid by the employer for services rendered by the employee, the reasonable value of board, rent, housing, lodging or similar advance by the employer, except if it continues to be provided to the employee for the period of disability, it is not included in calculating the average weekly wage. "Wages" also includes gratuity received in the course of employment from individuals other than the employer that are reported for income tax purposes. "Wages" does not include fringe benefits such as retirement, pension, health and welfare, life insurance, training, Social Security or other employee or dependent benefit plan provided by the employer. **Please See Special Notes #1**	M
Wage Period	A code indicating the time period during which the wage was earned.	Please use the weekly wage rate paid to the employee.	M
Number of Days Worked	The number of the employee's regularly scheduled workdays per week.		O
Full Wages Paid for the Date of Injury Indicator	Indicates whether full wages for the date of the accident/injury or illness were paid by the employer.		O
Salary Continued Indicator	The employer has paid or is paying the employee's salary in lieu of compensation during an absence caused by a work-related injury.	Did the employer continue to pay salary to the employee after the injury? N=No Y=Yes	O
Time Employee Began Work	Time at which the employee began work on the day of the accident/injury or illness.		O
Date of Injury/Illness	For traumatic injury, the date on which the accident occurred. For occupational disease or cumulative injury, the date of injury is the date of last injurious exposure to the cause or substance creating the condition, unless otherwise defined by statute.	Date that injury/illness occurred or became known to employee; whichever is later.	M

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Time of Occurrence	The time at which the accident occurred.	To the extent that the time of the occurrence of the accident/injury is available, you should provide it to the Division. Please indicate a.m. or p.m.	O
Date Last Day Worked	The last paid workday prior to the initial date of disability as defined by jurisdiction.	Must be valid date.	O
Date Employer Notified	The date that the injury was reported to a representative of the employer.		M
Date Disability Began	The first day on which the employee originally lost time from work due to the occupational injury or disease or as otherwise defined by jurisdiction.	**Date of disability must be greater than Date of Injury.** First date employee starts losing time from work after the date of injury. This is the day after the date of injury or the first day of work missed, if later. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days. **Please See Special Notes #2**	C
Contact Name & Phone Number	List the name and phone number for a representative of the employer.		C
Type of Injury/Illness	List the type of injury/illness sustained by the employee.		O
Part of Body Affected	List the part of body to which the employee sustained injury.		O
Employer Premises Indicator	An indicator to denote whether the accident occurred at the employer's address provided.	If the injury/illness occurred on the employer's property indicate "YES." If it occurred elsewhere indicate "NO."	M
Type of Injury/Illness Code	The code, which corresponds to the nature of the injury sustained by the employee.	Choose from the list of code numbers, which corresponds with the nature of the injury. A list of codes with description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx **Please See Special Notes #2**	M
Part of Body Affected Code	The code, which corresponds to the part of the body to which the employee sustained injury.	Choose from the list of code numbers, which corresponds with the part of body injured. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx	M

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Zip Code of the Location Where Accident or Illness Exposure Occurred	The zip (postal code) that corresponds to the location where the injury occurred.	The code is required to assist with docket setting if needed.	M
All Equipment Using	List all the equipment; materials or chemicals the employee was using at the time of the accident/injury or illness exposure occurred.		O
Specific Activity Engaged In	Describe the specific activity that the employee was doing at the time the accident/injury or illness exposure occurred.		O
Work Process Engaged In	Describe the work process the employee was doing when the accident/injury or illness exposure occurred.		O
How the Injury or Illness Occurred	A free form description of how the accident occurred and the resulting injuries.	Describe how the injury/illness occurred. Please include the events that led to the injury/illness and any objects or substances that directly injured the employee or made the employee ill. Maximum of 150 characters, including spaces. *For example: Employee was on ladder putting away product, fell on chemical barrel breaking lower arm; arm lacerations; exposed to chemical liquid and fumes (141 characters).*	M
Cause of Injury Code	The code which corresponds to the cause of injury.	Choose from the list of code numbers, which corresponds with the cause of the injury. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx (Struck by, fell, auto accident, exposure, etc.)	M
Date Returned to Work	The first date on which the employee returned to work following the injury.	Must be a valid date. Must be entered if employee lost days of work and returned to work before first report of injury is filed.	C
Employee Date of Death	The date the injured worker died.	Must be a valid date.	C
Safeguards	Indicate whether safeguards or safety equipment was provided by checking "Yes" or "No."		O
Were They Used	Indicate whether the safeguards or safety equipment was used by the employee by checking "Yes" or "No."		O
Physician/Health Care Provider	List the name and address of the physician or health care provider who provided initial medical treatment to the injured employee after the accident/injury or illness.		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Hospital	List the name and address of the hospital where the employee received initial medical treatment.		O
Initial Treatment	A code used to identify the extent of medical treatment received by the employee immediately following the accident. 0= No medical treatment 1= Minor on-site remedies by employer medical staff 2= Minor clinic/hospital medical remedies and diagnostic testing 3= Emergency evaluation, diagnostic testing, and medical procedures 4= Hospitalization > 24 hours 5= Future major medical/lost time anticipated	First Aid includes the administration of immediate and temporary medical aid to the employee that a lay person may provide, such as the application of Band-Aid to treat a minor scratch or the removal of a splinter that would not result in the need for a referral to a doctor or other health care professional for additional medical treatment or would not result in further lost-time from work. The on-site company nurse or physician may be the individual that provides the first aid. If the company nurse or physician provides service beyond first aid, then the injury must be reported even if the treatment occurs on-site. **Please see Special Notes #2**	M
Witness	List the name and address of all witnesses who were present when the employee sustained the accident/injury or illness.		O
Date Reported to Claims Administrator	The date the claim administrator who is processing the claim received notice of the loss or occurrence.		M
Date Prepared	List the date that the representative for the claims administrator prepared this report of injury.		O
Preparer's Name and Title	List the name and title of the claims administrator's representative who prepared this report of injury.		C
Phone Number	List the phone number of the representative preparing this report of injury.		C

M – Mandatory – Cases missing mandatory information will NOT be accepted by the Missouri Division of Workers' Compensation system.

