



NSU Florida -2024

Employer Manual

(Employee Services and Supervisors only)

For more information regarding prevention of risk visit our website at
<https://www.nova.edu/risk/policies/compensation.html>

INTRODUCTION

This booklet is intended to give information to you as a supervisor of an injured Nova Southeastern University employee, and to outline your obligations, rights, and responsibilities as an employer under the Florida Workers' Compensation Statute. The Office of Risk Management (ORM), Department of Financial Operations administers Title XXXI Chapter 440.

Medical treatment for a work related injury is provided on a "medically necessary basis" that is determined by a treating physician.

The current contract for medical case management is with Cannon Cochran Management Services, Inc. since July 1, 2015.

This booklet is designed to provide general information to help you understand the employer's responsibilities under the statute. It is not intended to be used as a comprehensive guide on all workers' compensation issues you may encounter. The workers' compensation statute is constantly changing and many issues are determined by the factual circumstances of a claim and any applicable case law. In all instances, you will need to rely on the expertise of ORM's Workers' Compensation Manager, CCMSI, and defense counsel to manage claim(s). If you have questions regarding a particular claim in your department, please contact the Workers' Compensation Manager at 954-262-5404.

We, at ORM, believe that by working together we can effectively provide appropriate benefits to all injured workers in a cost efficient manner and appreciate your continued support in educating employees about their benefit/rights under workers' compensation. Should you require training on issues concerning workers' compensation management or ergonomics please sign up at the Risk Management website <http://www.nova.edu/cwis/fop/risk/training/index.html>. Additionally, we have created training videos to further our efforts about campus safety please direct your staff to review these videos at our training site <http://www.nova.edu/cwis/fop/risk/training/index.html>.

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NSU Florida Guidelines (Section A)

★ Employer Responsibilities during a Non-Emergency

1. Contact Novalert at 954-262-8999 about the accident/injury.
 2. Complete all pages of the injury document to include the First Report of Injury Form (DWC1), NSU Employee Statement Regarding Cause of Accident, CCMSI Authorization for Medical Records and Communication Release, and CCMSI False and Fraudulent Claim Warning. Forms may be downloaded at <https://www.nova.edu/risk/forms/workers-comp.pdf>.
 3. Provide the injured worker with a copy of the fully executed forms (Case # will be provided once injury is reported to CCMSI).
 4. Instruct the employee that he or she has the right to medical care. Assist the employee seeking care with calling HPD (Employee Health clinic) to ensure availability at 954-262-1860, 954-262-2183, or 954-262-4100. If HPD cannot schedule with the employee or is closed, the individual should be sent to UrgentMed or Concentra based on their location. Other PCP offices must be approved by the Office of Risk Management.
 5. Email all executed forms including the First Report of Injury Form, NSU Employee Statement Regarding Cause of Accident, CCMSI Authorization for Medical Records and Communication Release, and CCMSI False and Fraudulent Claim Warning to the Office of Risk Management to bcharmai@nova.edu. If Dr. Beckford is on vacation, please send to risk@nova.edu | workerscomp@nova.edu.
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★★ Steps for an Emergency

1. Contact Novalert at 954-262-8999 immediately. Novalert will contact 911 when needed.
2. Proceed by following steps 2 thru 5 above.



Dos & Don'ts of Reporting a Claim

DO

- Complete **all** pages of the injury report document (e.g. First Report of Injury Form, NSU Employee Statement Regarding Cause of Accident, CCMSI Authorization for Medical Records and Communication Release, and CCMSI False and Fraudulent Claim Warning).
- Write legibly on all pages of the injury report document.
- Report the injury immediately by scanning and e-mailing the injury packet to the Risk Management Office to bcharmai@nova.edu. If Dr. Beckford is on vacation, please send to risk@nova.edu | workerscomp@nova.edu.
- Use (current) First Report of Injury Form for Cannon Cochran Management Services, INC. Also found online at <http://www.nova.edu/risk/forms/workers-comp.pdf>.
- Complete all areas denoted on the sample *First Report of Injury form* prior to faxing or emailing the completed injury report document.
- E-mail the completed injury report document to the Risk Management Office to bcharmai@nova.edu immediately after you are notified of a work-related injury.
- Refer the injured employee to the NSU Employee Health Clinic (HPD), UrgentMed, or Concentra Medical. If your location is not within the vicinity of any of these medical clinics, please contact your NSU Workers' Compensation Manager (ext. 954-262-5404) or CCMSI adjuster (407-660-5637 /1- 866-291-0194) for an authorized location.
- Provide the employee with a copy of the completed injury report document.



Don't

- Use pencils or light colored pens to complete the injury report document including the *First Report of Injury form*.
- Use **First Report of Injury Form for any other insurance company.**
- Fax forms with missing information.

