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. **Commonwealth of Kentucky Workers' Compensation Posting Notice –** 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. **Kentucky Workers' Compensation Designated Physician form** – the injured employee may elect the physician/facility of his/her choice.
3. **When a Workplace Accident Occurs** – procedures to follow when reporting an injury.
4. **Initial Treatment Authorization** – to copy and send with your injured employee when treatment is sought.
5. **Pharmacy Benefits form** – to copy and send with injured employee to bring to the pharmacy when filling authorized prescriptions.
6. **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).
- For initial treatment have the injured worker elect a physician of his/her choice on the **Designated Physician** form.
- 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.

Form 113
Designation of Physician
Revised 03-12-03

Two-Sided Form

COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS' CLAIMS
Claim No. _____

NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: _____
Name

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

_____ _____
Date of Birth Social Security Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

_____
Name

_____
Street Address

_____
City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: _____

_____

DATE OF INJURY OR LAST EXPOSURE: _____

FIRST DESIGNATED PHYSICIAN:

_____
Name

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

Accepted by: _____

MEDICAL INFORMATION RELEASE: I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

_____ _____
Date Employee Signature

MEDICAL PAYMENT OBLIGOR:

_____
Name Of Obligor

_____
Representative

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.

Notice: The Workers' Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as "designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for medical services.

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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?

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Date:

INITIAL TREATMENT AUTHORIZATION

TO: _____

RE: Claimant: _____

DOB: _____

Insured: _____

Date of Accident:_____

Claim Number:_____

If this claim is determined to be the direct result of a compensable work related injury, your services for initial medical treatment will be authorized. If this injured worker requires additional medical treatment and/or referral, please call FFVA Mutual at (800) 226-0666.

Please mail your bill and report to:
FFVA Mutual
P.O. Box 945927
Maitland, FL 32794
Phone: (800) 226-0666
Fax: 321-214-0235

Adjuster: Barbara Cleveland
(800) 226-0666 x5362

Assistant: Trish Gibson
(800) 226-0666 x5318

Full Duty _____

Light Duty_____

Restrictions: _____

Diagnosis: _____

Next Office Visit: _____

Please provide the employee with a copy of this completed form.
Thank you for your attention to the above.

_____ _____
Physician's Signature Date

MyMatrixx
By EVERNORTH

To the Injured Worker:

On your first visit, please give this form to any pharmacy listed on the back side to speed processing of your approved work-related injury prescriptions (based on the guidelines established by your employer).

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

Atencion Trabajador Lesionado:

En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador).

¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

Temporary Prescription Card

ID#: _____
Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: ZX3A

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

Employee Information

_____
Full Name

_____
Street Address or PO Box

_____
City State ZIP

_____
Date of Birth

_____
Employer Name

To the Pharmacist:

MyMatrixx administers this Workers' Compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary.

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

1. Enter RxBin 003858
2. Enter PCN WC
3. Enter Rx Group Number ZX3A
4. Enter 9-digit member ID (Patient SSN)
5. Enter Date of Injury

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

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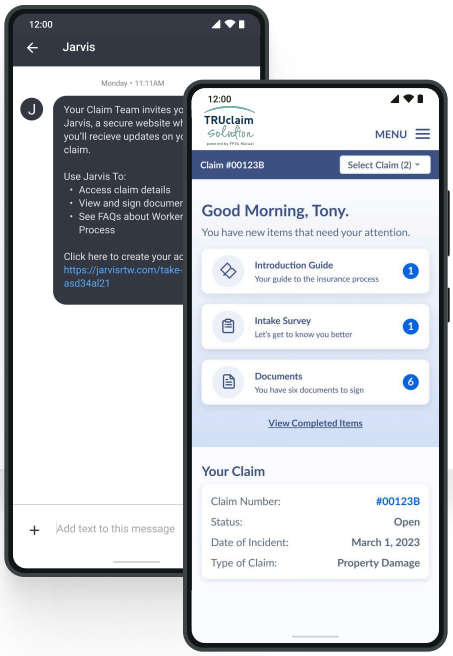
CROSSTIE

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 employees to claim and recovery resources, Jarvis helps maintain positive relationships while guiding your employees back to work.

Connect Employee to Insurer

Once the claim is in Jarvis, your employee will receive a message from their claims team within 24 hours.

Return to Work Faster

Jarvis helps to minimize prolonged claims through proactive check-ins and streamlined claim 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.

IA-1 WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)

Carrier/Administrator Claim Number | Report Purpose Code

Jurisdiction | Jurisdiction Claim Number

Insured Report Number

Employer's Location Address (if different) | Location No.

