

# I. ACCIDENT



**FHM** INSURANCE  
COMPANY

A POLICY TO DO MORE®

Workers' Comp Since 1954

## **ACCIDENT/INJURY REPORTING**

This section contains information to help you report accidents/injuries.

Accident/injury reporting can be done in a number of ways; you can report via telephone, fax or online using the FHM web site. The sooner an accident/injury is reported, the sooner the claim created by that report can be managed. A reported claim is a managed claim and a managed claim can often mean less cost!

Rapid reporting means more effective claims management. Effective claims management helps ensure you the utmost in savings by:

- Getting medical attention to the employee quickly. Proper medical treatment increases employee opportunity for recovery and speeds return to work.
- Reducing litigation. An employee who feels neglected and uncared for is much more likely to hire an attorney to protect his/her interests.
- Speeding up the claims management process. Fast response to and investigation of claims helps control medical and indemnity costs and discourages attorney involvement.

Statistics show when an employer doesn't report an accident/injury in a timely manner, the employee is much more likely to hire an attorney – and claims costs escalate.

When an accident is reported quickly, the injured employee knows immediately he or she is being cared for and you are concerned because someone contacts the employee within 24-hours to ensure medical care concerns are addressed.

As part of your overall Loss Control Program you should:

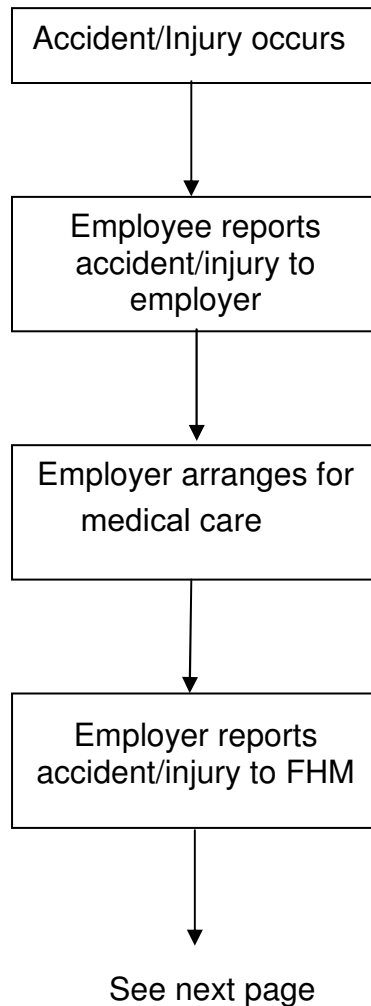
- Take every accident/injury seriously.
- Require employees to report any work-related accident/injury when it occurs but, no later than the end of the duty shift.
- If you suspect fraud or abuse, report the accident/injury anyway. Acting promptly will ensure timely investigation of the claim which will help your case should you later have to defend the claim.

Practice the rule, "Right away is the right way". It always pays to address workplace accidents immediately.

## THE ACCIDENT/INJURY REPORTING PROCESS

This chart describes the accident/injury reporting process and includes the steps taken by FHM to begin immediately managing the claim created by the report.

If you have any questions about this process, call our Claims Department at 407-351-1212 or Policy Services at 888-346-3461, or visit our web site [www.fhmic.com](http://www.fhmic.com).



## HOW TO REPORT AN ACCIDENT/INJURY

1. Within 24 hours of accident, injury or illness - via FHM web site, call or fax a completed First Report of Injury or Illness to FHM. (see State specific section for your state's form)
  - a. Submit online at [www.fhmic.com](http://www.fhmic.com) (must be registered for FHMconnect) or
  - b. Fax to (407-352-5788) or
  - c. Call 888-346-3461, Ext. 353
2. Have the following information ready:
  - a. Injured employee information:
    - Full name, address and telephone number;
    - Occupation, date of birth and sex;
    - Social Security Number; and
    - Hire date
  - b. Date and time of accident.
  - c. Employee's description of accident.
  - d. Injury/illness that occurred, part of body injured.
  - e. Company name, telephone and address.
  - f. Employer's location address if different from above.
  - g. Place/address accident/injury occurred.
  - h. Federal Employer ID# and FHM policy number; (i.e., 306 -xxxx).
  - i. Did the employee return to work?
  - j. Do you (the employer) agree with the accident?
  - k. Name of physician or hospital where employee was sent by you for treatment.

