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

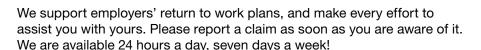
- 1. Click the Request Access link
- 2. Complete the Policyholder Registration form
- 3. Confirm the Insured Portal system generated "Identity Verification" email

Preregistration Required



Call our reporting center





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 Aliance 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® are registered service marks of Great American Insurance Group® are registered service marks of 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.

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 Insurance Group eagle logo and the word marks Great American Insurance Group eagle logo and the word marks Great American Insurance Company. © 2020 Great American Insurance Company. All rights reserved. 1251-ALT-CA (06/20)



State of Nevada DEPARTMENT OF BUSINESS & INDUSTRY DIVISION OF INDUSTRIAL RELATIONS

Workers' Compensation Section

ATTENTION

Caution: The information below is general in nature and is not intended to be legal advice. If you have any questions regarding your status as an employer or employee or your rights and qualification for specific benefits under an industrial injury or occupational disease claim, you should consult with an attorney experienced in industrial insurance.

Brief Description of Whether the Employer is Required to Obtain Industrial Insurance and Whether a Person is a Covered Employee

Every employer ... shall provide and secure compensation ... for any personal injuries by accident sustained by an employee arising out of and in the course of the employment. See NRS 616B.612(1).

An **employer** is defined as, "Every person, firm, voluntary association and private corporation, including any public service corporation, which has in service any person under a contract of hire." See NRS 616A.230(2). "A person is not an employer if: (a)The person enters into a contract with another person or business which is an independent enterprise; and (b) The person is not in the same trade, business, profession or occupation as the independent enterprise." See NRS 616B.603(1).

An **employee** is broadly defined as, "... every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed" (See NRS 616A.105), but excludes casual employees not in the same trade, business, profession or occupation; musicians not lasting more than 2 consecutive days; household servants, farming and ranching employees; voluntary ski patrol; sports officials paid a nominal fee; clergy, rabbi or lay readers; real estate brokers or sales persons; and commissioned sales persons (See NRS 616A.110).

An **independent contractor** is a person who is hired and paid solely to produce a result. It is defined as, "... any person who renders service for a specified recompense for a specified result, under the control of the person's principal as to the result of the person's work only and not as to the means by which such result is accomplished." See NRS 616A.255.

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

Notice of Injury or Occupational Disease (Incident Report Form C-1) If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any medical costs related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the Department of Administration, Hearing Officer, by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the Department of Administration, Appeals Officer. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a petition for judicial review with the District Court. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer hearing. NAIW is an independent state agency and is not affiliated with any insurer. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775)684-7270, or 3360 W. Sahara Ave., Suite 250, Las Vegas, NV 89102, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the State of Nevada Office for Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1- 888-333-1597, Web site: http://dhhs.nv.gov/Programs/CHA, E-mail http://dhhs.nv.gov/Programs/CHA, E-mail http://dhhs.nv.gov/Programs/CHA, E-mail

The information in this publication is derived from Chapters 616A and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administra	ator:		-	Contact Person:	
Address:				Telephone Number:	
Ci	ity	State	Zip		
MCO/Health Care	Provider:			Contact Person:	
Address:				Telephone Number:	•
Ci	ty	State	Zip		D-1 (rev. 11/19)

	6 WORKING DAYS		e or Print			OR (OCCUP/	ATIO	DNAL DI	SEA	SE		
ĒR	Employer's Name	•		Nature of I	Business (mf	g., etc.)		FEIN			OSHA Lo	g#	
EMPLOYER	Office Mail Address			Location .	If different	from m	ailing a	ddress	٦	Telep	hone		
Z	City	State	Zip	INSURER					1	THIRI	D-PARTY	D-PARTY ADMINISTRATOR	
	First Name	M.I.	Last Name	Social Sec	curity		Birthdate		7	Age		Prim	nary Language Spoken
JE	Home Address (Number a	and Street)		Sex □	Male □ I	Female	Mari	Marital Status ☐ Single ☐ Married			arried [□ Divorced □ Widowed	
EMPLOYEE	City	State	Zip	Was the e		i for the □ Yes				How long has this person been employed by yo in Nevada?			
Ē	In which state was employ	yee hired?	Employee's occupa	ation (job title) when hired or disabled			abled		Departm	ent ir	n which re	egular	rly employed:
	Telephone		I eloyee a corporate offic ∃ No		le proprietor? Yes 🗆 No		☐ Yes ☐ No by occupational disc						oy when injured or disabled D/D)? ☐ Yes ☐ No
	Date of Injury (if applicable)	Time of injury (I	Hours; Minute AM/PM)	(if applicable)	Date employ	yer noti	fied of i	njury or O/D	Supervis	or to	whom inj	jury o	r O/D reported
T OR SE	Address or location of accident (Also provide city, county, state) (if applicable)										on emplo	-	premises? (if applicable)
CIDENT (DISEASE	What was this employee	doing when the a	accident occurred (lo	ading truck	, walking dow	vn stairs	s, etc.)?	(if applicable))			-	
ACCIDENT OR DISEASE	How did this injury or acco	upational diseas	e occur? Include tim	ne employee	began work	Be sp	ecific a	nd answer in	detail. Us	se ad	ditional sl	heet i	if necessary.
	Specify machine, tool, su (if applicable)		ect most closely conn	nected with	the accident		Witnes	SS .					Was there more than one person injured in this accident? (if applicable)
ш	Part of body injured or at	ffected		If fatal, g	give date of d	eath	Witnes	ss					
DISEASE	Nature of Injury or Occup	pational Disease	e (scratch, cut, bruise	, strain, etc	.)		Witnes						☐ Yes ☐ No
OR DI	If validity of claim is doub				accider	ployee return t nt? (if applicabl on of Initial Tre	e)		ed shift afte	er	Will you have light duty work available if necessary? Yes No		
NJURY	Treating physician/chirop	practor name					Emergency Poom O Ves O No Hr				11	Obeliand III Man III No	
NJC	How m	any days per we	ek does				gy					oitalized	
		ree work? M T	W T F	From S F		lam D	m □ pm To □ am □ pm						
	days off □				Rotating	Are yo				nploy	ee's wag		uring disability? Yes No
٦ 50	Date employee wa	is nired	Last day of work af	ter injury or	disability		L	Date of return	to work			N	lumber of work days lost
TANT E INF	Was the employee hired work 40 hours per week?		If not, for how ma o was the employe		week		id the employee receive unemployment compensation any time during the last 12 conths? Yes No Do not know						
IMPORTANT IST TIME INF	the injured employee is a	expected to be o t include reimbu	If work 5 days or mo	re, attach w	age verificati	on form	i (Ď-8).⊤	Gross earning	js will incl	lude c	overtime,	bonu	te of injury or disability. If ises, and other rnings from the date of hire
 	Pay period ☐ SUN ☐ TL ends on: ☐ MON ☐ W				MONTHLY (SEMI-MON			On the date of he employee's				per [□ Hr □ Đay □ Wk □ Mo
	For assistance w Assistance <u>Toll I</u>												
*	I affirm that the information p the best of my knowledge. If payroll records of the employ Nevada law.	further affirm the w	age information provide	d is true and	correct as takei	aken from the			е				
Use		Denied 🗆 Def	erred □ 3 rd Party	Deemed	Wage		Account No.			Clas	ss Code		
Insurer Use Only	Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3 rd Party Claims Examiner's Signature Date							Status Clerk Date				e	