C – Conditional – Data Elements with Conditional fields indicate a value is required based on another Data Element or pre-existing condition.

Examples: When a death case is reported then the death date would be required.
If the employee has returned to work prior to the report being filed, the date of return to work would be entered.

O – Optional – Data Elements identified as Optional may be entered but are not required.

Special Notes

1) Wage Instructions

A) Missouri Notes: Report the wage information as the average weekly wage (AWW) of the employee. These rules apply for calculating the average weekly wage.

1) If the employee's wage is fixed by the year, the AWW is the yearly wage divided by 52;

2) If the employee's wage is fixed by the month, the AWW is the monthly wage multiplied by 12 and divided by 52;

3) If the employee's wage is fixed by the week, that amount is the AWW;

4) If the employee's wages are fixed by the day, hour or output, the numerator is the actual gross wages earned by the employee in the last thirteen calendar weeks immediately preceding the week in which the injury occurred; and the denominator is 13 to calculate the AWW.

   i) The formula is: Actual gross wages earned in prior 13 weeks/13=AWW. *For example, the employee's hourly wage is $9.00/hour. The overtime rate is $13.50/hour. The employee works 40 hours per week at $9.00 an hour plus occasional overtime. Employee worked overtime of 44 hours in the 13-week period immediately preceding the week of the injury. The employer has employed the employee for 2 years.*

   The gross wages are $9.00 X 40 hours X 13 weeks = $4,680. You also need to include the overtime 44 hours. Therefore, $13.50 X 44 hours = $594. The total wages are $4,680 plus $594 = $5,274. The AWW is $5,274/13=$405.69.

   ii) If the employee misses nonconsecutive workdays during the 13-week period in multiples of 5 those days shall be subtracted from the denominator. *For example: if the employee misses 5 days, one week is subtracted from 13 and the denominator becomes 12; if the employee misses 10 days, two weeks are subtracted from 13 and the denominator becomes 11; and so on.*

   iii) Partial weeks of time missed by the employee do not count to change the denominator. *For example: if the employee misses 4 days, the denominator is 13; if the employee misses 6 days, one week is subtracted from 13 and the denominator becomes 12; and so on.*

   iv) If the employee works less than 13 weeks but more than 2 weeks, the AWW is the same formula with the numerator as the gross wages calculated for the number of weeks of employment and the denominator is the number of weeks of employment. *For example, the employee worked for the employer 8 weeks prior to the week of the injury. The employee was paid $9.00 per hour and worked 40 hours per week. The employee worked 13 hours of overtime. The overtime rate is $13.50. The gross wages are $9.00 X 40 hours X 8 weeks plus $13.50 X 13 hours = $3,055.50. The AWW is $3,055.50/8=$381.94.*

5) If the employee works less than two weeks the AWW shall be equivalent to the AWW for the same or similar employment. However, if the employer has agreed to a certain hourly wage, then the hourly wage agreed upon multiplied by the number of weekly hours scheduled shall be the employee's AWW.

B) **When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.**

C) When Initial Treatment Code is reported as equal to 00, 01 or 02, the case will be considered as a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed. When the Initial Treatment Code is reported as equal to 03, 04 or 05, the case will be considered as an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

2) **Initial Treatment Code, Date Disability Began and Date Returned to Work:**

A) When Initial Treatment Code is reported as 00, 01 or 02, the case will be considered a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed.

B) When the Initial Treatment Code is reported as 03, 04 or 05, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

1) When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

C) The following are examples of First Aid treatment:

a) Use of non-prescription medication at non-prescription strength.

b) Cleaning, flushing or soaking wounds on the surface of the skin.

c) Using wound coverings such as bandages, Band-Aids, gauze pads, etc. or using butterfly bandages or Steri-Strips. (Other wound closing devises such as sutures, staples, glues, etc. are considered medical treatment.)

d) Use of any non-rigid means of support such as an elastic bandage, wrap, or non-rigid belt. (The use of devices with rigid stays or other systems designed to immobilize body parts is considered medical treatment.)

e) Use of temporary immobilization devices (e.g., splints, slings, neck collars, etc.) while transporting an accident victim.

f) Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs, or other simple means.

g) Use of finger guards.

h) Drinking of fluids for relief of heat stress.

3) **Mesothelioma Liability: Several changes to the Workers' Compensation Law went into effect January 1, 2014. Pursuant to §287.200.4, RSMo, employers may elect to accept mesothelioma liability in one of the following ways:**

a. Insuring their liability by purchasing a workers' compensation policy;

b. Meeting the requirements of the Division of Workers' Compensation to qualify as a self-insurer;

c. Joining a Group Insurance Pool that complies with §287.223. (An employer may become a member of the Missouri Mesothelioma Risk Management Fund);

d. Rejecting *mesothelioma* liability under the Missouri Workers' Compensation Law.

Please note that if an employer has rejected *mesothelioma* liability coverage under the Workers' Compensation Law, the exclusive remedy provision of the Workers' Compensation Law, §287.120, RSMo, does not apply.

4) **Occupational diseases:** Occupational diseases due to toxic exposure have been defined effective January 1, 2014. The "occupational diseases due to toxic exposure" includes the following: asbestosis, beryliosis, coal worker's pneumoconiosis, bronchiolitis obliterans, silicosis, silicotuberculosis, manganism, acute myelogenous leukemia and myelodysplastic syndrome. The reporting requirements relating to other occupational diseases such as carpal tunnel syndrome, etc. remains the same.

