Employee Copy

Workers' Compensation Procedures

IF YOU ARE INJURED AT WHILE AT WORK:

- Report your injury to your supervisor
- See campus nurse for evaluation if possible
- Complete injury forms and return to benefits
- Visit Network Physician as necessary
- Notify supervisor and benefits department of work status

WORKERS' COMPENSATION FORMS:

Complete and Return to Benefits

- *Employee Acknowledgment of Workers' Compensation Network* form
- *Employee Choice to Use Paid Leave* form
- *Accident Investigation Form*

Employee to Keep

- *Workers' Compensation Temporary Income Benefits and your Waller ISD Pay* document
- *Workers' Compensation Information* document
- *Workers' Compensation Verification of Coverage* document
- *Texas Star Network Clinics/Physicians near Waller* document

---

IMPORTANT! Do not file work related injuries on your group medical or prescription plans. File only with the Workers' Compensation Carrier.

Workers' Compensation Carrier
Texas Mutual
1-800-859-5995
Pharmacy Info: Optum
Pharmacy Phone: 1-888-220-2805

Employee Benefits Administrator
Becky Jimenez
Phone: 936-372-4037
Fax: 936-931-4080

WORKWELL,TX

Employee Acknowledgment of Workers' Compensation Network

I have received information that informs me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this packet, I understand that:

- I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual Insurance Company at (844) 867-2338 to notify them of my choice.
- I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me to a specialist. If I need emergency care, I may go anywhere.
- Texas Mutual will pay the treating doctor and other network providers for the treatment for my compensable injury.
- I may have to pay the bill if I get health care from someone other than a network doctor without prior network approval.

Knowingly making a false workers' compensation claim may lead to a criminal investigation that could result in criminal penalties such as fines and imprisonment.

_____ _____ _____

Signature Date Printed name

I live at: _____

Street address

_____

City State Zip code

Name of employer: _____

Name of network: WorkWell, TX

To the employer:

Each employee must sign this form when you begin the program or within 3 days of being hired, and at the time an injury occurs. Please indicate at which point this acknowledgement was completed.

□ Initiating the network program (companywide)
□ Initial employee notification (new hire)
□ Injury notification (Date of injury: / /)

Keep this completed form in the employee's personnel file. It could be requested by Texas Mutual.

EMPLOYEE CHOICE TO USE PAID LEAVE
WITH WORKERS' COMPENSATION BENEFITS

NAME_____ **SOCIAL SECURITY NO.**_____

POSITION_____ **DEPT/CAMPUS**_____

DATE OF WORK RELATED INJURY: _____

Workers' Compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

Employee Choice: (See DEC (Local) policy)

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I choose the following option:

□ I choose to use only _____days of available paid leave at this time.

□ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or pre-injury wage.

□ I choose **NOT** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Waller ISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will only receive workers' compensation wage benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

_____ _____

Employee Signature **Date**

Employee Copy

Workers' Compensation Temporary Income Benefits and your Waller ISD Pay

If you are injured while at work:

- Report your injury to your supervisor immediately
- See campus nurse for evaluation to determine if further medical evaluation is necessary
- Complete injury forms and return to the Benefits Department even for Report Only
- Visit Network Physician as necessary
- Notify supervisor and The Benefits Department of work status

NOTE: Workers' Compensation (WC) paperwork can be found on the Waller ISD website under Staff Resources and Workers' Compensation.

Scenario 1 – Return without Restrictions:

If you are injured at work, visit a network physician for evaluation. If the physician has determined you may return to work without restrictions the next day, the physician visit is covered under Texas Mutual Insurance Company; however, you will not be entitled to WC income benefits. If you left work to visit the doctor, you may use your available leave days to cover your absence for the one appointment. There are no WC income benefits available to you within the first 7 days of leave.

Scenario 2 – Return with Restrictions and Accommodation:

If you are injured and the network physician has determined you may return with restrictions, the supervisor in collaboration with the Benefits Administrator will review the restrictions and decide whether or not WISD can accommodate the restrictions given.