Please

TO AVOID PENALTY, THIS REPORT MUST BE

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

	TO AVOID PENALT COMPLETED AND MAII 6 WORKING DAYS OF	_	Please e or Prin	t	EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE								
ER	Employer's Name				Nature of E	Business (m	ifg., etc.)	FEIN		OSHA L	.og #	
EMPLOYER	Office Mail Address				Location .	If differen	it from m	nailing	address		Telephone		
EMP	City	State	Zip		INSURER						THIRD-PART	Y AD	MINISTRATOR
	First Name N	M.I.	Last Na	ne	Social Sec	urity		Bir	thdate		Age	Pri	mary Language Spoken
EE	Home Address (Number and	Street)			Sex □	Male □	l Female	Ma	Marital Status ☐ Single ☐ Married			□ D	ivorced
EMPLOYEE	City	State	Zip	_	Was the employee paid for the day o			ay of injury? How long ha			this	person been employed by you	
EME	In which state was employee	hired?	Employee's	occupa	tion (job title	<u> </u>				Departr	nent in which	regul	arly employed:
	Telephone Is the	•	nployee a corpo	rate offic		le proprietor Yes □ No		partner es □ N			nployee in you supational dise		oloy when injured or disabled O/D)? ☐ Yes ☐ No
	Date of Injury (if applicable)						oyer not	ified of	injury or O/D				or O/D reported
r on	Address or location of accide	ent (Alsa pro	ovide city, cou	nty, state	e) (if applica	able)				Ac	ident on emp Yes [•	s premises? (if applicable) D
DEN	What was this employee doi	ng when the	accident occ	urred (lo	ading truck,	, walking do	wn stair	s, etc.)	? (if applicable)			
ACCIDENT OR DISEASE	How did this injury or occupa	itional disea	ise occur? Ind	dude tim	ne employee	e began wor	k. Bes	pecific	and answer in	detail. U	Ise additional	sheel	t if necessary.
4													
	Specify machine, tool, subs (if applicable)	tance, or ot	oject most clos	ely conr	nected with	the acciden	t	Witne	ess		•		Was there more than one person injured in this accident? (if applicable)
ш	Part of body injured or affect	ted			If fatal, g	jive date of	death	Witne	ess				
DISEASE	Nature of Injury or Occupat	ional Diseas	se (scratch, cu	t, bruise	e, strain, etc.	.)		Witne	ess				☐ Yes ☐ No
									mployee return t ent? (if applicab	le)	heduted shift a		Will you have light duty work available if necessary?
Y OR	If validity of claim is doubted	d, state reas	son					Loca	tion of Initial Tr		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
JURY	Treating physician/chiropra							Emergency Room ☐ Yes ☐ No Hospitalized			pitalized Yes No		
S	IMPORTANT employee	y days per v work?	veek does		From	(□am	□ pm	То	0	am □ pm	Las	t day wages were earned
	Scheduled S M days off	T	W T	F	\$ F	Rotating	Are yo	ou payi	ng injured or d	isabled e	mployee's wa	iges d	luring disability? □ Yes □ No
ဝှ	Date employee was h	ired	Last day of	work af	ter injury ar	disability			Date of return	to work			Number of work days lost
ORTANT TIME INFO	Was the employee hired to work 40 hours per week?	□ Yes □			any hours a e hired?	week	Did th month		loyee receive u				n any time during the last 12 o not know
MP	For the purpose of calculati the injured employee is exp remuneration, but will not in to the date of injury or disab	ected to be clude reimb	off work 5 day	s or mo	re, attach w	rage verifica	tion form	n (D-8)	. Gross earning	gs will in	clude overtime	e, bon	
= 0	Pay period ☐ SUN ☐ TUE ends on: ☐ MON ☐ WED		SAT Emlo		WEEKLY C			IER	On the date of the employee'			per	r□Hr□Day□Wk□Mo
	For assistance with Assistance Toll Fro		-			-	-			-			
	I affirm that the information prov	rided above re	garding the acc	ident and	injury or occu	pational dise	ase is co	rrect to	Employer's			Da	
*	the best of my knowledge. I furti payroll records of the employee Nevada law.				viding false in	nformation is a			Account No				ace Cada
r Use ly	Claim is: ☐ Accepted ☐ D		eferred □ 3 rd	Party	Deemed	vvage			Account No.				ass Code
Insurer Use Only	Claims Examiner's Signatur		Date				Status Clerk			Da	ate		