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

REPORT OF INJURY

P.O. Box 58
Jefferson City, MO 65102-0058

(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*	CARRIER ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)*		LOCATION #
SIC CODE / EMPLOYER FEIN			PHONE #

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*	POLICY PERIOD to	CLAIMS ADMINISTRATOR *(NAME, ADDRESS & PHONE NO.)*
	CHECK IF APPROPRIATE ☐ SELF INSURANCE	

CARRIER FEIN	INSURANCE POLICY NUMBER	ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)*	DATE OF BIRTH	SOCIAL SECURITY #	DATE HIRED	STATE OF HIRE

ADDRESS *(INCLUDE ZIP)*	SEX	MARITAL STATUS	OCCUPATION JOB TITLE
	☐ MALE ☐ FEMALE ☐ UNKNOWN	☐ UNMARRIED SINGLE DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	EMPLOYMENT STATUS
PHONE # / # OF DEPENDENTS			NCCI CLASS CODE

WAGE

RATE PER ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER	# OF DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME PHONE NUMBER	TYPE OF INJURY ILLNESS	PART OF BODY AFFECTED
DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.	CAUSE OF INJURY CODE

DATE RETURN TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

TREAT-MENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*	HOSPITAL *(NAME & ADDRESS)*	INITIAL TREATMENT
		☐ 0 – NO MEDICAL TREATMENT ☐ 1 – MINOR: BY EMPLOYER ☐ 2 – MINOR CLINIC HOSPITAL ☐ 3 – EMERGENCY CASE ☐ 4 – HOSPITALIZED > 24 HOURS ☐ 5 – FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

NOTE: This form constitutes the detailed report of injury required by §287.380, RSMo, and rules applicable thereto. An injury that requires immediate first aid, but does not result in further medical treatment or lost time from work, need not be reported to the Division. Employers should report all injuries to their workers' compensation insurance carrier or third-party administrator (TPA) within five days of the date of the injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. See §287.380, RSMo. If the employer has been granted self-insurance authority by the Division pursuant to §287.280, RSMo, and rules applicable thereto, please report all injuries to your TPA or Service Company to enable them to file this report with the Division.

PRINT QUALITY: All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division MUST be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

Data Element Dictionary for Hard Copy Report of Injury

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Employer (Name & Address)	The name of the employer where the employee was employed at the time of the injury.	This is the name the employer does business under followed by the FULL address including mailing address, city, state and zip code.	M
Industry Code	The code which represents the nature of the employer's business which is contained in the North American Industry Classification System Manual published by the Federal Office of Management and Budget. See implementation note below: The industry code selected should represent the primary nature of the employer's business. If the employer is assigned multiple industry codes, use the code that relates to the specific business operation for which the employee was employed at the time of the injury. The data element may contain an SIC code or NAICS Code. SIC code will be identified with the characters 'SC' as the last two characters of the data element. If SC is not present, the code is presumed to be NAICS.	This is the Standard Industrial Classification Code for the employer. SIC/NAICS codes can be found at www.census.gov/epcd/www/naics.html	M
Employer FEIN	The FEIN of the employer where the employee was employed at the time of the injury.	Must be the primary FEIN for the Employer listed above.	M
Report Purpose Code (RPC)	Defines the specific purpose of the report being filed with the state of Missouri. 00 = Original FROI 02=Change CO=Correction AQ=Acquired Report of Injury AU=Acquired Unallocated Report of Injury	The Report of Injury that the employer is required to file with the Division of Workers' Compensation (Division) through the insurance carrier or third party administrator (TPA).	M
Claims Administrator's Number	Identifies a specific claim within a claim administrator's claims processing system.	Number used by the organization adjusting the claim (insurance company, third party administrator, etc.).	M
Jurisdiction	The governing body or territory whose statute applies.	This must always be Missouri.	M
Jurisdiction Claim Number		The injury number assigned by the Division upon receipt of the First Report of Injury with all mandatory information provided. The reporting entity is to leave this field blank.	

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Insured Report Number	A number used by the insured to identify a specific claim.		O
Employer's Location Address	List the physical address of where the employee sustained the accident or illness if that location is different from where the employer wishes to have correspondence sent.		O
Insured Location Number	A code defined by the insurer/employer, which is used to identify the employer's location of the accident.		O
Phone Number	List a phone number of the employer location where the employee worked at the time of the accident.		O
Carrier (insurer) Name & Address	The name and mailing address of the carrier or self-insured entity assuming the employer's financial responsibility for the workers' compensation claim.	If the employer is **individually** self-insured, the **individual** self-insured employer's name and mailing address would be indicated in this field. The FEIN and Name must match. **If the employer is self-insured by a trust, the trust's name would be submitted in this field.**	M
Carrier (insurer) FEIN Number	The FEIN of the carrier or self-insured assuming the employer's financial responsibility for the workers' compensation claim(s).		M
Carrier Policy Number	The number assigned to the contract/policy for the employer or association group.	A number assigned by the **insurance company, *(Not a number assigned by a TPA)*** for the specific workers' compensation policy for that employer. Not a required field for Division approved self-insureds.	**M**
Policy Period	List the effective and expiration dates of the contract/policy.	The date that the policy became effective and the date the policy expires or is no longer in effect. No date is required in this field if the injury falls within the Division approved self-insurer's self-insurance period.	M
Self-Insured Indicator	An indicator that identifies the employer as one who is authorized by the state of Missouri to retain the risks arising from their operations and bears the financial responsibility. Y=Yes, N=No	Condition – Must indicate Y(Yes) ONLY for an individual employer or a member of a self-insured trust authorized by the Missouri Division of Workers' Compensation to self-insure under § 287.280, RSMo. It does not include uninsured employers or employers under deductible insurance policies.	C
Claim Administrator (TPA) Name & Address	The name and mailing address of the Third Party Administrator (TPA), independent administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	Name and mailing address of the Third Party Administrator (TPA), independent adjuster, contracted to adjust the claim and phone number of the office adjusting the claim. If there is not a TPA, independent adjuster/administrator, contracted to adjust the claim please leave blank.	C