Departmental Information (Section B)

Risk Management Contact List

CONTACT NAMES	PHONE	E-MAIL	POSITION
Elizabeth Guimaraes	954-262-5271 (o) (954) 594-0087	guimarae@nova.edu	Director, Risk Management
	954-262-3814 (f)		
Charmaine Beckford	954-262-5404 (o) 954-262-3814 (f)	bcharmai@nova.edu	Workers' Compensation Manager
Ray Beverly	954-262-5273 954-262-3814	rbever1@nova.edu	Risk Management Program Manager
Jessie Gilley	954-262-4329 (o) 954-599-7477 (c) 954-262-3721 (f)	jg1932@nova.edu	Risk Management Program Manager

All Injuries/illnesses must be reported to the Risk Management Office (954-262-5404) by e-mail to bcharmai@nova.edu or risk@nova.edu | workerscomp@nova.edu. Public Safety must also be called to investigate the incident - Call Novalert immediately at ext. 28999. Novalert will call 911.

For injuries/illnesses that occur after clinic/physician hours, weekends and holidays call 1-877-253-5169, or in an emergency go to the nearest hospital for care.

Send Medical Bills To:

CCMSI Risk Services Group, Inc.
PO Box 948399 | Maitland | FL 32794-8399

Tel: 1-866-291-0194 * 217-477-6623 F



Completed injury report document including the First Report of Injury Form must be faxed to 954-262-6860 or emailed to bcharmai@nova.edu or risk@nova.edu immediately after you are notified of an injury.

Procedural Information & Injury Report Forms Section C

Workers' Compensation

Issue Date: June 1990; Revised: March 2, 2009/August 2, 2011/December 9, 2013/July 2015/October 18, 2019/March 6, 2023/September 6, 2023

Policy Number: 37

Policy Applies To: All Employees

The Florida Workers' Compensation Act is a system for providing necessary medical care and compensating workers who experience work-related illnesses or injuries and are unable to work as a result of their illnesses or injuries. Employees are covered by Workers' Compensation from their first day on the job; there is no waiting period for eligibility for Workers' Compensation. Under Florida law, the term "injury" means personal injury or death by accident arising out of and in the course of employment, and any diseases or infections that naturally result from the injury.

Workers' Compensation benefits include partial payment of lost wages if a work-related injury or illness causes the employee's absence for more than seven calendar days. In addition, Workers' Compensation, through the University's insurance carrier, pays all medical costs for medically necessary services pertaining to work-related injuries or illnesses when utilizing approved medical providers. The University will supplement wage payment by expending accrued personal, sick, or vacation leave, as necessary, once verification of the claim is received from the carrier, and the statutory "waiting period" has been met.

When a work-related injury or illness results in lost time for more than 21 days, the Workers' Compensation wage benefits are retroactive to the original date of injury. In cases where the Workers' Compensation insurance carrier provides payment of wages, it is at the rate of two-thirds of the employee's average gross weekly wage at the time of injury or illness up to a statutorily established cap. The University's supplemental wage payment, when available, is provided up to the amount of the employee's regular net pay.

During the time that an employee is absent from work but has not reverted to unpaid status, the employee's medical insurance continues with both NSU and the employee paying their respective contributions. If the employee reverts to unpaid status, the university continues to pay for the employee's medical insurance premiums to avoid lapse in coverage whereby the employee's portion of the premiums would be collected in arrears upon the employee's return to work.

When a work-related injury or illness occurs, the employee must immediately report the work-related injury to a supervisor (regardless of the severity of the injury). Either the supervisor or the employee must also notify the Risk Management Office and the Office of Public Safety directly. At that time the supervisor and employee must complete the First Report of Injury or Illness packet and submit it immediately to the Risk Management Office.

NSU is required by law to report work-related injuries or illnesses whether major or minor, to the state within seven days of such occurrence. Supervisors and or OHR contacts must provide the Risk Management staff with an executed First Report of Injury or Illness packet and any pertinent notes and information so the claim can be filed with CCMSI and other follow-up procedures completed. Failure to do so could result in monetary and other serious fines. Therefore, all supervisors and or employees must report all work-related injuries immediately for filing.

Arrangements for immediate medical care will be authorized and arranged by the Risk Management Office. NSU reserves the right to conduct drug and/or alcohol testing of all parties to work related accidents or incidents. Information about the drug testing policies may be accessed online at <https://www.nova.edu/hr/policies/drug-alcohol-free-workplace.html>.

Employees electing to utilize medical providers not authorized in advance by Nova Southeastern University and/or its workers' compensation insurance carrier may be responsible for any costs related to such services rendered.

Time away from work for the initial medical care should not be charged to the employee's sick, personal, or vacation time. Subsequent follow-up medical care should be recorded in Shark Time (KRONOS) or on a leave and absentee report utilizing the employee's accrued sick, personal, or vacation hours, or be unpaid.

Employees are responsible for coordinating medical leave of absence with OHR, Lincoln Financial Group, and their department.

Contact the Office of Public Safety; they will call 911 to provide medical attention for emergency situations. Medical care will be provided through the Workers' Compensation Network, NSU's insurance company and coordinated by the Risk Management Office.

List of Medical Treatment Locations

HPD Clinics

Davie

Sanford L. Ziff Health Center

3200 S. University Drive – 3rd floor

Davie, FL 33328

Phone: (954) 262-4100

Fax: (954) 262-3984

Hours: (M-F) 9:00 a.m. - 5:00 p.m.