If WISD can accommodate the restrictions, the employee will be expected to return to work. The supervisor will communicate the new parameters and the employee will work within the boundaries determined by the physician. The initial physician visit and any follow up appointments are covered under Texas Mutual Insurance Company; however, you will not be entitled to WC income benefits. If you miss work to visit the doctor, you may use your available leave days to cover your absence(s). There are no WC income benefits available to you within the first 7 days of leave.

Scenario 3 – Restrictions and No Accommodation:

If you are injured and the network physician has determined you may return with restrictions, the supervisor in collaboration with the Benefits Administrator will review the restrictions and decide whether or not WISD can accommodate the restrictions given.

If WISD cannot accommodate the restrictions, the employee will not be allowed to work. The initial physician visit and any follow up appointments are covered under Texas Mutual Insurance Company; however, you will not be entitled to WC income benefits for the first 7 days of leave.

When you miss work to visit the doctor or when you are unable to work under restrictions, you may use your available leave days to cover your absence(s). When you use your leave days, your WISD pay remains at 100% for that period of time. WC income benefits may begin on the 8th day of leave. You are not able to use your available leave at 100% pay **and** receive WC income benefits at the same time. You must choose whether to use all available leave and be paid at 100% from WISD **or** take a reduced WC income benefit check at about 70%. This decision must be communicated to the Benefits Administrator for proper processing.

If you choose not to use any available leave **and** are out more than the initial 7 days, WC will begin paying you income benefits on the 8th day and retroactively to the date of injury.

Scenario 4 – Return to Work without Restrictions after an Extended Leave:

After you have been out for an extended amount of time beyond the 8th day but have been given a full release to return to work, you are expected to return to full duty. Your WC income benefits will end and your WISD income will begin again.

When completing the Employee Choice to Use Paid Leave form in the WC packet, please indicate how you want to be paid for the days not at work by marking the appropriate box understanding the pay scenarios given previously.

Employee Elected Benefit Premiums

When you chose to use WC income benefits over your available leave, you will still be responsible for all employee elected benefit premiums such as medical, dental, disability, etc. The Benefits Administrator will contact you when payment is due and you will be able to either pay by check, cash or money order.

ACCIDENT INVESTIGATION FORM

- Accident investigation and analysis helps you in reducing or preventing future occupational injuries and illnesses.
- This form requests all the information that DWC says you must record for each on-the-job injury, fatality, and occupational disease. Employers must keep injury records for five years after the last day of the year in which the injury occurred.

This is an ☐ **Report Only** ☐ **Injury** ☐ **Disease** ☐ **Fatality** ☐ **Near-miss**

TODAY'S DATE _____

DATE REPORTED _____

COMPANY WALLER ISD

DEPARTMENT _____

SUPERVISOR _____

PHONE NO. _____

1. Name of Person Involved	2. Sex	3. Social Security Number	4. DOB	5. Date of Incident

6. Home Address _____ _____ Phone ( )	**7. Time and Day of Incident** _____ a.m; _____ p.m; day of week ____ **9. Employee's Occupation**	**8. Specific Location of Incident** Was it on employer's premises? ☐ yes ☐ no **10. Job Task at Time of Incident**
13. Name and Address of Treating Physician _____ _____ Phone ( )	**11. Length of Service** _____Years; _____ Months **14. Employment Category** ☐ Regular, full-time ☐ Temporary ☐ Regular, part-time ☐ Non-employee ☐ Seasonal	**12. Employee was Working** ☐ Alone ☐ With Fellow Workers ☐ Other **15. Experience in Occupation at Time of Incident** ☐ Less than 1 month ☐ 1 to 5 month ☐ 6 months to 1 year ☐ 1 to less than 5 years ☐ 5 or more years
16. Name and Address of Hospital _____ _____	**17. Phase of Employee's Workday at Time of Injury** ☐ During break period ☐ During meal period ☐ Working overtime ☐ Entering or leaving the building ☐ Performing work duties ☐ Other (explain below) **18. Name of employee's immediate Supervisor at time of incident Witnessed Incident?** ☐ Yes ☐ No	
19. Employee's Wage (pay per Hour)	**20. Other Witnesses**	
21. Voluntary benefits paid by the employer, if any	_____	