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Claim Administrator (TPA) FEIN Number	The FEIN of the Third Party Administrator (TPA), independent adjuster/administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	FEIN number for the company hired as a TPA. Note: If there is no Third Party Administrator, please leave blank.	C
Agent Name & Code Number	List the name and code number of the carrier or claim administrator agent who administers the workers' compensation claims for the employer.		O
Employee Name	The injured worker's legally recognized name which is used on legal documents, employment, Social Security, banking, records, etc.	Name to include last, first and middle initial.	M
Employee Date of Birth	The date the injured worker was born.	Must be a valid date.	M
Social Security Number	A number assigned by the Social Security Administration used to identify the employee.	If a SSN is not available please call 573-526-3542.	M
Date of Hire	The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.	Must be valid date.	O
State of Hire	List the state where the employer hired the employee.		O
Employee Address	The mailing address used by the injured worker.	The address should not be listed as unknown. Please include the last known address provided by the injured worker that is on file with the employer.	M
Employee Phone	A telephone number where the injured worker can be reached.	This is an optional field, although if the employer or insurance company has this information, **please** report it to the Division. This will improve communication between the parties. This will be a numeric field only *5736367777.*	O
Gender Code	The code which indicates the sex of the employee. Gender of employee F=Female M=Male U=Unknown		M
Number of Dependents	The number of dependents as defined by the administrating jurisdiction.	Spouse, minor children or others if known. Required if date of death is entered. Numeric field 0-9.	C
Marital Status Code	The code, which indicates the marital status of the employee. U = Widowed, divorced, single, unmarried, M = Married, S = Separated, K = Unknown		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Occupational/ Job Title or Description	Identifies the primary occupation of the employee at the time of the accident or injurious exposure.		O
Employment Status Code	Indicate the employee's primary work code status at the time of the injury with the covered employer.		O
NCCI Class Code	A code, which, corresponds to the primary occupation in which the employee was engaged at the time of the accident/injury or injurious exposure.	MO uses NCCI codes.	M
Wage	The reported employee's pre-injury wage for the wage period. Implementation Note: This amount may include commission, piecework earnings, and other forms of income converted to a normal scheduled work week, plus the estimated value of lodging, food, laundry and other payments in kind; and concurrent employment earnings, as prejurisdictional requirement.	"Gross Wages" includes, in addition to money paid by the employer for services rendered by the employee, the reasonable value of board, rent, housing, lodging or similar advance by the employer, except if it continues to be provided to the employee for the period of disability, it is not included in calculating the average weekly wage. "Wages" also includes gratuity received in the course of employment from individuals other than the employer that are reported for income tax purposes. "Wages" does not include fringe benefits such as retirement, pension, health and welfare, life insurance, training, Social Security or other employee or dependent benefit plan provided by the employer. **Please See Special Notes #1**	M
Wage Period	A code indicating the time period during which the wage was earned.	Please use the weekly wage rate paid to the employee.	M
Number of Days Worked	The number of the employee's regularly scheduled workdays per week.		O
Full Wages Paid for the Date of Injury Indicator	Indicates whether full wages for the date of the accident/injury or illness were paid by the employer.		O
Salary Continued Indicator	The employer has paid or is paying the employee's salary in lieu of compensation during an absence caused by a work-related injury.	Did the employer continue to pay salary to the employee after the injury? N=No Y=Yes	O
Time Employee Began Work	Time at which the employee began work on the day of the accident/injury or illness.		O
Date of Injury/Illness	For traumatic injury, the date on which the accident occurred. For occupational disease or cumulative injury, the date of injury is the date of last injurious exposure to the cause or substance creating the condition, unless otherwise defined by statute.	Date that injury/illness occurred or became known to employee; whichever is later.	M

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Time of Occurrence	The time at which the accident occurred.	To the extent that the time of the occurrence of the accident/injury is available, you should provide it to the Division. Please indicate a.m. or p.m.	O
Date Last Day Worked	The last paid workday prior to the initial date of disability as defined by jurisdiction.	Must be valid date.	O
Date Employer Notified	The date that the injury was reported to a representative of the employer.		M
Date Disability Began	The first day on which the employee originally lost time from work due to the occupational injury or disease or as otherwise defined by jurisdiction.	**Date of disability must be greater than Date of Injury.** First date employee starts losing time from work after the date of injury. This is the day after the date of injury or the first day of work missed, if later. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days. **Please See Special Notes #2**	C
Contact Name & Phone Number	List the name and phone number for a representative of the employer.		C
Type of Injury/Illness	List the type of injury/illness sustained by the employee.		O
Part of Body Affected	List the part of body to which the employee sustained injury.		O
Employer Premises Indicator	An indicator to denote whether the accident occurred at the employer's address provided.	If the injury/illness occurred on the employer's property indicate "YES." If it occurred elsewhere indicate "NO."	M
Type of Injury/Illness Code	The code, which corresponds to the nature of the injury sustained by the employee.	Choose from the list of code numbers, which corresponds with the nature of the injury. A list of codes with description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx **Please See Special Notes #2**	M
Part of Body Affected Code	The code, which corresponds to the part of the body to which the employee sustained injury.	Choose from the list of code numbers, which corresponds with the part of body injured. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx	M