### Need First Report of Injury Form?

1. Go to <http://www.fhmic.com>
2. Move your cursor over the **Policyholders** button and then click on the **Forms** drop down button
3. Click on the "First Report of Injury" form for your state
4. Print the form

## **EMPLOYER LEGAL RESPONSIBILITIES TO RECORD AND REPORT ACCIDENTS**

1. Employers must record all industrial accidents, using the form identified for your state:
2. Employers must report all industrial accidents as follows:
  - a. First Aid Cases do not need to be reported to the workers' compensation carrier unless outside medical treatment is necessary.
    - If the case later becomes a Medical Only or Lost Time case, the employer must report to the worker's compensation carrier on a First Report of Injury or Illness form and on a Wage Statement form, within seven days after the employer has knowledge of the change in status.
    - In the event the information that is required to be furnished on the Wage Statement is not readily available at the employer's site within seven (7) days after the employer has knowledge of the injury, the employer has thirty (30) days from the date of employer's knowledge of the injury to submit the Wage Statement to the workers' compensation carrier.
  - b. All other cases must be reported to the workers' compensation carrier on the First Report of Injury or Illness form and Wage Statement form within seven (7) days after the employer has knowledge of the injury.
  - c. Refer to your state's regulations to determine if a fine can be levied for each failure to report.
  - d. If the injury results in death prior to the filing of a First Report of Injury or Illness, the employer must give notice as described in state's statutes.
  - e. Whenever an employer submits a First Report of Injury or Illness, or a Wage Statement, to the workers' compensation carrier, the employer must also provide a copy of the report to the injured employee.
3. Employers must retain a copy of all information recorded pursuant to the law for not less than two (2) years and six (6) months.

## SUBMITTING A FIRST REPORT OF INJURY ONLINE

1. If you are *not* a registered user of FHMconnect, please use another method to report your claim until you have received a username and password.
2. Go to [www.fhmic.com](http://www.fhmic.com)
3. If you already have a username and password, click on “Login to FHMconnect”.
4. If you don’t have a username and password, click on “Policyholders” under “Register,” fill out the “Policyholder Registration” form and click “Send!” You will be sent a username and password. As noted earlier, you should go ahead and report the injury by another method this time, as it can take up to two days to receive a username and password.
5. After you have logged in, click on the gold “Report Claim” button.
6. Select the accident date and click “Continue.”
7. Select a workplace and click “Continue.”
8. The “Main FROI” form will be displayed. Complete all boxes.
  - a. Use the tab key to move between boxes.
  - b. Do not use an apostrophe in any of the boxes.
  - c. The **red** \* indicates required information. You will not be able to submit the form without entering this information.
9. Click “Save and Submit.”
10. You will not be able to print a copy of the form from this screen, but if we have your email address on file, a copy of the First Report of Injury will be emailed to you. If we do not have your email address, a copy will be mailed you.

## ABOUT REPORTING ACCIDENTS/INJURIES

1. The employer should explain to the injured employee his/her rights and benefits under the Workers' Compensation law. FHM claims staff will provide each injured employee with a copy of the First Report of Injury or Illness when the accident/injury is reported.
2. By law:
  - a. Employers may not "discharge, threaten to discharge, intimidate or coerce any employee" because of his "valid" claim for compensation or his attempt to claim compensation.
  - b. Employee, employer, carrier and attorney must file medical reports within five (5) days after receipt.
  - c. Employer or carrier must, at the request of the employee or his/her attorney, furnish a copy of any medical information or earnings information.
  - d. If any installment of compensation for death or dependency benefits, disability, permanent impairment or wage loss payable without an award is not paid within fourteen (14) days after it becomes due, a punitive penalty is due. It will be assessed by the state workers' compensation division against either the employer or the carrier, "depending on who was at fault in causing the delay."
3. The forms listed in the State Specific section of this manual are used for normal reporting procedures. However, under certain conditions, additional forms may be required of the employer. These forms are available from FHM's Claims Department at 888-346-3461 and on the website at [www.fhmic.com](http://www.fhmic.com).
  - a. First Report of Injury or Illness.
  - b. Wage Statement.
4. In addition to completing the state-required forms, FHM requests all employers:
  - a. Keep FHM informed about changes in injured workers' status (i.e., back to work, change in physician, etc.).
  - b. Create a light duty work program.
  - c. Help injured workers return to work as soon as possible.
  - d. Notify the Claims Department in a timely manner if employee tested positive on a post-injury drug test.