	TO AVOID PENAL COMPLETED AND MA 6 WORKING DAYS (AILED TO THE	INSURER WITHIN	-	Please Type or Print			EMPLOYER'S REPORT OF INDUSTRIAL OR OCCUPATIONAL DISEASE					
ER	Employer's Name			Nature of E	Business (mf	g., etc.)	:	FEIN		OSHA L	og#		
EMPLOYER	Office Mail Address			Location .	If different	from m	ailing a	address	Telephone				
EMP	City	State	Zip	INSURER				THIRD-PART			Y AD	YADMINISTRATOR	
	First Name	M.I.	Last Name	Social Sec	curity		Birthdate A			Age	Prir	mary Language Spoken	
Щ	Home Address (Number a	ind Street)		Sex □	Sex ☐ Male ☐ Female			e Marital Status □ Single □ Ma			I Married □ Divorced □ Widowed		
EMPLOYE	City	State	Zip	Was the e		d for the □ Yes				How long has in Nevada?	this	person been employed by you	
EM	In which state was employ	ee hired?	Employee's occup	ation (job title	e) when hired	d or disa	abled		Departi	ment in which i	regula	arly employed:	
		☐ Ye	ployee a corporate off	. 🗖	le proprietor Yes □ No		oartner? es □ N		by occ	cupational dise	ase (· · · · · · · · · · · · · · · · · · ·	
	Date of Injury (if applicable)	Time of injury ((Hours; Minute AM/PM)	(if applicable)	Date emplo	yer noti	fied of	injury or O/D	Superv	risor to whom in	njury (or O/D reported	
OR	Address or location of acc	ident (Also pro	vide city, county, sta	te) (if applica	able)				Ac	cident on emp	-	s premises? (if applicable)	
ACCIDENT DISEASE	What was this employee d	loing when the	accident occurred (I	oading truck	, walking dov	vn stairs	s, etc.)	? (if applicable)				
DIST	How did this injury or occu	pational diseas	se occur? Include ti	me employee	e began worl	c. Be sp	ecific :	and answer in	detail. (Jse additional	sheel	if necessary.	
AC													
	Specify machine, tool, su	bstance, or ob	ject most closely cor	nected with	the accident		Witne	ess				Was there more than one	
	(if applicable) Part of body injured or aff				give date of c		Witne	· · · · · · · · · · · · · · · · · · ·				person injured in this accident? (if applicable)	
SE	Notice of lainer of Occur	eties al Dianas	a (agratab aut basia	a atraia ata			Witne					☐ Yes ☐ No	
DISEASE	Nature of Injury or Occup	alional Diseas	e (scratch, cut, bruis	e, strain, etc	··)								
								nployee return t ent? (if applicab	le)	cheduled shift at		Wilt you have light duty work available if necessary? Yes No	
Y OR	If validity of claim is doub	ted, state reas	on				Locat	ion of Initial Tr	eatment			,	
JURY	Treating physician/chirop	ractor name					Emer	gency Room	□ Yes	i □ No	Hos	pitalized Yes No	
INJ		any days per w ee work?	eek does	From] am (⊐ pm	То		am □ pm	Las	t day wages were earned	
		M T	W T F	S F	Rotating	Are yo	u payii	ng injured or d	isabled (employee's wa	ges d	luring disability? ☐ Yes ☐ No	
0	Date employee was	s hired	Last day of work a	after injury or	disability		•	Date of return	to work			Number of work days lost	
ORTANT TIME INFO	Was the employee hired work 40 hours per week?		If not, for how no		week	Did the month		oyee receive u				n any time during the last 12 o not know	
	the injured employee is e	expected to be	off work 5 days or m	ore, attach w	vage verificat	ion form	ı (D-8)	. Gross earning	gs will in	clude overtime	e, bon		
IMP OST	to the date of injury or dis		ursement for expens	es. If the em	ipioyee was i	empioye	eo by y	ou for less that	n iz wee	eks, provide gr	oss e	arnings from the date of hire	
Ľ	Pay period □ SUN □ TU ends on: □ MON □ Wi				☐ MONTHLY			On the date of the employee'			pe	r □ Hr □ Day □ Wk □ Mo	
	For assistance wi Assistance <u>Toll F</u>		-		~	•			_			Consumer Health s.state.nv.us	
*	I affirm that the information p the best of my knowledge. I fi payroll records of the employ Nevada law.	urther affirm the v	wage information provid	led is true and	correct as take	en from th	ne	Employer's	Signatur	re and Title	Da	ate	
Use	Claim is: ☐ Accepted ☐	Denied □ De	ferred □ 3 rd Party	Deemed	l Wage			Account No.			CI	ass Code	
Insurer Use Only	Claims Examiner's Signa	ture		Date				Status Clerk			Da	ate	
								1					

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report) Pursuant to NRS 616C.015

Name of Employee				Social Secur	ity Nun	nber	Telepho	ne Number
Date of Accident (if applicable)	Time of Acci	dent	Place	where accider	nt occur	red (if applicable)		
What is the nature of the	linjury or occup	ational disease	?			List any body parts in	volved:	
Briefly describe accident o Note: if you are claiming an o					ee first be	came aware of connection	between con	dition and employment)
Did the employee eave work because of the injury or eccupational disease?	_ YES _ NO	If yes, when	(date a	nd time)?		• / —	res NO	If yes, when (date and time)?
Was first aidYES provided?NO		If yes, by wh	om?		Name	and address of treating	physician,	if applicable or known
Did the accident happen n the normal course of work? (if applicable)	N	YES O						
Was anyone else involved?	YES NO		Na	nmes of others	s involve	d	· · · · · · · · · · · · · · · · · · ·	
								OVIDER FOR MEDICAL THESE ARRANGEMENTS.
apervisor's Signature		Date			— Siar	ature of Injured or	Disablad	Employee Date

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance <u>Toll Free</u>: 1-888-333-1597 <u>Web site</u>: http://govcha.state.nv.us <u>E-mail</u> cha@govcha.state.nv.us

Employee should sign, date and <u>retain</u> a copy. Original to Employer, Copy to Employee

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report) Pursuant to NRS 616C.015

Name of Employee				Social Secur	ity Nun	nber	Telepho	ne Number
Date of Accident if applicable)	Time of Acci (if applicable)	dent	Place	where accider	nt occur	red (if applicable)	<u> </u>	
What is the nature of the	l injury or occup	ational disease	e?			List any body parts inv	olved:	
Briefly describe accident o Note: if you are claiming an o					e first be	came aware of connection	between cor	idition and employment)
Names of witnesses:								
Did the employee eave work because of the injury or occupational disease?	_ YES _ NO	If yes, when	(date a	and time)?		ne employee Y ned to work! N	ES O	If yes, when (date and time)
Was first aid YES provided? NO		If yes, by wh	iom?		Name	and address of treating	physician,	if applicable or known
Did the accident happen n the normal course of work? (if applicable)	N	YES O						
Was anyoneelse involved?	YES NO		N	ames of others	involve	ed		
								OVIDER FOR MEDICAL THESE ARRANGEMENTS
upervisor's Signature		Dat				nature of Injured or	D. 11.1	Employee Date

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance <u>Toll Free</u>: 1-888-333-1597 <u>Web site</u>: http://govcha.state.nv.us <u>E-mail</u> cha@govcha.state.nv.us

Employee should sign, date and <u>retain</u> a copy. *Original to Employer, Copy to Employee*

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report) Pursuant to NRS 616C.015

