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. **South Carolina Workers' Compensation Notice** – this poster **must be posted** in a conspicuous place for your employees to view. 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 online**, 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

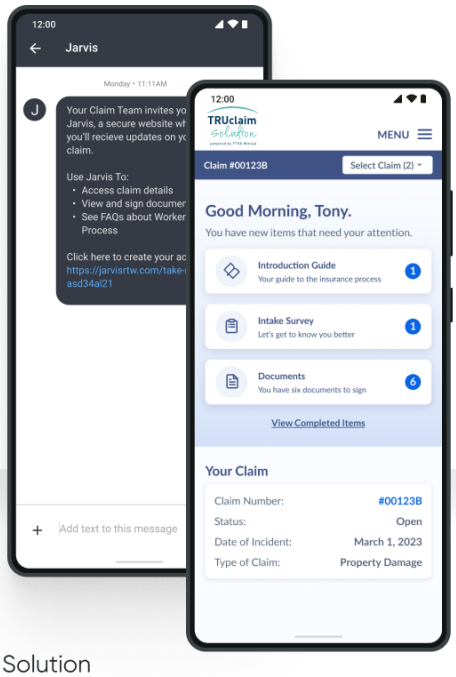
_____

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.

S.C. WORKERS' COMPENSATION COMMISSION – 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 #

PHONE #

INDUSTRY CODE | EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

FFVA Mutual

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
☐ Unknow

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

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:
Enter all dates in MM/DD/YYYY 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, (e.g. Lacerations to the forearm).

PART OF BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (e.g. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(e.g. 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.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS – cont'd

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

(e.g. 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:

(e.g. 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 (e.g. 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.

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