## FAQS ACCIDENT/INJURY REPORTING

**Q: When a First Report of Injury is “called in”, will a claim number be assigned?**

A: Yes.

**Q: Is it necessary to mail/fax the First Report of Injury after reporting it via telephone?**

A: No. FHM will draft the First Report of Injury from the telephone report and send copies to the employee, employer and the State.

**Q: Because I am reporting online/faxing/calling in the First Report of Injury, must I still maintain the OSHA log?**

A: Yes. OSHA record keeping requirements can be reviewed online at [www.OSHA.gov](http://www.OSHA.gov). Be sure you are not exempt from record keeping.

**Q: If reporting by fax, do I need to wait until the employee can sign the form before reporting?**

A: No. Never delay reporting because you do not have the injured employee's signature. Indicate "not available" if the employee is not available for signature and submit the report immediately.

**Q: What if I don't report the accident/injury in a timely manner?**

A: A failure by the employer to report the accident/injury to the workers' compensation carrier in a timely manner can result in the employer incurring a fine. See the State Specific section of this manual for information related to your state's law.

**Q: Must an employer report all accidents/injuries?**

A: Injuries that require first aid treatment only, need not be reported.

**Q: What should an employer do if an injured worker refuses treatment?**

A: Complete the Refusal of Treatment form, have the employee read and sign it and place it in the employee's file. Send employee for post-accident drug test where applicable.

## **THE WAGE STATEMENT**

The Wage Statement is completed when the injured employee misses more than seven (7) days of work due to the accident/injury as prescribed by the physician. This form is completed by the employer and returned to FHM. A full description of how to complete this form can be found on the back of the form.

### **SECTION 1 – Employee and Employer Information**

**All items must be completed.** This section identifies the injured employee's name, address and telephone number, the employer's name, address and telephone number, the Social Security number of the injured employee and the date of Injury. The information requested on "a similar employee" should be completed if wages earned for thirteen (13) consecutive weeks are not available for the injured employee.

### **SECTION 2 - Wage Information**

The employee's earnings for the thirteen (13) weeks, (91 consecutive days), prior to the injury should be listed.

Also include in the thirteen (13) weeks earnings any other benefits that the employee received such as health insurance paid for by employer.

If the employee received gratuities (tips), include only those reported.

### **SECTION 3 - Preparer**

The signature and title of the person completing the form and the date signed.

CARRIER INFORMATION WILL BE COMPLETED BY FHM.

## **ACCIDENT/INJURY INVESTIGATION**

An important part of the reporting process is accident/injury investigation. The following pages contain a guide for investigating accidents/injuries effectively and efficiently.

When an employee experiences an accident, no matter how minor, the company is being told that something in the Loss Control Program is weak and initiative must be taken to correct this weakness before a serious accident occurs.

### **What Is An Accident?**

An accident is an *unplanned* (nobody wants to get hurt); *uncontrolled* (once you've had the accident, there is not much you can do to control the end results); and *unexpected* (if you expected to get hurt doing something, you wouldn't do it) event that causes damage, injury, waste or inefficiency.

### **Why Investigate Accidents?**

We investigate accidents to find the cause, not to fix the blame. If we know what really caused or contributed to causing the accident, we may be able to prevent it from happening again. Also, if the injured person knows he or she caused or contributed to causing the accident, then they probably won't do the same thing again.

## **SUPERVISOR'S GUIDE TO ACCIDENT INVESTIGATION**

The following steps should be used as a guide in the accident investigation and correction process.

1. The immediate supervisor should investigate the accident to determine cause.
2. The investigation should be completed as soon as possible after the accident. The time element is important because accident facts are still fresh in any witness' mind and physical evidence is still in place.
3. Once the cause of the accident is determined, then the supervisor must take the necessary action to prevent this type of accident from occurring again.
4. The accident investigation and corrective action taken should be reported to management in a timely manner.
5. Management should review each accident in a timely manner to ensure:
  - a. The accident was properly reported and investigated.
  - b. The true cause(s) were identified.
  - c. Appropriate corrective action was taken to prevent the recurrence of a similar type accident.
6. The results of the accident investigation should be reviewed by the company's Safety Committee.
7. The completed Supervisor's Accident Investigation form, including Employee Description and Witness Accident Report should be:
  - a. Sent to FHM: Attn: Loss Control;
  - b. Photocopied and placed in the employer's file; and
  - c. Used by the Safety Coordinator at the next Safety Meeting as a training tool to help prevent future accidents of the same type.