Briefly describe accident or circumstance (Note: if you are claiming an occupational disease! Names of witnesses: Did the employee YES leave work because of the injury or NO occupational disease!	pational disease?	sease: on which employ		parts involved:	If yes, when (date and time)?	
leave work because of the injury or occupational disease? Was first aid YES	es of occupational dis sease, indicate the date o	on which employ	yee first became aware of con	nnection between con		
Note: if you are claiming an occupational dis Names of witnesses: Did the employee YES eave work because of the injury or NO occupational disease? Was first aid YES	sease, indicate the date of	on which employ	Has the employee	YES		
Did the employee YES leave work because of the injury or NO occupational disease? Was first aid YES	If yes, when (date	e and time)?			If yes, when (date and time)?	
eave work because of the injury or NO occupational disease? Was first aid YES	If yes, when (date	e and time)?			If yes, when (date and time)?	
	ve work because the injury orNO				If yes, when (date and time)	
	If yes, by whom?		Name and address of	treating physician	, if applicable or known	
Did the accident happen n the normal course of work? (if applicable)	YES NO		- 			
Was anyone YES else involved? NO	1	Names of other	rs involved			
IY EMPLOYER/INSURER MAY HAV REATMENT OF MY INDUSTRIAL II						
upervisor's Signature	Date		Signature of Inju	red or Disable	d Employee Date	

Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

Employee should sign, date and <u>retain</u> a copy. Original to Employee, Copy to Employee

EMPLOYER'S WAGE VERIFICATION FORM (Pursuant to NRS 616C.045(2)(d))

Please provide the following information for the employee named below by completing this form. The information is needed so that the amount of disability compensation to which your employee is entitled may be calculated. Prompt completion and return of this form will ensure the timely payment of any compensation due this injured worker. Please answer all questions and sign the form where indicated.

			NG INFORMATION		-	
Date:Inju						
Claim No.:						
Was employee hired to work 40 h						
On the date of injury, the employe	•	•		_		
Was vacation paid during the appl						
Was sick leave paid during the app						
week period? Did em			the applicable twelve wee	ek period?	Did en	iployee receive
termination pay during the applica	•		a		16 (182 (1114	.1
Provide prior wage if current wage						
During this 12-week period did en	•		= =	nent, (3) rat	te of pay? [] Yes []	No
f so, date:						
Does the employee receive comm					<u>_</u> ·	
Indicate the amount of commissio						
Does the employee receive bonus		= =			to	
Indicate the amount of bonuses re-						
Are the commission and bonus an			• • • • • • • • • • • • • • • • • • • •			
Does the employee declare tips fo						
Does the employee receive meals						rnings)
How many meals per day?			per [] l	Day [] Wee	k [] Month	
Lodging \$	per[]Day[]Week[Month				
except reimbursement for expens Give payroll information from If absent from work for the f 1. Certified illness or disabilit	through ollowing reasons, plea	If employed less the se specify the dat	e(s) absent and the num	iber code f	for the reason of abs	ence.
attendance; 4. In military serv because of leave approved pur	vice other than training	duty conducted on				
Payroll Period Beginning Ending	Gross Salary (Excluding Tips)	Declared Tips	Payroll Period Beginning End	ding	Gross Salary (Excluding Tips)	Declared Tips
Dates of Absence Reas	Ditto	- CAL D-	Dates of Al	<u></u>	Danasa	
Dates of Absence Reas Begin End	Begin End	of Absence Re	ason Dates of Al Begin End	оѕепсе	Reason	
Pay period ends on (check one Employee is paid: [] Week Employee scheduled day(s) off Explain "other": Date the employee last worked	ly [] Bi-Weekly f:[] Sunday [] Monda	[] Semi-Monthly y [] Tuesday []	[] Monthly [] Oth Wednesday [] Thursday	her y [] Friday	/ [] Saturday [] Otl	
This information is true and corr Print Name:	ect as taken from the en	nployee's payroll r				
		Elavan				
Date:		Employer:				

Insurer:

Third-Party Administrator:

D-8 (rev10/10)

EMPLOYER'S WAGE VERIFICATION FORM (Pursuant to NRS 616C.045(2)(d))

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	PLEASE PROVIDE T					
Date: Ir						
Claim No.:						
Was employee hired to work 40	-		=			
On the date of injury, the emplo						
Was vacation paid during the ap						
Was sick leave paid during the a						
week period? Did ex		_	the applicable to	velve week period	? Did en	ipioyee receive
termination pay during the appli	-			53.15	(10 (10) 1514	.1
Provide prior wage if current wa	-	-				
During this 12-week period did				employment, (3)	rate of pay? [] Yes []	No
If so, date:				.		
Does the employee receive com					·	
Indicate the amount of commiss					4-	
Does the employee receive bonu	= :			= =	to	
Indicate the amount of bonuses			-			
Are the commission and bonus a						43 6
Does the employee declare tips						
Does the employee receive meal			-		-	rnings)
How many meals per day?				per[]Day[]W	/eek [] Month	
Lodging S	per[]Day[]Week[] Month				
Give payroll information from _ If absent from work for the 1. Certified illness or disabil attendance; 4. In military se because of leave approved proceedings of the proceeding of the proce	e following reasons, plea lity; 2. Institutionalized in ervice other than training of	se specify the dat n a hospital, or oth duty conducted on	e(s) absent and ner institution;	the number cod 3. Enrolled as ful	ll-time student, not empl	ence. oyed on days of
Payroll Period Beginning Ending	Gross Salary (Excluding Tips)	Declared Tips	Payro Beginning	oll Period Ending	Gross Salary (Excluding Tips)	Declared Tips
-						
					T	
D		0.11				
		of Absence Rea		Dates of Absence	Reason	
Begin End	Begin End		Begin	End		.
Pay period ends on (check or Employee is paid: [] Wee Employee scheduled day(s) of Explain "other": Date the employee last worke	ekly []Bi-Weekly off:[]Sunday []Monda	[] Semi-Monthly y [] Tuesday []	[] Monthly Wednesday []	[] Other Thursday [] Fric	day [] Saturday [] Otl	•
This information is true and co Print Name:						
Date:		Employer:				

Third-Party Administrator:

D-8 (rev10/10)

Insurer:

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Date:Inju					
Claim No.:					
Was employee hired to work 40 ho					
On the date of injury, the employe	_			-	
Was vacation paid during the appli					
Was sick leave paid during the app					
week period? Did emp	loyee receive payment f	for overtime during	the applicable twelve week period	d? Did en	nployee receive
termination pay during the applica					
Provide prior wage if current wage	was in effect less than	12 weeks prior to da	ate of injury: \$ per [] Hou	.r [] Day [] Week [] Mo:	nth
During this 12-week period did em) rate of pay? [] Yes []] No
If so, date:	Explain:				
Does the employee receive commi	ssions? [] Yes [] No	Period of commiss	sion earned to	·	
Indicate the amount of commission					
Does the employee receive bonuse	s/incentive pay? [] Yes	[] No Period of t	onuses/incentive pay earned	to	
Indicate the amount of bonuses rec	eived over last 12 mont	hs, or since date of	hire: \$		
Are the commission and bonus am	ounts included in GROS	SS EARNINGS belo	ow? [] Yes [] No		
Does the employee declare tips for	the purpose of worker's	s compensation? []	Yes [] No See payroll declara	tion below. Attach decla	ration forms.
Does the employee receive meals of	or lodging (excluding re-	imbursement for tra	vel per diem)? [] Yes [] No (D	o not include in gross ea	rnings)
How many meals per day?	Monetary value	ue of meals \$	per [] Day [] \	Week [] Month	
Lodging S	per [] Day [] Week [[] Month			
TWELVE WEEK VERIFICATI	ON FROM PAYROLI	L RECORDS. Rep	ort GROSS EARNINGS, include	overtime payment and an	y other remuneration
(except reimbursement for expense					
Give payroll information from					
	•	- •	e(s) absent and the number co		
			ner institution; 3. Enrolled as fu		
because of leave approved purs			weekends; 5. Absent because	of officially sanctioned s	arke, o. Absence
	<u> </u>				
Payroll Period	Gross Salary	Declared	Payroll Period	Gross Salary	Declared
Beginning Ending	(Excluding Tips)	Tips	Beginning Ending	(Excluding Tips)	Tips
				+	
-	<u> </u>				
Dates of Absence Reas	on Dates	of Absence Rea	ason Dates of Absence	Reason	
Begin End	Begin End		Begin End		
Employee is paid: [] Weekl	y []Bi-Weekly :[]Sunday []Monda	[] Semi-Monthly y [] Tuesday []	Wednesday [] Thursday [] Fr		
This information is true and corre				<u> </u>	
Print Name:					_
Date:		Employer:			

Third-Party Administrator:

D-8 (rev10/10)

Insurer: __

APPLICATION FOR REIMBURSEMENT OF CLAIM RELATED TRAVEL EXPENSES

(Pursuant to NAC 616C.150)

Please type or print and provide all the information requested. Keep and be prepared to provide, if requested, any receipts relating to your reimbursement request.

•		•								
Name (L	ast, First, Middle Initial)						Claim Numl	ber		
Present A	Address (P.O. Box, Apt. No	o., Street)					Social Secur	rity Number		
City		State		Zip			Date of Inju	гу		
Residenc	e at time of injury:						[] Appro		s Use Only) itials & Date	-
reimburs	T TRAVEL WEEK sed for claim related n of Nevada law.				_			=	=	is in
VIOIMETO	The vacuum law.					Daily Evna	nse Reimburser	mant		
	Beginning Point of Travel	Destination	Enter Travel Time	Leave Travel		Meal:		III.	Miles One	Mileage Allowed
Date	Address	Name/Address		Time	В	L	D	Lodging	Way	(For Insurers Use Only)
										-
								_		
	+					-				
						-				
						•	TOT M	AL ILES:		
		Total of _		Mile	s X 2 @	\$	•	_ per Mi	le =	
reimburse NRS. I u	certify that the record prement is related to or is anderstand that the replect me to criminal and ge.	for treatment authorize	ed under Nev nation may	ada Revis disqualify	ed Statut me fron	e (NRS) n receiv	616A to 616 ing workers	6D, inclusi s' compens	ve or chapte sation bene	er 617 of fits, and
Injured E	mployee's Signature					D	ate			_

Reimbursement for Costs of Transportation and Meals

Nevada Administrative Code (NAC) 616C.150 Eligibility and computation.

- 1. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from:
 - (a) His residence to the place where he receives medical care; or
 - (b) His place of employment to the place where he receives medical care if the care is required during his normal working hours.
- 2. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from his residence or place of employment to a place of hearing designated by the insurer or the department of administration if the hearing concerns an appeal by the employer or insurer from a decision in favor of the injured employee and the decision is upheld on appeal.
- 3. An injured employee who does not qualify for reimbursement under paragraph (a) or (b) of subsection 1 but is required to travel a total of 40 miles or more in any one week for medical care or for attendance at the system's rehabilitation center is entitled to be reimbursed for the cost of his transportation.
 - 4. Except as otherwise provided in subsection 6, reimbursement for the cost of transportation must be computed at a rate equal to:
 - (a) The mileage allowance for state employees who use their personal vehicles for the convenience of the state; or
- (b) The expense actually incurred by the injured employee for transportation, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).
- 5. Except as otherwise provided in subsection 6, if an injured employee must travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his home or place of employment until after 7:00 p.m., or any combination thereof, reimbursement for meals required to be purchased must be computed at a rate equal to:
 - (a) That allowed for state employees; or
- (b) The expense actually incurred by the injured employee for meals, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).
- 6. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for his expenses of travel if he is required to travel 50 miles or more, one way, from his residence or place of employment and is required to remain away from his residence or place of employment overnight. Reimbursement must be computed at a rate equal to:
 - (a) The per diem allowance authorized for state employees; or
 - (b) The expenses actually incurred by the injured employee, whichever is less.
- 7. A claim for reimbursement of expenses governed by this section may be disallowed unless it is submitted to the insurer or employer within 60 days after the expenses are incurred.

NAC 616C.153 Reimbursement for air fare. With the prior approval of the insurer or those employers who have elected to provide accident benefits, an injured employee may be reimbursed for air fare where the time, distance, convenience or cost justifies his travel by air

NAC 616C.156 Limitations on reimbursements.

- 1. Unless otherwise directed or approved by the insurer, or the injured employee's treating physician or chiropractor, an injured employee who chooses to obtain his medical services at a more distant place although adequate medical care is available at a closer place may be reimbursed under NAC 616C.150 only for mileage to the closer place.
- 2. If a person moves outside this state or to a new location within this state for his own convenience after becoming an injured employee, the maximum mileage for one direction for which he may be reimbursed is the mileage allowable before the move or 40 miles, whichever is greater.
- 3. No reimbursement will be allowed for a person traveling with an injured employee unless there is a medical necessity that precludes the injured employee from traveling alone. The medical necessity must be substantiated in writing by the injured employee's treating physician or chiropractor.

Notice

An injured employee or any other person who knowingly makes a false statement or representation or knowingly conceals a material fact in order to obtain or attempt to obtain any benefit may be subject to both civil penalties and criminal prosecution. If convicted, a person forfeits all rights to workers' compensation benefits and is liable for reasonable investigation costs of the insurer and attorney general's office, court costs, and restitution for payment or benefits fraudulently obtained. If the amount of the benefit or payment is less than \$250, the penalty is a misdemeanor which may result in county jail time not to exceed six months and a fine up to \$1,000. If the amount of the benefit or payment is \$250 or more, the penalty is a category D felony which may result in imprisonment in the state prison for at least 1 year and not more than 4 years and a fine up to \$5,000. Insurance fraud includes, but is not limited to: 1) requesting temporary total disability compensation or rehabilitation maintenance compensation while gainfully employed; 2) making false statements about potential employer contacts, mileage or compensation, 3) misrepresenting facts concerning an industrial accident, injury or illness to others such as an employer, insurer, physician or chiropractor, vocational rehabilitation counselor, and 4) filing an invalid claim in order to obtain controlled substances.

