PO Box 945927
Maitland, FL 32794-5927
321-214-5350 • Fax 321-214-0235
800-226-0666 • ffvamutual.com

Welcome to the FFVA Mutual family.

As a policyholder, your company has access to a variety of tools and resources to help provide a safe environment for your employees. Our services include support from our safety consultants, a library of online resources, access to *Safety Key*, and ongoing training programs to reduce workplace injuries and manage claim costs.

In this welcome packet you will find:

1. **Florida Workers' Compensation Notice of Compliance** – this poster **must be posted** in a conspicuous place for your employees to see. This poster should be present at all locations for your business.
2. **When a Workplace Accident Occurs** – procedures to follow when reporting an injury.
3. **Initial Treatment Authorization** – to copy and send with your injured employee when treatment is sought.
4. **Pharmacy Benefits form** – to copy and send with injured employee to bring to the pharmacy when filling authorized prescriptions.
5. **First Report of Injury (FROI)** – We encourage employers to immediately report all workplace injuries. Report injuries 24/7 by phone, fax, email or online.

To access **state-specific forms**, visit www.ffvamutual.com/employers/claims/forms – click to expand state.

- **For medical emergencies, call 911**, and report the injury to FFVA Mutual's Claims Center at 800-226-0666 (available 24/7).
- For non-life-threatening injuries, call our Claims Center at 800-226-0666 (available 24/7). You may send injured workers to the closest walk-in clinic or hospital.
- After the claim is reported, your dedicated claims adjuster will begin to manage the injured worker's care and return to work transition.

Login assistance:

- Online Policyholder account, please contact our customer support staff at 800-346-4825 or customersupport@ffvamutual.com.

Rest assured your workers' compensation needs are covered with FFVA Mutual.

PO Box 945927
Maitland, FL 32794-5927
321-214-5350 • Fax 321-214-0235
800-226-0666 • ffvamutual.com

WHEN A WORKPLACE ACCIDENT OCCURS

Immediately report all workplace injuries to our Claims Center at 800-226-0666 for 24-hour assistance and healthcare provider referrals. Notice of Injuries can be reported by email to claimsnoi@ffvamutual.com or by fax to 321-214-0235. **Please do not delay your call for lack of information**.

We will always ask for your tax ID number and policy number. Fill in below for quick reference:

Tax ID #_____ Policy # _____

Employee Information

- Address and Phone
- Date of birth
- Gender
- Marital status
- Name
- Social Security Number

Employee Job Information

- Average hourly wages
- Date disability began
- Hire Date
- Hours worked per day
- Payroll job class code

Employer Information

- Date employer first notified of injury
- Did injury occur due to not using a safety device?
- Do you agree with employee's description of the accident?
- Name, address and phone number
- Tax ID #
- Type of business

Injury Information

- Accident description
- Date and time injury reported to employer
- Time of day accident occurred
- Where accident occurred (address and county)

Medical Care Information

- Did employee request medical care?
- Name, address, phone of doctor or hospital providing initial care
- Was medical care provided?
- Was medical treatment authorized?

Work Information

- Has employee returned to work? (If yes, what date?)
- Last day employee worked
- What was the employee doing when injured?

PO Box 945927
Maitland, FL 32794-5927
321-214-5350 • Fax 321-214-0235
800-226-0666 • ffvamutual.com

INITIAL TREATMENT AUTHORIZATION

To: Medical Facility:

From: Employer

Date:

RE: Claimant :
D/B :
Soc. Sec. No. :
Employer :
D/A :

Please accept this as authorization for initial medical treatment on the above-captioned injured employee. If this injured worker needs to be referred out, please call FFVA Mutual at 800-226-0666.

Please mail your bill and report to FFVA Mutual, PO Box 945927, Maitland, Florida 32794-5927; telephone number 800-226-0666; fax number (321) 214-0235.

Date: _____

_____ Full Duty

_____ Light Duty (as the employer participates in an Early-Return-to-Work Program)

Restrictions: _____

Diagnosis: _____

Next Office Visit: _____

Please provide the employee with a copy of the completed form.

Thank you for your prompt attention to the above.

Workers' Compensation Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy to speed up the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? **Call the Patient Care Contact Center at 800.945.5951.**

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, **por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.**

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____/_____/_____
MM/DD/YYYY

Group #: ZX3A

Employee Date of Birth: _____/_____/_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

To the Pharmacist:

myMatrixx, an Express Scripts company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of $500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