## **COMPLETING THE SUPERVISOR'S ACCIDENT INVESTIGATION FORM**

When completing the Supervisor's Accident Investigation form, keep the following in mind:

- 1. How did the accident occur? Where and how did the employee get hurt? Get all the facts.**

Describe the accident in detail; don't leave anything out. You have to ask a lot of questions – even some you might think are unnecessary. A good tip is to ask 5 or 6 more questions than you think necessary. Be sure you have all the facts before continuing.

- 2. Was the accident the result of some physical hazard? What went wrong? And why?**

Was it an unsafe condition (physical hazard) such as improperly guarded, defective, misused, missing equipment; a housekeeping issue, improper illumination, improper ventilation; unsafe design; unsafe dress; unsafe hazardous materials arrangement?

Are there conditions likely to cause any of the following types of accidents: Caught in or between – pinch points; fall to same or lower level; an abrasion, laceration, or puncture wound; a sprain or strain; struck by or against – falling, moving, sliding, flying objects; a contact – electrical conductor, a caustic or acid, radioactive particle, hot objects, fire, dust, vapor gases.

**If it was one of these – why?**

- 3. Was the accident the result of unsafe acts? Would a cautious or well-trained person have done the same thing under the same circumstances? If no, why?**

Was it an unsafe act, such as: operating without authority; operating or working at unsafe speed; making safety devices inoperative; using unsafe equipment or not using equipment safely; unsafe loading – mixing, piling, etc.; unsafe position or posture – working on moving machinery; horseplay, distracting, etc.; failure to warn; other?

**If it was one of these – why was it? Did someone else contribute to the accident?**

- 4. What do you recommend we do to keep this accident from happening again?**

If one employee did it, what will keep the others from doing it? If it happened to one, will it happen to others?

Use the sample questions on the next two pages to help get to the true facts about accidents.

## ACCIDENT INVESTIGATION – THE SIX KEY QUESTIONS

- WHO**
1. Who was injured? Who saw the accident?
  2. Who was working with him/her?
  3. Who had instructed/assigned him/her? Who else was involved?
  4. Who else can help prevent recurrence?

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- WHAT**
1. What was the accident?
  2. What was the injury?
  3. What was he/she doing?
  4. What had he/she been told to do?
  5. What tools was he/she using?
  6. What machine was involved?
  7. What operations was he/she performing?
  8. What instructions had he/she been given?
  9. What specific precautions were necessary?
  10. What specific precautions was he/she given? Did he/she use?
  11. What protective equipment was he/she using?
  12. What had other persons done that contributed to the accident?
  13. What problem or question did he/she encounter?
  14. What did he/she or witnesses do when accident occurred?
  15. What extenuating circumstances were involved?
  16. What did he/she or witnesses see?
  17. What will be done to prevent recurrence?
  18. What safety rules were violated?
  19. What new rules are needed?

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- WHEN**
1. When did the accident occur?
  2. When did he/she start on that job?
  3. When was he/she assigned to the job?
  4. When were the hazards pointed out to him/her?
  5. When had his/her supervisor last checked on job progress?
  6. When did he/she first sense something was wrong?
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**WHY**

1. Why was he/she injured?
2. Why did he/she do what he/she did?
3. Why did the other person do what he/she did?
4. Why wasn't protective equipment used?
5. Why weren't specific instructions given to him/her?
6. Why was he/she in the position he/she was?
7. Why was he/she using the tools or machine he/she used?
8. Why didn't he/she check with his/her supervisor when he/she noted things weren't as they should be?
9. Why did he/she continue working under the circumstances?
10. Why wasn't the supervisor there at the time?

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**WHERE**

1. Where did the accident occur?
2. Where was he/she at the time?
3. Where was the supervisor at the time?
4. Where were co-workers at the time?
5. Where were other people who were involved at the time?
6. Where were witnesses when accident occurred?

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**HOW**

1. How did he/she get hurt?
2. How could he/she have avoided it?
3. How could co-workers have avoided it?
4. Could supervisor have prevented it? How?

## SUPERVISOR'S ACCIDENT INVESTIGATION

**(NOT a First Report of Injury Form)\*** Please use your state appropriate form to report an injury

**NOTE TO SUPERVISOR:**

Remember, an accident investigation is not designed to find fault or blame. It is an analysis to determine cause that can be controlled or eliminated.