IF APPLICABLE:
CAMPUS NURSE EVALUATION: _____

_____

_____

Signature of Campus Nurse **Date**

22. PART of BODY INFURIED or AFFECTED

☐ Skull, Scalp ☐ Jaw ☐ Abdomen ☐ Shoulder ☐ Wrist ☐ Knee ☐ Foot
☐ Eye ☐ Neck ☐ Back ☐ Upper Arm ☐ Hand ☐ Thigh ☐ Toe
☐ Nose ☐ Spine ☐ Pelvis ☐ Elbow ☐ Finger ☐ Lower Leg ☐ Ankle
☐ Mouth ☐ Chest ☐ Other Body Part ☐ Forearm ☐ Hip ☐ Other _____

23. NATURE of INJURY or ILLINESS

☐ Puncture ☐ Bruise, Contusion ☐ Skin Disorder ☐ Amputation ☐ Muscle Sprain ☐ Cumulative Trauma Disorder
☐ Laceration ☐ Dislocation ☐ Burn ☐ Insect/Animal Bite ☐ Muscle Strain ☐ Irritation
☐ Fracture ☐ Abrasion ☐ Respiratory ☐ Foreign Body ☐ Hernia ☐ Infection
☐ Heat/Cold Stress ☐ Hearing Loss ☐ Chemical Exp. ☐ Other _____

24. DISPOSITION

☐ Days away from work # _____
☐ Restricted work days # _____
☐ Date returned to work # _____
Sent to: ☐ Doctor ☐ Hospital

25. DIAGNOSIS

_____
_____
_____

26. SEVERITY

☐ First Aid ☐ Medical Treatment
☐ Lost Work Days ☐ Fatality
☐ Other: Specify
_____

27. WHAT CONDITION of TOOLS, EQUIPMENT, or WORK AREA CONTRIBUTED TO INCIDENT? ☐ Not Applicable

☐ Close Clearance/Congestion ☐ Floors/Work Surfaces ☐ Inadequate Housekeeping ☐ Defective Tools/Equipment/Vehicle
☐ Hazardous Placement ☐ Inadequate Ventilation ☐ Equipment Failure ☐ Illumination
☐ Inadequate Warning System ☐ Equipment/Workstation Design ☐ Inadequate Guards/Barrier ☐ Inadequate/Improper P.P.E.

28. WHAT CAUSED or INFLUENCED SUBSTANDARD CONDITIONS? ☐ No Substandard Conditions

☐ Abuse or Misuse ☐ Inadequate Supervision ☐ Inadequate Purchasing ☐ Inadequate Engineering
☐ Inadequate Maintenance ☐ Inadequate Tools/Equip..Mat. ☐ Improper Work Surfaces ☐ Wear and Tear
☐ Lack of Knowledge/Training ☐ Improper Motivation ☐ Inadequate Capacity ☐ Lack of Skill

29. WHAT ACTION or INACTION CONTRIBUTED to the INCIDENT? ☐ Not Applicable

☐ Failure to Make Secure ☐ Under Influence Drugs/Alcohol ☐ Failure to Warn/Signal ☐ Inadequate/Improper P. P. E. Use
☐ Nullified Safety/Control Devices ☐ Used Defective Equipment ☐ Horseplay/Distractive Active ☐ Operating at Improper Speed
☐ Used Equipment Improperly ☐ Improper Lifting ☐ Operating Procedure Deviation
☐ Running/Rushing/Acting in Haste ☐ Improper Loading ☐ Unauthorized Actions ☐ Used Wrong Tool/Equipment
☐ Improper Technique ☐ Improper Position ☐ Servicing/Operating Equipment
☐ Other _____