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Zip Code of the Location Where Accident or Illness Exposure Occurred	The zip (postal code) that corresponds to the location where the injury occurred.	The code is required to assist with docket setting if needed.	M
All Equipment Using	List all the equipment; materials or chemicals the employee was using at the time of the accident/injury or illness exposure occurred.		O
Specific Activity Engaged In	Describe the specific activity that the employee was doing at the time the accident/injury or illness exposure occurred.		O
Work Process Engaged In	Describe the work process the employee was doing when the accident/injury or illness exposure occurred.		O
How the Injury or Illness Occurred	A free form description of how the accident occurred and the resulting injuries.	Describe how the injury/illness occurred. Please include the events that led to the injury/illness and any objects or substances that directly injured the employee or made the employee ill. Maximum of 150 characters, including spaces. *For example: Employee was on ladder putting away product, fell on chemical barrel breaking lower arm; arm lacerations; exposed to chemical liquid and fumes (141 characters).*	M
Cause of Injury Code	The code which corresponds to the cause of injury.	Choose from the list of code numbers, which corresponds with the cause of the injury. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx (Struck by, fell, auto accident, exposure, etc.)	M
Date Returned to Work	The first date on which the employee returned to work following the injury.	Must be a valid date. Must be entered if employee lost days of work and returned to work before first report of injury is filed.	C
Employee Date of Death	The date the injured worker died.	Must be a valid date.	C
Safeguards	Indicate whether safeguards or safety equipment was provided by checking "Yes" or "No."		O
Were They Used	Indicate whether the safeguards or safety equipment was used by the employee by checking "Yes" or "No."		O
Physician/Health Care Provider	List the name and address of the physician or health care provider who provided initial medical treatment to the injured employee after the accident/injury or illness.		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Hospital	List the name and address of the hospital where the employee received initial medical treatment.		O
Initial Treatment	A code used to identify the extent of medical treatment received by the employee immediately following the accident. 0= No medical treatment 1= Minor on-site remedies by employer medical staff 2= Minor clinic/hospital medical remedies and diagnostic testing 3= Emergency evaluation, diagnostic testing, and medical procedures 4= Hospitalization > 24 hours 5= Future major medical/lost time anticipated	First Aid includes the administration of immediate and temporary medical aid to the employee that a lay person may provide, such as the application of Band-Aid to treat a minor scratch or the removal of a splinter that would not result in the need for a referral to a doctor or other health care professional for additional medical treatment or would not result in further lost-time from work. The on-site company nurse or physician may be the individual that provides the first aid. If the company nurse or physician provides service beyond first aid, then the injury must be reported even if the treatment occurs on-site. **Please see Special Notes #2**	M
Witness	List the name and address of all witnesses who were present when the employee sustained the accident/injury or illness.		O
Date Reported to Claims Administrator	The date the claim administrator who is processing the claim received notice of the loss or occurrence.		M
Date Prepared	List the date that the representative for the claims administrator prepared this report of injury.		O
Preparer's Name and Title	List the name and title of the claims administrator's representative who prepared this report of injury.		C
Phone Number	List the phone number of the representative preparing this report of injury.		C

M – Mandatory – Cases missing mandatory information will NOT be accepted by the Missouri Division of Workers' Compensation system.

C – Conditional – Data Elements with Conditional fields indicate a value is required based on another Data Element or pre-existing condition.

Examples: When a death case is reported then the death date would be required.
If the employee has returned to work prior to the report being filed, the date of return to work would be entered.

O – Optional – Data Elements identified as Optional may be entered but are not required.

Special Notes

1) Wage Instructions

A) Missouri Notes: Report the wage information as the average weekly wage (AWW) of the employee. These rules apply for calculating the average weekly wage.

1) If the employee's wage is fixed by the year, the AWW is the yearly wage divided by 52;
2) If the employee's wage is fixed by the month, the AWW is the monthly wage multiplied by 12 and divided by 52;
3) If the employee's wage is fixed by the week, that amount is the AWW;
4) If the employee's wages are fixed by the day, hour or output, the numerator is the actual gross wages earned by the employee in the last thirteen calendar weeks immediately preceding the week in which the injury occurred; and the denominator is 13 to calculate the AWW.

   i) The formula is: Actual gross wages earned in prior 13 weeks/13=AWW. *For example, the employee's hourly wage is $9.00/hour. The overtime rate is $13.50/hour. The employee works 40 hours per week at $9.00 an hour plus occasional overtime. Employee worked overtime of 44 hours in the 13-week period immediately preceding the week of the injury. The employer has employed the employee for 2 years.*

   The gross wages are $9.00 X 40 hours X 13 weeks = $4,680. You also need to include the overtime 44 hours. Therefore, $13.50 X 44 hours = $594. The total wages are $4,680 plus $594 = $5,274. The AWW is $5,274/13=$405.69.

   ii) If the employee misses nonconsecutive workdays during the 13-week period in multiples of 5 those days shall be subtracted from the denominator. *For example: if the employee misses 5 days, one week is subtracted from 13 and the denominator becomes 12; if the employee misses 10 days, two weeks are subtracted from 13 and the denominator becomes 11; and so on.*

   iii) Partial weeks of time missed by the employee do not count to change the denominator. *For example: if the employee misses 4 days, the denominator is 13; if the employee misses 6 days, one week is subtracted from 13 and the denominator becomes 12; and so on.*

   iv) If the employee works less than 13 weeks but more than 2 weeks, the AWW is the same formula with the numerator as the gross wages calculated for the number of weeks of employment and the denominator is the number of weeks of employment. *For example, the employee worked for the employer 8 weeks prior to the week of the injury. The employee was paid $9.00 per hour and worked 40 hours per week. The employee worked 13 hours of overtime. The overtime rate is $13.50. The gross wages are $9.00 X 40 hours X 8 weeks plus $13.50 X 13 hours = $3,055.50. The AWW is $3,055.50/8=$381.94.*

5) If the employee works less than two weeks the AWW shall be equivalent to the AWW for the same or similar employment. However, if the employer has agreed to a certain hourly wage, then the hourly wage agreed upon multiplied by the number of weekly hours scheduled shall be the employee's AWW.

B) **When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.**

C) When Initial Treatment Code is reported as equal to 00, 01 or 02, the case will be considered as a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed. When the Initial Treatment Code is reported as equal to 03, 04 or 05, the case will be considered as an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

2) **Initial Treatment Code, Date Disability Began and Date Returned to Work:**

A) When Initial Treatment Code is reported as 00, 01 or 02, the case will be considered a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed.

