February 20, 2014

South Carolina Workers' Compensation

Workers' Compensation Compliance Poster

We are operating under and subject to the South Carolina Workers' Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

Workers' Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

If you are injured on the job, you should:

1. Notify your employer at once. You cannot receive benefits unless your employer knows you are injured.
2. Tell the doctor your employer sends you to that you are covered by workers' compensation.
3. Notify the Workers' Compensation Provider listed on this poster or the South Carolina Workers' Compensation Commission at 803.737.5700 if you experience undue delays or problems with your claim.

South Carolina
Workers' Compensation Commission
P.O. Box 1715, 1333 Main Street, Suite 500
Columbia, S.C. 29202-1715
803-737-5700
www.wcc.sc.gov

Workers' Compensation Provider Name

Berkley Industrial Comp

Mailing Address

P.O. Box 660847
Birmingham, AL 35266

Claims Telephone Number

(800) 448-5621

Compensación del Trabajador

Si usted se lesiona en el trabajo, usted debe:

1. Notificar a su patrón inmediatamente. Usted n puede recibir beneficios a menos que su patrón sepaque se ha lesionado.
2. Decirle al doctor al que su patrón le envíe que usted está cubierto por la Compensación del Trabajador.
3. Notificar al Proveedor de Compensación del Trabajador abajo mencionado o a la Comisión de Compensación del Trabajador de Carolina del Sur al (803) 737-5700 si usted tiene retrasos o problemas indebidos con su reclamación.

La Compensación del Trabajador:

1. Paga el 100% de sus recibos médicos y otros gastos.
2. Le compensa por el 66 2/3% de su salario, limitado al salario máximo establecido por la ley, si usted no puede trabajar por más de siete (7) días calendario.

Trabajamos conforme al Acto de Compensación del Trabajador de Carolina del Sur

En caso de lesión accidental o muerte de un empleado, el empleado lesionado, o alguien que le represente, tiene que avisar inmediatamente al patrón o agente autorizado general. El hecho de no avisar inmediatamente puede causar una demora seria en el pago de la compensación al empleado lesionado o a sus dependientes y puede resultar en el impago de los beneficios de compensación según estipula la ley.

S.C. Workers' Compensation Commission
(Comisión de Compensación de Trabajadores)
1333 Main Street
Columbia, SC 29201
(803) 737-5700
www.wcc.state.sc.us

SOUTH CAROLINA WORK INJURY REPORTING PROCEDURES

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

First Report of Injury or Illness (WCC Form 12-A)

This form must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, First Reports of Injury or Illness (FROI's) may be submitted to us online at: www.berkindcomp.com. Online Reporting Instructions are enclosed. Maintain a copy of the Employer's Report of Occupational Injury or Disease for your records. Keep a separate file for each workers' compensation claim.

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the FROI. If the FROI is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

Statement of Earnings (WCC Form 20)

The Statement of Earnings must be completed on claims involving lost time from work.

Please contact our claims department if you have questions about completing the Statement of Wage Information.

Do not delay reporting the First Report of Injury or Illness for completion of the Statement of Earnings.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

WORKERS' COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX ☐ Male ☐ Female ☐ Unknown	MARITAL STATUS ☐ Unmarried/Single/Divorced ☐ Married ☐ Separated ☐ Unknown	OCCUPATION/JOB TITLE EMPLOYMENT STATUS NCCI CLASS CODE	
PHONE	# OF DEPENDENTS			
RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO		

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ☐ AM (☐) CANNOT BE DETERMINED ☐ 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
DEPARTMENT OR LOCATION WHERE 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(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO		
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT 0 ☐ NO MEDICAL TREATMENT 1 ☐ MINOR: BY EMPLOYER 2 ☐ MINOR CLINIC/HOSP 3 ☐ EMERGENCY CARE 4 ☐ HOSPITALIZED > 24 HOURS 5 ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED		

OTHER

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

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:
Full-Time On Strike Unknown Volunteer
Part-Time Disabled Apprenticeship Full-Time Seasonal
Not Employed Retired Apprenticeship Part-Time Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

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:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Insurance Carrier: _____

Preparer's Name: _____ Preparer's Phone #: _____

Date of Injury: _____
month day year

A. Total Wages Paid

1. Check Applicable Method:
   - ☐ Report of earnings of injured employee based on four completed quarters.
   - ☐ Report of earnings of injured employee who did not complete four quarters based on actual time worked.
   - ☐ Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire date: _____
   - ☐ Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just (attach documentation to show how average weekly wage and compensation rate were calculated).

2. List total wages paid as reported to the Employment Security Commission on the Employer Quarterly Contribution and Age Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

Quarter	Ending Date	Total Wages Paid
1st		$
2nd		$
3rd		$
4th		$

Total Paid 2. $ _____

3. List total value of other allowances of any character made in lieu of wages during four quarters above. 3. $ _____
4. Add lines 2 and 3. **TOTAL WAGES PAID:** 4. $ _____
5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. _____

B. Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5).
   AVERAGE WEEKLY WAGE: 6. $ _____

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667. Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. $ _____
8. The compensation rate is as follows (choose one):
   - ☐ When average weekly wage (line 6) is less than $75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
   - ☐ When the estimated compensation rate (line 7) is less than $75.00 and average weekly wage (line 6) is more than $75.00, the compensation rate is $75.00. Enter $75.00 on line 8.
   - ☐ When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
   - ☐ Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8. _____
   - ☐ The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.

WEEKLY COMPENSATION RATE: 8. $ _____

Employer's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED, THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803)737-5723.