When completing the investigation, try to answer these questions.

- How did the accident occur?
- Where did it happen?
- What materials, machines, equipment or conditions were involved?
- Who was injured?
- When did it happen?

**MAKE RECOMMENDATIONS!**

No investigation is complete unless corrective action is suggested.

**FOLLOW-UP**

Determine what action is being taken on your recommendations.

DATE	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	
EMPLOYEE INVOLVED	AGE	
POSITION	DATE EMPLOYED	
SUPERVISOR	DEPARTMENT	
HOW LONG WAS EMPLOYEE PERFORMING THIS OPERATION?		
WAS THE EMPLOYEE INSTRUCTED?	DID THE ACCIDENT RESULT IN AN INJURY?	
NATURE AND EXTENT OF INJURY		
DATE INJURY REPORTED	WAS FIRST AID GIVEN?	
IF SO, WHEN AND BY WHOM?		
HOW DID THE ACCIDENT OCCUR?		
CAUSE OF ACCIDENT		
RECOMMENDATIONS TO PREVENT A RECURRENCE		
WHAT ACTION HAS BEEN TAKEN?		
SIGNED	DEPARTMENT	DATE

**SAFETY OFFICIAL OR COMMITTEE COMMENTS**

RECOMMENDATIONS	
SIGNED	DATE

**EXECUTIVE**

SPECIAL ORDERS	
SIGNED	DATE

**ACCIDENT INVESTIGATION REPORT  
EMPLOYEE DESCRIPTION  
(Employee To Fill Out This Page)**

<b>NAME</b>		<b>DEPARTMENT</b>		<b>DATE</b>
<b>SEX</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<b>OCCUPATION</b>		<b>SUPERVISOR</b>	
<b>DATE OF INJURY</b>	<b>TIME</b> <input type="checkbox"/> AM <input type="checkbox"/> PM	<b>DATE FIRST REPORTED</b>	<b>TIME</b> <input type="checkbox"/> AM <input type="checkbox"/> PM	
<b>NATURE OF INJURY</b>				
<b>PART OF THE BODY</b>				
<b>LOCATION OF ACCIDENT</b>				
<b>INJURED EMPLOYEE'S DESCRIPTION OF ACCIDENT</b>				

I do \_\_\_\_ do not \_\_\_\_ feel that this injury will result in lost time from work. Please read the following paragraph:

If an injury requires lost time from work or you need to be seen by a physician, you must clear this with your supervisor. For all medical treatment, **other than an emergency**, a Medical Authorization for Treatment form must be picked-up from: \_\_\_\_\_

and presented to the approved treating facility. A failure to present this form at the treating facility means the company has not authorized the treatment and our insurance will not pay. Please sign below to indicate you have read the above and understand its meaning in full.

Signed: \_\_\_\_\_  
Employee
Witness

Employee Sent:     Back to Work     Doctor     Hospital     Home

Supervisor's Investigation must be completed within 24 hours after notification of accident.

# WITNESS ACCIDENT REPORT

Return to \_\_\_\_\_ within 2 days of accident

You have been listed as a witness to an injury experienced by \_\_\_\_\_ that occurred on \_\_\_\_\_, 20\_\_\_\_. To assist FHM Insurance in investigating this incident, please complete and return this form to the loss control representative at the address below. This is not a sworn statement.

Witness Information- Job Title: \_\_\_\_\_ Dept.: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Ext.: \_\_\_\_\_

Address: \_\_\_\_\_

## Incident Information

Did you witness the personal injury involving the above named person (please check)?  yes  no

Location of the incident (be specific): \_\_\_\_\_

Approximate time of the incident: \_\_\_\_\_ Date of the Incident: \_\_\_\_\_

Describe what you witnessed concerning this incident: \_\_\_\_\_

\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide the names of other known witnesses to this incident: \_\_\_\_\_

\_\_\_\_\_

What suggestions do you have to prevent this incident from happening again? \_\_\_\_\_

\_\_\_\_\_

Have you reported this problem to any other departments ?

\_\_\_\_\_



A POLICY TO DO MORE®

Workers' Comp Since 1954

### Please Return this Form to:

FHM Loss Control Dept.

P.O. Box 616648

Orlando, FL 32861

888-346-3461

Fax: 407-926-9419

## **FORMS**

Please refer to Section VII – State Specific Information, for the statutes and forms related to the implementation of these procedures in your state.