If the employee is so severely injured that he is unable to complete this form, a friend, member of the family, labor representative, or other agent may complete and sign for the injured employee.

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		•								
Name (La	st, First, Middle Initial)						Claim Numb	oer		
Present A	ddress (P.O. Box, Apt. No	o., Street)					Social Secur	ity Number	•	
City		State		Zip			Date of Inju	ry		
Residence	e at time of injury:						[_] Approv	(For Insurer'	s Use Only)	
							Disapp		itials & Date	_
	TTRAVEL WEEK				_			=	-	
	ed for claim related of Nevada law.	l travel. Be aware	that any	misrepr	esentati	ion ma	y be cons	idered f	raud and	is in
			Daily Expense Reimburseme					nent	ent	
	Beginning Point of Travel	Destination	Enter Travel Time	Leave Travel		Meals			Miles One Allo	Mileage Allowed
Date	Address	Name/Address		Time	В	L	D	Lodging	Way	(For Insurers Use Only)
							-			
	, i							- "		
							тот	AL		
							Ml	ILES:		
		Total of _		Mile:	s X 2 @	\$	·	_ per Mi	le =	
reimburse NRS. I u	ertify that the record pr ment is related to or is nderstand that the rep ect me to criminal and e.	for treatment authorize porting of false inforn	d under Nev	ada Revise disqualify	ed Statute me fron	e (NRS) 1 receiv	616A to 616 ing workers	5D, inclusi ' compens	ve or chapte sation bene	er 617 of fits, and
Injured Er	nployee's Signature					- <u></u>	ate			

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•	<i>5</i> ,	1								
Name (La	st, First, Middle Initial)						Claim Numb	per		
Present A	ddress (P.O. Box, Apt. No	o., Street)					Social Secur	ity Number	•	-
City		State		Zip	**		Date of Injur	гу		
Residence	e at time of injury:						[] Approv		s Use Only) nitials & Date	;
REPOR?	Γ TRAVEL WEEKI	LY. See reverse si	ide of this	form for	the reg	ulation	s under wl	hich you	may be	_
	ed for claim related of Nevada law.	travel. Be aware	that any	misrepr	esentati	ion ma	y be cons	idered fi	raud and	is in
					Daily Exper		nse Reimbursement			Mileage
Duta	Beginning Point of Travel Address	Destination Name/Address	Enter Travel Time	Leave Travel	Meal		:	l Ladatie	Miles One	Allowed (For Insurers Use
Date	Address	Name/Audress		Time	В	L	D	Lodging	Way	Only)
								:		
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		Total of _		Mile	s X 2 @	\$	·	_ per Mi	le =	
reimburse NRS. I u	ertify that the record proment is related to or is finderstand that the repect me to criminal and e.	or treatment authorize orting of false inforn	ed under Nev nation may	ada Revis disqualify	ed Statute me fron	e (NRS) n receivi	616A to 616 ing workers	5D, inclusi compens	ve or chapte sation bene	er 617 of fits, and
Injured Er	mployee's Signature					Da	ate			

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- 3. No reimbursement will be allowed for a person traveling with an injured employee unless there is a medical necessity that precludes the injured employee from traveling alone. The medical necessity must be substantiated in writing by the injured employee's treating physician or chiropractor.

Notice

An injured employee or any other person who knowingly makes a false statement or representation or knowingly conceals a material fact in order to obtain or attempt to obtain any benefit may be subject to both civil penalties and criminal prosecution. If convicted, a person forfeits all rights to workers' compensation benefits and is liable for reasonable investigation costs of the insurer and attorney general's office, court costs, and restitution for payment or benefits fraudulently obtained. If the amount of the benefit or payment is less than \$250, the penalty is a misdemeanor which may result in county jail time not to exceed six months and a fine up to \$1,000. If the amount of the benefit or payment is \$250 or more, the penalty is a category D felony which may result in imprisonment in the state prison for at least 1 year and not more than 4 years and a fine up to \$5,000. Insurance fraud includes, but is not limited to: 1) requesting temporary total disability compensation or rehabilitation maintenance compensation while gainfully employed; 2) making false statements about potential employer contacts, mileage or compensation, 3) misrepresenting facts concerning an industrial accident, injury or illness to others such as an employer, insurer, physician or chiropractor, vocational rehabilitation counselor, and 4) filing an invalid claim in order to obtain controlled substances.

If the employee is so severely injured that he is unable to complete this form, a friend, member of the family, labor representative, or other agent may complete and sign for the injured employee.

EMPLOYEE'S DECLARATION OF ELECTION TO REPORT TIPS

For the Purpose of Workers' Compensation

Pursuant to NRS 616B.227

EMPLOYER:	
EMPLOYEE:	
EMPLOYEE IDENTIFICATION NUMBER:	
DEPARTMENT:	
SOCIAL SECURITY NUMBER:	
PAY PERIOD:T	0
AMOUNT OF TIPS RECEIVED DURING PERIOD:	\$
I understand that the reporting of false informat compensation benefits, and may subject me to criminal perjury that the information provided concerning the ar correct to the best of my knowledge. Those tips are decompensation.	and civil penalties. I declare under penalty of nount of tips which I have received is true and
Employee Signature	 Date

THIS FORM MUST BE SUBMITTED TO YOUR EMPLOYER BEFORE THE END OF THE PAY PERIOD THAT FOLLOWS THE PAY PERIOD INDICATED ABOVE.

EMPLOYEE'S DECLARATION OF ELECTION TO REPORT TIPS

For the Purpose of Workers' Compensation

Pursuant to NRS 616B.227

EMPLOYER:	
	UMBER:
PAY PERIOD:	TO
	URING PERIOD: \$
I understand that the reporting	g of false information may disqualify me from receiving workers'
compensation benefits, and may subj	ect me to criminal and civil penalties. I declare under penalty of
perjury that the information provided	I concerning the amount of tips which I have received is true and
correct to the best of my knowledge.	Those tips are declared as wages for the calculation of workers'
compensation.	
Employee Signature	Date

THIS FORM MUST BE SUBMITTED TO YOUR EMPLOYER BEFORE THE END OF THE PAY PERIOD THAT FOLLOWS THE PAY PERIOD INDICATED ABOVE.