B) When the Initial Treatment Code is reported as 03, 04 or 05, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

1) When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

C) The following are examples of First Aid treatment:

a) Use of non-prescription medication at non-prescription strength.

b) Cleaning, flushing or soaking wounds on the surface of the skin.

c) Using wound coverings such as bandages, Band-Aids, gauze pads, etc. or using butterfly bandages or Steri-Strips. (Other wound closing devises such as sutures, staples, glues, etc. are considered medical treatment.)

d) Use of any non-rigid means of support such as an elastic bandage, wrap, or non-rigid belt. (The use of devices with rigid stays or other systems designed to immobilize body parts is considered medical treatment.)

e) Use of temporary immobilization devices (e.g., splints, slings, neck collars, etc.) while transporting an accident victim.

f) Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs, or other simple means.

g) Use of finger guards.

h) Drinking of fluids for relief of heat stress.

3) **Mesothelioma Liability: Several changes to the Workers' Compensation Law went into effect January 1, 2014. Pursuant to §287.200.4, RSMo, employers may elect to accept mesothelioma liability in one of the following ways:**

a. Insuring their liability by purchasing a workers' compensation policy;

b. Meeting the requirements of the Division of Workers' Compensation to qualify as a self-insurer;

c. Joining a Group Insurance Pool that complies with §287.223. (An employer may become a member of the Missouri Mesothelioma Risk Management Fund);

d. Rejecting *mesothelioma* liability under the Missouri Workers' Compensation Law.

Please note that if an employer has rejected *mesothelioma* liability coverage under the Workers' Compensation Law, the exclusive remedy provision of the Workers' Compensation Law, §287.120, RSMo, does not apply.

4) **Occupational diseases:** Occupational diseases due to toxic exposure have been defined effective January 1, 2014. The "occupational diseases due to toxic exposure" includes the following: asbestosis, berylliosis, coal worker's pneumoconiosis, bronchiolitis obliterans, silicosis, silicotuberculosis, manganism, acute myelogenous leukemia and myelodysplastic syndrome. The reporting requirements relating to other occupational diseases such as carpal tunnel syndrome, etc. remains the same.

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Aseguradora, administrador externo, compañía de servicios o individuo designado si es autoasegurado

Nombre ____________________

____

Dirección ____________________

____

____

Teléfono ____________________

Información del empleado

La División de Compensación al Trabajador de Missouri (DWC en inglés) administra programas para trabajadores que han sido lesionados en el trabajo o han sido expuestos a una enfermedad ocupacional que son como consecuencia del trabajo y durante el mismo. Los Jueces de la Ley Administrativa de la División tienen la autoridad de aprobar acuerdos o conceder indemnizaciones después de una audiencia relacionada a los derechos de prestaciones por lesiones a un trabajador.

Pasos a seguir si se lesiona en el trabajo

1. Notifique a su empleador inmediatamente (se debe proporcionar aviso por escrito en un plazo de 30 días a partir de haber ocurrido la lesión o 30 días cuando se esté bastante consciente de la enfermedad ocupacional relacionada con el trabajo) poniéndose en contacto con

   ____________________, ____________________.
   representante del empleador *número de teléfono*

   ***No hacerlo puede poner en peligro su capacidad para recibir los beneficios**
2. **Busque atención médica (su empleador/aseguradora es responsable de proporcionar tratamiento médico y pagar las cuotas y cargos médicos a menos que elija usted buscar atención con otro médico bajo su propia cuenta sin aprobación previa de su empleador/aseguradora).**
3. Obtenga más información de los beneficios disponibles bajo el programa de compensación de trabajadores o de los pasos que puede tomar para recibir los beneficios que necesita.

Visite www.labor.mo.gov/DWC o llame al 800-775-2667.

Beneficios para trabajadores lesionados

Cuidados médicos:
El empleador o la aseguradora tienen la obligación de proporcionar tratamiento médico y cuidado para curar o aliviar los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. No hay deducibles y todos los costos los paga su empleador o la aseguradora de compensación al trabajador de su empleador. Si usted recibe una factura, **comuníquese con su empleador o con la aseguradora inmediatamente**. El empleador/la aseguradora tiene el derecho a elegir al proveedor del cuidados médicos o al médico que lo atienda. Puede elegir a otro proveedor de cuidados médicos o médico que lo atienda, pero de hacerlo, puede ser a su propia cuenta.

Pago por pérdida de ingresos:
- Si el médico dice que usted no puede regresar a trabajar debido a sus lesiones o para recuperarse de una cirugía, puede que tenga derecho a beneficios por **discapacidad total temporal** (TTD en inglés). Si el médico indica que usted puede realizar un trabajo ligero o modificado y su empleador le ofrece ese trabajo, es posible que no sea elegible para los beneficios de TTD. Los beneficios de TTD deben continuar hasta que el médico diga que usted puede regresar a trabajar o cuando su tratamiento concluya porque su condición ha alcanzado la "máxima mejoría médica", lo que ocurra primero.
- Si usted regresa a un trabajo ligero o modificado por menos del pago completo, puede tener derecho a beneficios por **discapacidad parcial temporal**.

Beneficios por discapacidad permanente:
Si la lesión o enfermedad resulta en una discapacidad permanente, usted puede tener el derecho a recibir beneficios permanentes por discapacidad parcial o discapacidad total.

Beneficios de sobreviviente:
Si un empleado muere en el trabajo, los dependientes sobrevivientes pueden recibir beneficios semanales por muerte pagados a 66 2/3% del salario semanal promedio del empleado fallecido junto con los gastos de funeral hasta $5,000 por parte del empleador o de la aseguradora. Para recibir más información sobre los beneficios de sobreviviente, incluyendo oportunidades de becas universitarias para niños sobrevivientes, por favor visite www.labor.mo.gov/DWC.