30. PROBABLE RECURRENCE

☐ Frequent ☐ Occasional ☐ Rare

31. LOSS SEVERITY POTENTIAL

☐ Major ☐ Serious ☐ Minor

32. PREVENTIVE MEASURES: (What corrective actions have been taken or are planned to prevent a recurrence?)

☐ Improve Enforcement ☐ Improve Clean-up Procedures ☐ Repair/Replace Equipment ☐ Corrective Counseling
☐ Improve Storage/Arrangement ☐ Rotation of Employee ☐ Eliminate Congestion ☐ Improve/Change Work Method
☐ Identify/Improve P. P. E ☐ Install/Revise Guards/Devices ☐ Task Analysis to Be Completed
☐ Task Analysis/Procedure Revision ☐ Improve Design/Construction ☐ Job Reassignment of Employees
☐ Use Other Materials/Supplies ☐ Improve Illumination ☐ Mandatory Pre-Job Instructions
☐ Improve Ventilation ☐ Reinstruction of Employees ☐ Other _____

33. EMPLOYEE'S DESCRIPTION of INCIDENT (Attach sheet for additional comments) ☐ Comments sheet

_____
_____
_____
_____
_____

Employee to complete this section Employee Signature Date

34. SUPERVISOR'S DESCRIPTION of INCIDENT (Attach sheet for additional comments) ☐ Comments sheet

_____
_____
_____
_____
_____

35. SPECIFIC CORRECTIVE ACTIONS or PREVENTIVE MEASURES TAKEN

Corrective Action Taken	Person Responsible	Target Date	Date Completed

_____ _____
Supervisor's Signature Date

Employee Copy

WORKERS' COMPENSATION INFORMATION

IF YOU DO NOT USE A WORKERS' COMPENSATION NETWORK PROVIDER, WALLER ISD WILL NOT BE RESPONSIBLE FOR PAYMENT OF YOUR MEDICAL BILLS. DO NOT FILE WORK RELATED INJURIES ON YOUR GROUP MEDICAL OR PRESCRIPTION PLANS.

TO FIND A NETWORK PROVIDER, CALL 1-800-381-8067.

Give the network provider the following Workers' Compensation insurance and district contact information:

Provider Network Name:	WorkWell, TX
Provider Network Phone:	1-844-867-2338
Carrier Name:	Texas Mutual
Carrier Phone:	1-800-859-5995
Carrier Address:	P.O. Box 12029 Austin, TX 78711
Carrier Group #:	0001135603
Pharmacy Info:	Optum
Pharmacy Phone:	1-888-220-2805
Pharmacy Email:	www.optum.com
Pharmacy Group #:	CC3778

Waller ISD Employee Benefits Administrator
Becky Jimenez
Phone: 936-372-4037
Fax: 936-931-4080

You are required to submit the following to your supervisor or Becky Jimenez in Employee Benefits:

1. Status report(s) from provider stating return to work date
2. Follow up appointment date(s)
3. Time off requests related to injury

IMPORTANT

Return to work statuses with restrictions may or may not be honored dependent on the essential duties of the position.

If an employee is sent for treatment or a medical evaluation at the District's request, he/she will not be penalized for any lost time on the day of the injury. Any medical treatments or appointments after the day of injury may require the employee to use available leave or be subject to loss of pay.

Waller
Independent School District

Employee Benefits Department

1918 Key Street
Waller, Texas 77484

Phone: 936-372-4037
Fax: 936-931-4080
website: www.wallerisd.net
e-mail: bjimenez@wallerisd.net

Employee Copy

WORKERS' COMPENSATION
VERIFICATION OF COVERAGE

_____, has reported a work-related injury/illness that occurred on _____. Waller ISD maintains workers' compensation coverage with Texas Mutual, a member of the Texas Property and Casualty Insurance Guaranty Association, which directly contracts with health care providers for the provision of workers' compensation benefits to the injured employees. A list of approved contracted providers can be found at www.texasmutual.com.

