



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.

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

NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: _____
Name

Street Address

City, State, Zip

Date of Birth Social Security Number

() _____
Telephone 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

First Fill Pharmacy Program

Employer:

Immediately upon receiving notice of injury, fill in the information below and give it to your injured employee.

Injured Worker:

1. If you need a prescription filled for a work-related injury or illness, go to a myMatrixx participating network pharmacy.
2. Give this page to the pharmacist.
3. The pharmacist will fill your prescription at no cost.

Empleado Lesionado:

1. Si usted necesita surtir una receta relacionada con un accidente de trabajo o enfermedad ocupacional, por favor utilice una de las farmacias participantes en la red de myMatrixx.
2. Entregue esta hoja al farmacéutico
3. El farmacéutico le surtirá su medicina sin costo alguno.

ATTENTION INJURED PARTY:

Use of this prescription form is restricted to prescriptions for your allowed condition only. To receive your medication coverage, present this form to a network pharmacy. This is for a one-time prescription fill. If you require additional prescriptions, a permanent card will be mailed to you. For questions, please call myMatrixx at **877-804-4900**.

ATENCIÓN PERSONAS LESIONADAS:

El uso de este formulario de prescripciones se limita solamente a las recetas aprobadas de acuerdo a su diagnostico. Para recibir cobertura de sus medicinas, presente este formulario en una de las farmacias participantes de la red. Este formulario solo cubre medicinas una vez. Si usted requiere prescripciones adicionales , una tarjeta permanente le será enviada por correo. En caso de preguntas, por favor llame a myMatrixx al **877-804-4900**.

Pharmacist:

Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only.

For questions or rejections please call **(877) 804-4900**. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.



First Fill Prescription Card

Name: _____

Employer: _____

RxBIN: 014211

Processor: myMatrixx

Group #: 10602910

Member ID: _____

[Member ID is the claimant's Social Security number (i.e. 111-11-1111)]

myMatrixx has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at **(877) 804-4900**.

myMatrixx tiene un red de más de 60,000 farmacias dentro del país. Si quiere saber si una farmacia en particular esta dentro de nuestra red favor de llamar al **(877) 804-4900**.

- | | | | |
|---------------|-------------------|--------------|--------------|
| ✓ CostCo | ✓ Kmart | ✓ Publix | ✓ Target |
| ✓ CVS Health | ✓ Kroger | ✓ Rite Aid | ✓ Walgreens |
| ✓ Food Lion | ✓ Medicine Shoppe | ✓ Safeway | ✓ Wal-Mart |
| ✓ Giant Eagle | ✓ Meijer | ✓ Sam's Club | ✓ Winn Dixie |

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		Claims Admin (Name, Address & Phone Number)						
					To								
					<input type="checkbox"/>		Check if self insured						
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		Marital Status		Occupation/Job Title					
				<input type="checkbox"/> Male		<input type="checkbox"/> Unmarried/Single/Div.		Employment Status					
				<input type="checkbox"/> Female		<input type="checkbox"/> Married							
				<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated							
Phone			No. of Dependents		<input type="checkbox"/> Unknown		NCCI Class Code						
Wage Rate		<input type="checkbox"/> Day		<input type="checkbox"/> Month		# Days Worked/WK		Full Pay for Date of Injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
\$		<input type="checkbox"/> Week		<input type="checkbox"/> Other		# Hrs Worked per Day		Did Salary Continue?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Time Employee Began Work		<input type="checkbox"/> AM <input type="checkbox"/> PM		Date of Injury or Illness		Time Occurred		<input type="checkbox"/> AM <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>		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?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
								Were they used?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment	Physician/Health Care Provider (Name & Address)				Hospital (Name & Address)				Initial Treatment				
									0 <input type="checkbox"/> No Medical Treatment 1 <input type="checkbox"/> Minor: By Employer 2 <input type="checkbox"/> Minor Clinic/Hosp 3 <input type="checkbox"/> Emergency Care 4 <input type="checkbox"/> Hospitalized > 24 hr. 5 <input type="checkbox"/> 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									

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)



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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 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