Beneficios adicionales para las enfermedades ocupacionales causadas por exposición a sustancias tóxicas – discapacidad total permanente y/o muerte:
Para recibir más información relacionada con los beneficios adicionales disponibles, por favor consulte el sitio web de la División a www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

**Asegure que sus servicio de datos está activado y escanee el código QR Code con la cámara de su teléfono inteligente para ir al sitio web de la División de Compensación para Trabajadores para obtener más información. Si no es reorientado, puede que necesite actualizar el sistema operativo de su teléfono inteligente o descargar una aplicación de Lector de Códigos QR.

Ley de Compensación al Trabajador

Funciones y responsabilidades para empleadores y trabajadores

INFORMACIÓN DEL EMPLEADOR

Con algunas excepciones, se requiere a todos los empleadores con cinco o más trabajadores, y empleadores de la industria de la construcción con un trabajador o más, para garantizar la compensación al trabajador, ya sea a través de la compra de una póliza de seguro o por adquirir autoridad de autoasegurarse. El seguro por compensación al trabajador proporciona beneficios a los trabajadores lesionados en el trabajo. A los empleadores también se les requiere publicar este aviso en el lugar de trabajo a la vista de todos los empleados. Se requiere poner este cartel de acuerdo a la sección 287.127, RSMo, y el mismo está disponible para todos los empleadores y aseguradoras sin cargo alguno al comunicarse con la División al 800-775-2667.

Pasos a tomar cuando ocurre una lesión

1. Asegúrese de que se administren los primeros auxilios y que se lleve al empleado al médico o al hospital para recibir atención médica adicional, si es necesario.
2. Reporte la lesión a la aseguradora o un Administrador tercero (TPA en inglés) dentro de los cinco días siguientes a la fecha de la lesión o dentro de los cinco días siguientes a la fecha en que fue reportada la lesión al empleador por el trabajador, lo que ocurra después. La Aseguradora, TPA, o autoaseguradora aprobado por la División es responsable para entregar un Informe primero de lesión con la División de Compensación al Trabajador **en un plazo de 30 días** a partir de haberse hecho a conocer la lesión.
3. Pague las cuentas relacionadas a la lesión en el trabajo para curar y aliviar al trabajador de los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. El empleador tiene derecho a elegir al proveedor de cuidado de la salud o al médico que lo atienda. (Usted como el trabajador puede elegir otro proveedor de cuidados médicos o médico de tratamiento, pero de hacerlo, puede ser por su propia cuenta.)
4. Para obtener más información sobre la responsabilidad o el seguro relacionados con el Programa de compensación al trabajador, viste www.labor.mo.gov/DWC o llame al 800-775-2667.

Seguridad del trabajador

Desarrollar e implementar un programa integral de seguridad y salud puede reducir las lesiones ocupacionales y ayudan a reducir los costos de compensación al trabajador. Las compañías de seguro en el estado de Missouri deben proporcionar ayuda de seguridad a petición del empleador asegurado. El Departamento del Trabajo de Missouri evalúa estos servicios y proporciona ayuda adicional a través de su Programa de Seguridad del Trabajador de Missouri.
Visite www.labor.mo.gov/MWSP o llame al 573-751-4231 para obtener más información acerca de estos programas o para un registro de asesores independientes certificados en el estado de Missouri para proporcionar ayuda de seguridad.

Fraude/no cumplimiento

Fraude del trabajador – deliberadamente presentar un reclamo para beneficios de compensación al trabajador a los cuales un empleado sabe que él o ella no tiene derecho o deliberadamente presentar múltiples reclamos por el mismo evento con el intento de defraudar es un delito mayor clase E, castigado con una multa de hasta $10,000, o el doble de la cantidad del fraude, lo que sea mayor. Una violación posterior es un delito mayor clase D.

Fraude del empleador – deliberadamente distorsionar una clasificación del trabajo del empleado para conseguir seguro por debajo de la tarifa apropiada es un delito menor clase A. Una violación posterior es un delito mayor clase E. Un empleador que deliberadamente hace una declaración falsa o fraudulenta relacionada con el derecho del trabajador a beneficios para disuadir que el trabajador haga un reclamo legítimo o quien deliberadamente hace una declaración de material fraudulento o representación fraudulenta a negar beneficios a un trabajador es culpable de un delito menor clase A, castigado con una multa de hasta $10,000. Una violación posterior es un delito mayor clase D.

Fraude de la aseguradora – deliberadamente e intencionalmente rehusar cumplir con las obligaciones de compensación al trabajador a las cuales sabe la aseguradora o la autoaseguradora tiene derecho un empleado es un delito mayor clase E, castigado con una multa de hasta $10,000 o el doble del valor del fraude, lo que sea mayor. Una violación posterior es un delito mayor clase D.

No cumplimiento del empleador – Faltar a propósito a asegurar la obligación legal de la compensación al trabajador es un delito menor clase A y también se castiga con una multa civil de hasta tres veces la prima anual que el empleador habría tenido que pagar de estar asegurado, o hasta $50,000, lo que sea mayor. Una violación posterior es un delito mayor clase E. Un empleador que intencionalmente no publica el aviso de compensación al trabajador en el lugar del trabajo es culpable de un delito menor clase A, castigado con una multa de $50 a $10,000, o con prisión o con ambos multa y prisión.

La División de Compensación al Trabajador de Missouri es un empleador/programa con igualdad de oportunidades.
Hay recursos y servicios disponibles para personas discapacitadas previa solicitud. TDD/TTY: 800-735-2966 Relay Missouri: 711

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Insurance Company, Third Party Administrator, Service Company, or Designated Individual If Self-Insured

Name ______________________________

____

Address ______________________________

____

____

Phone ______________________________

Employee Information

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the accident/or 30 days after the diagnosis of any occupational disease or repetitive trauma) by contacting

   ______________________________, ______________________.
   employer representative *phone number*

   Failure to do so may jeopardize your ability to receive benefits
2. **Ask your employer to provide medical treatment (your employer/insurer is responsible for providing medical treatment and paying the medical fees and charges unless you choose to treat with another doctor at your own expense without your employer/insurer's approval).**
3. Get more information about the benefits available under the Workers' Compensation Program or about the steps you may take to get the benefits you need. **Visit www.labor.mo.gov/DWC or call 800-775-COMP.**

Benefits for Injured Employees

Medical Care:

The employer or insurer is required to provide medical treatment and care that is reasonably required to cure and relieve the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately**. The employer/insurer has the right to choose the healthcare provider or treating physician. You may select a different healthcare provider or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages:

- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:

If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:

If a work-related injury causes an employee's death, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage along with funeral expenses up to $5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC.