Please contact Texas Mutual at the phone number below to verify reasonable and necessary medical treatment. To file expenses incurred for this claim, please submit all bills to:

Texas Mutual
P.O. Box 12029
Austin, TX 78711-2029
Policy Number: 0001135603
Phone: 1-800-859-5995
Fax: 512-224-3889

To locate a pharmacy or for pharmacy questions:

Optum
Phone: 1-888-220-2805
www.optum.com

This notice is verification that workers' compensation coverage exists. It does not guarantee compensability of the reported injury. If you have any questions or should you need additional information regarding this injury, please contact Waller ISD at 936-372-4037.

District Contact: Becky Jimenez, Employee Benefits Administrator
Phone: 936-372-4037
Email: bjimenez@wallerisd.net

Employee Copy

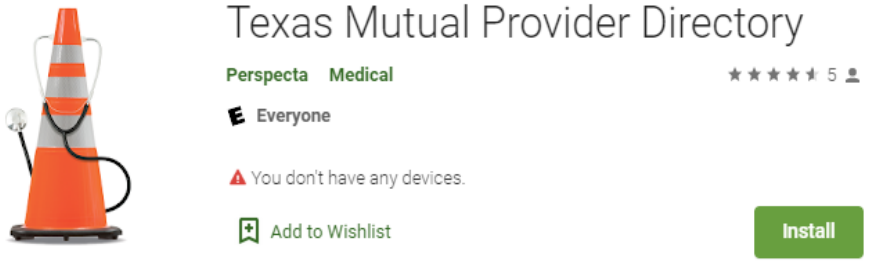
To Locate a Provider in the Workwell, TX network please visit:

https://www.viiad.com/tmi/public/main/Home

OR

You can download the Texas Mutual Provider Directory app from your Apple or Android device.

Google Play Store



Apple App Store

Employee Copy

First Fill

Simplifying the prescription process and helping workers take the first step toward getting well

Texas Mutual's First Fill Program enables your employees to get prescribed medication quickly after an injury occurs, even if you haven't had the opportunity to file a claim. Injured workers can get a seven-day supply for each covered prescription with a maximum of $500 per prescription with just the First Fill form.

Complete the First Fill form on the back of this sheet and advise your employee to present it at a participating Optum pharmacy.

The form is valid for the first fill and cannot be used if the first prescription fill is being requested more than 10 days after the injury occurred.

If additional forms are needed, visit the employer forms section at texasmutual.com.

TexasMutual®
WORKERS' COMPENSATION INSURANCE
WORK SAFE, TEXAS®

texasmutual.com

WorkSafeTexas.com • SafeHandTexas.com • TexasOilAndGasSafety.com • TexasMutual.WordPress.com

Employee Copy

Prescription First Fill Form

Prescription First Fill Instructions

1. Participating Optum pharmacies include Walgreens, CVS, Walmart, Kroger, Target, Costco, Sam's Club, Brookshire, HEB and Tom Thumb. To locate other participating pharmacies, visit www.texasmutual.com/hcn/hcn.shtm or www.cypresscare.com.
2. Complete the form and take to the pharmacy along with your prescription from the provider.
3. This form allows you to fill your initial prescription(s) with a maximum cost of $500 per covered prescription and a maximum 7 day supply.
4. If you have questions, please call us at 1-888-220-2805, available 24 hours a day, seven days a week.

Bin #: **Pharmacy to Call for BIN** **Group Number:** **TEXASMUTUALFF**

Member ID:		Last 4 digits of SSN + date of injury; No spaces (i.e. 9999050206)
Member Name:		Injured worker's first & last name
Employer Name:		
Date of Injury:		

Policyholder Information

Pharmacy Help Desk: **1-888-220-2805**

PLEASE NOTE: This form is only **valid within 10 days** of the injury date. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive a pharmacy card, please call us **at 1-888-220-2805**.

Issuance of this letter or dispensing of a prescription does not constitute acceptance of your claim.