Sic Code | Employer FEIN | Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)

Policy Period

To

☐ Check if self insured

Claims Admin (Name, Address & Phone Number)

Carrier FEIN | Policy Number or Self-Insured Number | Administrator FEIN

Agent Name & Code Number

Employee/Wage

Legal 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/Div. ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

Phone | No. of Dependents | NCCI Class Code

Wage Rate $ ☐ Day ☐ Week ☐ Month ☐ Other

Days Worked/WK

Hrs Worked per Day

Full Pay for Date of Injury? ☐ Yes ☐ No

Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM

Date of Injury or Illness

Time Occurred ☐ AM ☐ PM

Last Work Date | Date Employer Notified | Date Disability Began

Employer Contact Name/Phone Number

Type of Illness/Injury | Part of Body Affected

Did Injury/Illness Exposure Occur on Employer's Premises? ☐ Yes ☐ No

Type of Illness/Injury 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 Returned to Work | If Fatal, Date of Death

Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No

Were they used? ☐ Yes ☐ No

Treatment

Physician/Health Care Provider (Name & Address)

Hospital (Name & Address)

Initial Treatment

0 ☐ No Medical Treatment
1 ☐ Minor: By Employer
2 ☐ Minor Clinic/Hosp
3 ☐ Emergency Care
4 ☐ Hospitalized > 24 hr.
5 ☐ Future Major Medical/Lost Time Anticipated

Other

Witness to Accident (Name & Phone Number)

Date Administrator Notified | Date Prepared | Preparer's Name & Title | Preparer's Phone Number

IA-1 (2/95)

SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE

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Applicable in Alaska

A person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception.

Applicable in Arkansas

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding worker's compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

Applicable in California

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Applicable in Connecticut

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Applicable in Delaware and Oklahoma

Any person who, knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. *Delaware Statutes Regulation: Del #C Section 913(B)

Applicable in Florida

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Applicable in Idaho

Any person who Knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company, Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kentucky and New York

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Michigan

Any person who knowingly and with intent to injure or defraud any insurer submits a claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to $5,000.00.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Pennsylvania

Any person who knowingly and with intent to injure or defraud any insurer files a claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years or payment of a fine of up to $50,000.

Applicable in Utah

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

EMPLOYEE SIGNATURE: _____

IA-1 (2-95)

Tap into Our Safety Expertise

As an FFVA Mutual policyholder, you have access to our in-house safety experts for workplace training and resources to prevent injuries and reduce claim costs. Together, they are committed to providing you with industry-leading knowledge and resources to keep your employees safe at work. Learn more about our safety consultants and their areas of expertise below.

Safety and Loss Control Leadership



Ernesto Medina
Vice President of Safety & Loss Control



Karen Johnson
Safety Training & Resource Development Manager



David Kohl
Supervise Out-of-State (FL) Consultants
NC, SC, VA



Doug Maglich
Safety Supervisor
Central, West FL

Safety Consultants, Area of Expertise, and Territory



Arian Collick
Major Claim Investigations
North FL, South GA



Benjamin Smith
Ergonomic
IN,KY,MS,North GA,TN



Carol Norris
Education, Trending Topic & Training
North FL, South GA



Christina Luecke
Industrial Hygiene
Central, West FL



Christopher Tucker
Compliance & Life Safety
AL, GA



David Medina
Safety Consultant Trainee
FL



Jose Graulau
Training English and Spanish, Safety Key
Central, FL



Leonardo Nina
Safety Consultant
Central, East FL



Raul Gonzalez
Workers' Compensation
South FL



Yadira Richeson
Admin Support
Maitland, FL

* The combined expertise of our team is available to all policyholders no matter what state you are located in. Your consultant will collaborate with the appropriate *Solutionist* to provide the safety information and resources you need.

For contact information and to connect with your FFVA Mutual safety consultant, visit www.ffvamutual.com/safety/safety-team

Discover our free 30+ safety training courses at www.ffvamutual.com/safety/safety-training-request

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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 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 webcast
- Safety program guides, general and by industry
- Workplace safety tips

To request a Safety Key login, visit https://www.ffvamutual.com/safety-key-login-request/ and submit form.

TOP 10 WAYS TO PREVENT MOTOR VEHICLE ACCIDENTS WHILE DRIVING FOR WORK

FFVA Mutual's Safety ***Solutionists*** are here to help you identify and eliminate motor vehicle accidents to keep employees safe on the road.

1	**Stay Focused Behind the Wheel:** Distracted driving is one of the top causes of work-related crashes. Avoid texting, eating, or adjusting devices. Always keep your eyes on the road.
2	**Buckle Up Every Time:** Seat belts save lives and reduce injury severity. Whether it's a short trip or a long haul, make buckling up automatic.
3	**Follow the Speed Limit:** Speeding cuts your reaction time. Drive at a speed that is safe for the road, traffic, and weather conditions.
4	**Avoid Driving When Fatigued:** Drowsy driving is as dangerous as impaired driving. Know your limits and take breaks during long shifts.
5	**Drive Only When Clear and Alert:** Prescriptions and over the counter medications can impair focus and reaction time. Know the risks and your responsibilities.
6	**Plan Your Route and Stops in Advance:** Map out your trip before you go. Planning reduces stress and helps avoid rushed decisions on the road.
7	**Keep a Safe Distance:** Tailgating increases crash risk. Leave enough space to stop safely, especially at higher speeds or in poor conditions.
8	**Adapt to Changing Conditions:** Weather, construction, and traffic require constant awareness. Adjust your driving as conditions change.
9	**Drive Defensively:** Expect the unexpected. Stay alert, anticipate the actions of other drivers, and always respond safely. Keeping your composure on the road protects everyone.
10	**Maintain Your Vehicle:** Regular maintenance prevents breakdowns and accidents. Report any mechanical issues as soon as you notice them.

Learn more and download your free safety resource packet at **ffvamutual.com/MVA-prevention-stand-down**