Additional Benefits for Occupational Diseases Due to Toxic Exposure - Permanent Total Disability and/or Death:

For information relating to additional benefits available, please refer to the Division's website at www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

**Make sure your data is turned on and scan the QR Code with your smartphone's camera to go to the Division of Workers Compensation's Website for more information. If you are not redirected, you may need to update your smartphone's operating system or download a QR Code reader app.

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

With some exceptions, all employers with five or more employees, and construction industry employers with one or more employees, are required to insure their workers' compensation liability, either by purchasing a policy or obtaining self-insurance authority. Workers' compensation insurance provides benefits to workers injured on the job. Employers also are required to post this notice in the workplace for employees to view. This poster is required by section 287.127, RSMo, and is available to employers and insurers free of charge by contacting the Division at 800-775-Comp.

Steps to Take When an Injury Occurs

1. Be sure first aid is administered and the employee is taken to a physician or hospital for further medical care, if necessary.
2. Report the injury to the insurance company or Third Party Administrator (TPA) within five days of the date of injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. The insurer, TPA, or Division approved self-insurer is responsible for filing a First Report of Injury with the Division of Workers' Compensation **within 30 days** of knowledge of the injury.
3. Pay medical bills related to the work injury for treatment reasonably required to cure and relieve the employee of the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. The employer has the right to choose the healthcare provider or treating physician. (The employee may select a different healthcare provider or treating physician, but if the employee does so, it may be at his/her own expense.)
4. For more liability and insurance information relating to the Workers' Compensation Program, visit www.labor.mo.gov/DWC or call 800-775-COMP.

Workers' Safety

Developing and implementing a comprehensive safety and health program can reduce occupational injuries and help lower workers' compensation costs. Insurance carriers in the state of Missouri must provide safety assistance at the request of the insured employer. The Missouri Department of Labor evaluates these services and provides additional assistance through its Missouri Workers' Safety Program.
Visit www.labor.mo.gov/MWSP or call 573-751-4231 for more information about these programs or for a registry of independent consultants who are certified in the state of Missouri to provide safety assistance.

Fraud/Noncompliance

Employee Fraud – knowingly making a claim for workers' compensation benefits to which an employee knows he/she is not entitled or knowingly presenting multiple claims for the same occurrence with intent to defraud is a class E felony, punishable by a fine of up to $10,000, or double the value of the fraud, whichever is greater. A subsequent violation is a class D felony.

Employer Fraud – knowingly misrepresenting an employee's job classification or any other fact to obtain insurance at less than the proper rate is a class A misdemeanor. A subsequent violation is a class E felony. An employer who knowingly makes a false or fraudulent statement regarding an employee's entitlement to benefits to discourage the worker from making a legitimate claim or who knowingly makes a false or fraudulent material statement or material representation to deny benefits to a worker is guilty of a class A misdemeanor punishable by a fine of up to $10,000. A subsequent violation is a class D felony.

Insurer Fraud – knowingly and intentionally refusing to comply with workers' compensation obligations to which an insurance company or self-insurer knows an employee is entitled is a class E felony, punishable by a fine of up to $10,000 or double the value of the fraud, whichever is greater. A subsequent violation is a class D felony.

Employer Noncompliance – knowingly failing to insure workers' compensation liability under the law is a class A misdemeanor punishable by a fine of up to three times the annual premium the employer would have paid had it been insured or up to $50,000, whichever is greater. A subsequent violation is a class E felony. An employer who willfully fails to post the notice of workers' compensation at the workplace is guilty of a class A misdemeanor punishable by a fine of $50 to $1,000 or by imprisonment or both fine and imprisonment.

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

Establishing a Managed Care Panel

Great American Insurance Group has contracted with Procura/Optum to provide customizable Physician and Clinic Networks for our insureds. These networks provide injured workers with industry leading care and medical treatment at significant cost savings to employers.

Most states have specific guidelines governing the right for an employer or employee to direct care in the event of an industrial injury. Some states require the establishment of a Medical Panel for the initial treatment of work-related injuries. Due to the significant cost savings associated with Medical Panels, Great American – Alternative Markets recommends that employers establish medical Panels for all work locations.

Mandatory Panel States: GA, PA, TN, VA

Medical Provider Network (Opt-in): California

Medical Panels will need to be established BEFORE you have your first claim. Please fill out the below questionnaire listing all work locations and send to:

AlternativeMarketsAccountServices@GAIG.COM

Once received, you will be contacted by a member of our account services team to discuss the needs of your business and how to best construct the medical panel that will deliver appropriate coverage to your employee population.

Questionnaire

Named Insured: ______________________________

Location: ______________________________

Address: ______________________________

Contact name: ______________________________

Contact phone number: ______________________________

Employee count: ______________________________

Current network: ☐ Yes ☐ No

Great American Insurance Group, 301 E Fourth Street, Cincinnti, OH 45202. This is not intended as legal advice; if you have any questions or issues of a specific nature, you should consult appropriate legal or regulatory counsel to review the specific circumstances involved. The Great American Insurance Group eagle logo and the word marks Great American® and Great American Insurance Group® are registered service marks of Great American Insurance Company. © 2020 Great American Insurance Company. All rights reserved. 1251-ALT-CA (06/20)

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