EMPLOYEE'S DECLARATION OF ELECTION TO REPORT TIPS

For the Purpose of Workers' Compensation

Pursuant to NRS 616B.227

EMPLOYER:
EMPLOYEE:
EMPLOYEE IDENTIFICATION NUMBER:
DEPARTMENT:
SOCIAL SECURITY NUMBER:
PAY PERIOD: TO
AMOUNT OF TIPS RECEIVED DURING PERIOD: \$
I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties. I declare under penalty of perjury that the information provided concerning the amount of tips which I have received is true and correct to the best of my knowledge. Those tips are declared as wages for the calculation of workers' compensation.
Employee Signature Date

THIS FORM MUST BE SUBMITTED TO YOUR EMPLOYER BEFORE THE END OF THE PAY PERIOD THAT FOLLOWS THE PAY PERIOD INDICATED ABOVE.

NOTICE TO EMPLOYEES

Pursuant to: NRS 616B.227 Election by employee to report his tips; effect; regulation.

- 1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.
- 2. Upon receipt of such notice the employer shall:
 - (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;
 - (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and
 - (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.
- 3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

State of Nevada Department of Business and Industry Division of Industrial Relations

OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)

Submit within 30 days of acceptance/denial and any changes to the claim – PART 1
Submit within 30 days of appeal, closure, reopening, or confirmed diagnosis – PARTS 1 & 2

Submitted By:		Insurer	☐ TPA						
Company:									
Submitter Name:									
Telephone:									
Email:									
PART 1 (Claim	Information)	,							
Insurer Name:									
Insurer FEIN:									
Insurer Certificate l									
Claimant's Employ	er:								
Claimant's Name:		irst:		Last:					
Claim Number:									
Claim Disposition:		Accepted	Der	nied					
Reason for	☐ 1-Pending me	edical inves	tigation	☐ 2-N	egative test/no exposure 🔲 3	-Not in course/scope			
Denial:	4-Not compe	nsable/no d	isease		te reporting	correct predisposing condition			
Dellial.	7-Misc (dupl	icate claim,	wrong ins	surer/un	nsured, etc)				
CLAIMANT (Cho	ose one) & CLA	M ACCEI	TED/DE	NIED F	URSUANT TO NRS (Choose	one):			
FIREFIGHTER					POLICE OFFICER (PEACE OF	FICERS PER NRS 289.010 INCLUDED)			
☐ NRS 617.45	3 CANCER				NRS 617.455 LUNG DISE	·			
_	5 LUNG DISEASE				NRS 617.457 HEART DIS	·			
	7 HEART DISEASE				NRS 617.481 CERTAIN C				
	1 CERTAIN CONTA	GIOUS DISE	ASES		NRS 617.485 HEPATITIS				
☐ NRS 617.48		dioos pist	NOLO						
	J HEI ATTIS				☐ NRS 617.487 HEPATITIS				
ARSON INVESTI	GATOR				EMERGENCY MEDICAL ATTENDANT				
l —	LUNG DISEASE				☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES				
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 □ NRS 617.457 HEART DISEASE □ NRS 617.481 CERTAIN CONTAGIOUS DISEASES 						· .			
Date of Injury:	023333	100000000000000000000000000000000000000	1020						
Date Claim (C4) Re	ceived by Insure	/TPA:			· ·				
Date Accepted/Den									
Estimated Medical		\$			Diagnosis Co	onfirmed: Yes No			
Description of Clair	m;								
Initial Claim Closus	re Date:	Date Cl	aim Reope	ened (if	applicable): Subsequent C	Claim Closure Date			
					(if applicable):			
PART 2 (Appeal									
INITIAL APPEAI					SUBSEQUENT APPEAL OF	F DECISION BY:			
CLAIM DENIAL					☐ HO ☐ AO ☐ DC				
	Claimant/Depende	nt/Represer	ntative		· · · · =	ependent/Representative			
	mployer/Insurer				Employer/Insurer				
Appeal Number:					Appeal Number:				
Date Appeal Filed:					Date Appeal Filed:				
Hearing Date:					Hearing Date:				
Decision Date:	1 🗆 🗅	,	. 1. 1		Decision Date:				
Decision: Affirm	_	d Rem			Decision: Affirmed Reversed Remanded				
Modified Dismissed Stip (Explain):					Modified Dismissed Stip (Explain):				
Decision By:					Decision By:				
Hearing Officer Appeals Officer				Appeals Officer District Court Supreme Court					

State of Nevada Department of Business and Industry Division of Industrial Relations

OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)

Submit within 30 days of acceptance/denial and any changes to the claim - PART 1 Submit within 30 days of appeal, closure, reopening, or confirmed diagnosis - PARTS 1 & 2

Submitted By:	☐ Insurer ☐ TPA					
Company:						
Submitter Name:						
Telephone:						
Email:						
PART 1 (Claim Information)						
Insurer Name:						
Insurer FEIN:						
Insurer Certificate Number:						
Claimant's Employer:						
Claimant's Name:	First: Last:					
Claim Number:						
Claim Disposition:	Accepted Denied					
Reason for	medical investigation 🔲 2-1	Negative test/no exposure 3-Not in course/scope				
Denial: 4-Not com	pensable/no disease 🔲 5-I	Late reporting				
7-Misc (du	plicate claim, wrong insurer/u	ninsured, etc)				
CLAIMANT (Choose one) & CL	AIM ACCEPTED/DENIED	PURSUANT TO NRS (Choose one):				
FIREFIGHTER		POLICE OFFICER (PEACE OFFICERS PER NRS 289.010 INCLUDED)				
NRS 617.453 CANCER		NRS 617.455 LUNG DISEASE				
NRS 617.455 LUNG DISEASI	:	□ NRS 617.457 HEART DISEASE				
□ NRS 617.457 HEART DISEAS						
☐ NRS 617.481 CERTAIN CON		NRS 617.481 CERTAIN CONTAGIOUS DISEASES				
☐ NRS 617.485 HEPATITIS	IAGIOUS DISEASES	NRS 617.485 HEPATITIS				
INKS 017.465 HEPATITIS		□ NRS 617.487 HEPATITIS				
ARSON INVESTIGATOR		EMERGENCY MEDICAL ATTENDANT				
☐ NRS 617.455 LUNG DISEASE		☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES				
NRS 617.457 HEART DISEAS		NRS 617.485 HEPATITIS				
NRS 617.481 CERTAIN CONT		I Mes of Mes mes mes mes				
Date of Injury:	Adiod3 DisLASE3					
Date Claim (C4) Received by Insu	rer/TPA·					
Date Accepted/Denied:						
Estimated Medical Costs of Claims	\$	Diagnosis Confirmed: Yes No				
Description of Claim:						
Initial Claim Closure Date:	Date Claim Reopened (i	f applicable): Subsequent Claim Closure Date				
		(if applicable):				
PART 2 (Appeal Information)		<u>, </u>				
INITIAL APPEAL OF:		SUBSEQUENT APPEAL OF DECISION BY:				
	CCEPTANCE	□ HO □ AO □ DC				
	dent/Representative	Appealed By: Claimant/Dependent/Representative				
Employer/Insure	<u>r </u>	Employer/Insurer				
Appeal Number:		Appeal Number:				
Date Appeal Filed:		Date Appeal Filed:				
Hearing Date:		Hearing Date:				
Decision Date:		Decision Date:				
Decision: Affirmed Rever Modified Dismissed S	_	Decision: Affirmed Reversed Remanded Modified Dismissed Stin (Explain):				
☐ Modified ☐ Dismissed ☐ S Decision By:	пр (схрівін).	☐ Modified ☐ Dismissed ☐ Stip (Explain): Decision By:				
Hearing Officer Appeals	Officer	Appeals Officer District Court Supreme Court				
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State of Nevada Department of Business and Industry Division of Industrial Relations

OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)

Submit within 30 days of acceptance/denial and any changes to the claim – PART 1
Submit within 30 days of appeal, closure, reopening, or confirmed diagnosis – PARTS 1 & 2

Submitted By:		Insurer	TPA				
Company:							
Submitter Name:							
Telephone:							
Email:							
PART 1 (Claim I	nformation)						
Insurer Name:							
Insurer FEIN:							
Insurer Certificate N							
Claimant's Employer:							
Claimant's Name:		it:	I,	ast:	· .		
Claim Number:							
Claim Disposition:		Accepted	Denie	i			
Reason for	☐ 1-Pending med	ical inves	tigation 🔲	2-Negative test/no e	xposure 3-Not in course/scope		
Denial:	4-Not compens	able/no d	isease 🗌	5-Late reporting [6-Failure to correct predisposing condition		
Demai.	7-Misc (duplication)	ate claim,	wrong insur	er/uninsured, etc)			
CLAIMANT (Cho	ose one) & CLAIM	1 ACCEP	TED/DENI	ED PURSUANT TO	NRS (Choose one):		
FIREFIGHTER				D POLICE OFF	ICER (PEACE OFFICERS PER NRS 289.010 INCLUDED)		
NRS 617.453	3 CANCER				.455 LUNG DISEASE		
	5 LUNG DISEASE				.457 HEART DISEASE		
_	7 HEART DISEASE			=	.481 CERTAIN CONTAGIOUS DISEASES		
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	, illimited		☐ NRS 617.487 HEPATITIS				
ARSON INVESTIG	GATOR			■ EMERGENC	Y MEDICAL ATTENDANT		
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NRS 617.457 HEART DISEASE				□ NK2 01 /	.481 CERTAIN CONTAGIOUS DISEASES		
☐ NRS 617.457				=	.481 CERTAIN CONTAGIOUS DISEASES .485 HEPATITIS		
		OUS DISEA	ASES	=	1		
	HEART DISEASE	OUS DISEA	ASES	=	1		
☐ NRS 617.481	HEART DISEASE CERTAIN CONTAGI		ASES	=	1		
NRS 617.481 Date of Injury:	HEART DISEASE CERTAIN CONTAGE ceived by Insurer/1		ASES	=	1		
NRS 617.481 Date of Injury: Date Claim (C4) Re Date Accepted/Deni Estimated Medical (HEART DISEASE CERTAIN CONTAGIO Exceived by Insurer/Tied: Costs of Claim:		ASES	=	1		
NRS 617.481 Date of Injury: Date Claim (C4) Re Date Accepted/Deni Estimated Medical (Description of Clair	HEART DISEASE CERTAIN CONTAGIO CECEIVED by Insurer/Tied: Costs of Claim: n:	FPA:		□ NRS 617	.485 HEPATITIS Diagnosis Confirmed: Yes No		
NRS 617.481 Date of Injury: Date Claim (C4) Re Date Accepted/Deni Estimated Medical (HEART DISEASE CERTAIN CONTAGIO CECEIVED by Insurer/Tied: Costs of Claim: n:	FPA:		=	Diagnosis Confirmed: Yes No Subsequent Claim Closure Date		
NRS 617.481 Date of Injury: Date Claim (C4) Re Date Accepted/Deni Estimated Medical (Description of Clair Initial Claim Closur	HEART DISEASE CERTAIN CONTAGE received by Insurer/Tied: Costs of Claim: m: re Date:	FPA:		□ NRS 617	.485 HEPATITIS Diagnosis Confirmed: Yes No		
NRS 617.481 Date of Injury: Date Claim (C4) Re Date Accepted/Dent Estimated Medical (Description of Clair Initial Claim Closur PART 2 (Appeal	ceived by Insurer/Tied: Costs of Claim: n: ee Date: Information)	FPA:		□ NRS 617	Diagnosis Confirmed: Yes No Subsequent Claim Closure Date (if applicable):		
NRS 617.481 Date of Injury: Date Claim (C4) Re Date Accepted/Dent Estimated Medical (Description of Claim Initial Claim Closur PART 2 (Appeal INITIAL APPEAL	ceived by Insurer/Tied: Costs of Claim: n: Date: Information	PA: \$ Date Cla		d (if applicable):	Diagnosis Confirmed: Yes No Subsequent Claim Closure Date (if applicable): TAPPEAL OF DECISION BY:		
□ NRS 617.481 Date of Injury: Date Claim (C4) Re Date Accepted/Dent Estimated Medical (Description of Clair Initial Claim Closur PART 2 (Appeal INITIAL APPEAL □ CLAIM DENIAL	ceived by Insurer/Tied: Costs of Claim: n: de Date: Information OF: CLAIM ACC	PA: \$ Date Cla	aim Reopene	d (if applicable): SUBSEQUEN HO	Diagnosis Confirmed: Yes No Subsequent Claim Closure Date (if applicable): TAPPEAL OF DECISION BY: D DC		
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NRS 617.481 Date of Injury: Date Claim (C4) Re Date Accepted/Dent Estimated Medical (Description of Claim Initial Claim Closur PART 2 (Appeal INITIAL APPEAL CLAIM DENIAL Appealed By: C Appeal Number: Date Appeal Filed: Hearing Date: Decision: Affirm	ceived by Insurer/Tied: Costs of Claim: n: e Date: Information OF: CLAIM ACCI	PA: \$ Date Cla EPTANCE /Represer	ntative	SUBSEQUEN HO	Diagnosis Confirmed: Yes No Subsequent Claim Closure Date (if applicable): TAPPEAL OF DECISION BY: D DC Claimant/Dependent/Representative Employer/Insurer Titled: Affirmed Reversed Remanded		

OD-8 (7/18)