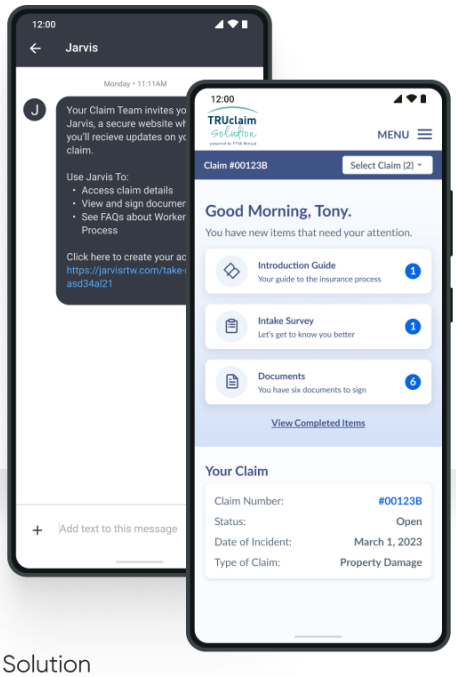
_____

FFVA mutual

gain life | TRUclaim Solution powered by FFVA Mutual

Making Workplace Insurance Claims Easier

TRUclaim Solution is a website designed to support and guide injured workers through the Workers' Compensation process.



Top Benefits for Employers

By quickly connecting your injured employees to claim and recovery resources, TRUclaim Solution helps maintain positive relationships while guiding your employees back to work.

Connect Employee to Insurer

Once the claim is in TRUclaim Solution, your employee will be contacted by their claims team within 24 hours.

Return to Work Faster

TRUclaim Solution helps to minimize prolonged claims through proactive check-ins and streamlined processing.

Top Benefits for your Injured Workers

By increasing transparency and access to resources, TRUclaim Solution empowers injured employees to understand and easily navigate the claims process to achieve better outcomes.

Send messages anytime

Securely communicate with your insurance claims team via text, email, or in-app messaging 24/7.

View & sign documents faster

Read, upload, and e-sign documents directly in TRUclaim Solution without waiting for mail.

Appointments and Reminders

Reminders for upcoming appointments and to share updates with their claims team.

Expectation-Setting Content

Access to a library of resources and FAQs to reduce anxiety and extra communications.

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)

Social Security Number

Date of Accident (Month-Day-Year)

Time of Accident ☐ AM ☐ PM

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION

DATE OF BIRTH

_____ / _____ / _____

SEX ☐ M ☐ F

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

EMPLOYER INFORMATION

COMPANY NAME: _____

D. B. A.: _____

Street: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

DATE EMPLOYED

_____ / _____ / _____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED

_____ / _____ / _____

RETURNED TO WORK ☐ YES ☐ NO
IF YES, GIVE DATE

_____ / _____ / _____

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP

_____ / _____ / _____

PLACE OF ACCIDENT (Street, City, State, Zip)

Street: _____

City: _____ State: _____ Zip: _____

COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable)

_____ / _____ / _____

AGREE WITH DESCRIPTION OF ACCIDENT?

☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK

$ _____ PER ☐ DAY ☐ MO

Number of hours per day _____

Number of hours per week _____

Number of days per week _____

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.

I have reviewed, understand and acknowledge the above statement.

_____ EMPLOYEE SIGNATURE (If available to sign)

_____ DATE

_____ EMPLOYER SIGNATURE

_____ DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case - DWC-12, Notice of Denial Attached

☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)

Employee's 8TH Day of Disability _____ / _____ / _____

Entity's Knowledge of 8TH Day of Disability _____ / _____ / _____

☐ 3. Lost Time Case - 1st day of disability _____ / _____ / _____ Full Salary in lieu of comp? ☐ YES Full Salary End Date _____ / _____ / _____

Date First Payment Mailed _____ / _____ / _____ AWW _____ Comp Rate _____

☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH ☐ SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:

INSURER CODE #

EMPLOYEE'S CLASS CODE

EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #

CLAIMS-HANDLING ENTITY FILE #

INSURER NAME

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

FFVA Mutual Insurance Co.
P.O. Box 945927
Maitland, FL. 32794-5927
Phone: 321-214-5350
Fax: 321-214-0235

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

PO Box 945927
Maitland, FL 32794-5927
321-214-5350 • Fax 321-214-0235
800-226-0666 • ffvamutual.com

SAFETY & LOSS CONTROL

What sets FFVA Mutual apart is our hands-on approach to loss control provided by expert safety consultants. We offer a variety of services, training and resources at no additional cost to our policyholders.

Safety Services

- Ergonomic assessments
- Hazard identification
- Incident and accident analysis
- Industrial hygiene evaluations
- On-site and off-site training courses
- Regulatory compliance assistance
- *Safety Key*, an online toolkit
- Webcasts

Training Courses and Events

- Defensive driving
- First aid
- Hazardous communications
- Job hazard analysis (JHA)
- OSHA (10-hour) for construction and general industry
- Personal protective equipment (PPE)
- Recordkeeping
- Safety Foundations
- Safety Leadership Academy

Unlock Safety Resources

Safety Key is an online area that provides access to:

- Customizable programs and policies
- Meeting materials, forms and checklists by topic
- On-demand webcasts and short talks
- Safety program guides, general and by industry
- Workplace safety tips

To request a Safety Key login, visit go.ffvamutual.com/get-safetykey
For in-person training, visit go.ffvamutual.com/get-training