Sat: 9:00 am - 1:00 pm

***Please contact the NSU Risk Management Office for other locations if the employee does not wish to go to the NSU Clinic.**

URGENTMED

To be used only if employees are outside NSU area or if Injury occurs and NSU's clinic is closed/cannot accommodate the employee

2337 South University Drive

Davie, FL 33324

Phone: (954) 423-9234

Fax: (954) 423-9231

(*In the Promenade Plaza
Near Longhorn Restaurant)

10199 Cleary Blvd – Suite 10

Plantation, FL 33324

Phone: (954) 473-8565

Fax: (954) 473-8015

Concentra Medical Centers

To be used only if employees are outside NSU area or if Injury occurs and NSU's clinic is closed/cannot accommodate the employee

Fort Lauderdale (Sunshine)

1347 South Andrews Avenue

Ft. Lauderdale, FL 33316

Phone: 954-767-9999

Fax: 954-763-9828

Hours: (M-F) 8:00 am – 08:00 pm

Sat & Sun: 10:00 am – 4:00 pm

Miami

7800 NW 25th St., Ste. 4

Miami, Florida 33122

Phone: 305-593-2174

Fax: 305-593-1417

Hours: (M-F) 8:00a.m. – 08:00 pm

West Palm Beach

4455 Medical Center Way

West Palm Beach, FL 33407

Phone: 561-881-0066

Fax: 561-881-5533;

Hours: (M-F) 7:30 am - 6:30 pm

Sat & Sun: 8:00 am – 4:00 pm

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
Report all deaths within 24 hours 1-800-219-8953 or (850) 921-8953

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 <input type="checkbox"/> AM <input type="checkbox"/> PM
HOME ADDRESS Street/Apt #: _____ City: _____ State: _____ Zip: _____		EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)		
TELEPHONE Area Code Number		OCCUPATION		
DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	INJURY/ILLNESS THAT OCCURRED		PART OF BODY AFFECTED

EMPLOYER INFORMATION

NAME: <u>New Southeastern University</u> COMPANY		FEDERAL I.D. NUMBER (FEIN) <u>59-1083502</u>	DATE FIRST REPORTED (Month/Day/Year)
D. B. A.: <u>Same</u>		NATURE OF BUSINESS <u>Education</u>	POLICY/MEMBER NUMBER <u>2499209</u>
Street: <u>2281 College Avenue</u>		DATE EMPLOYED ____/____/____	
City: <u> Ft Lauderdale</u> State: <u>Florida</u> Zip: <u>33314</u>		PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	
TELEPHONE Area Code Number		EMPLOYER'S LOCATION ADDRESS (If different) Street: _____ City: _____ State: _____ Zip: _____	
EMPLOYER'S LOCATION ADDRESS (If different)		LAST DATE EMPLOYEE WORKED ____/____/____	
EDUCATION # (If applicable)		RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE ____/____/____	
PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: _____ Zip: _____		DATE OF DEATH (If applicable) ____/____/____	
COUNTY OF ACCIDENT _____		AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
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, understood and acknowledge the above statement.		RATE OF PAY <input type="checkbox"/> HR <input type="checkbox"/> WK \$ _____ PER <input type="checkbox"/> DAY <input type="checkbox"/> MO Number of hours per day _____ Number of hours per week _____ Number of days per week _____	
EMPLOYEE SIGNATURE (If available to sign) _____ DATE _____		NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL	
EMPLOYER SIGNATURE _____ DATE _____		AUTHORIZED BY EMPLOYER <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	

CLAIMS-HANDLING ENTITY INFORMATION

<input type="checkbox"/> (a) Denial Case - DWC-12, Notice of Denial Attached	<input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required information in #3)
<input type="checkbox"/> (b) Indemnity Only Denial Case - DWC-12, Not a Denial Attached	Employee's 8TH Day of Disability _____/_____/_____
<input type="checkbox"/> 3. Lost Time Case - 1st day of disability _____/_____/_____	Entity's Knowledge of 8TH Day of Disability _____/_____/_____
Date First Payment Made _____/_____/_____	Full Salary in lieu of comp? <input checked="" type="checkbox"/> Full Salary End Date _____/_____/_____
<input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> B. <input type="checkbox"/> P.T. <input type="checkbox"/> DEATH <input type="checkbox"/> SETTLEMENT ONLY	AWW _____ Comp Rate _____
Penalty Amount Paid in 1st Payment \$ _____	Interest Amount Paid in 1st Payment \$ _____

REMARKS:

INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE	INSURER NAME CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE Cannon Cochran Management Services, Inc. PO Box 948399 Maitland FL 32794-8399 866-291-0194 407-660-5600 Fax: 217-477-6946 FIGURMAmail@ccmsi.com
SERVICE CODE #	CLAIMS-HANDLING ENTITY F.I.E.#		

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.

WORKERS' COMPENSATION TREATMENT AUTHORIZATION FORM

This is a Worker's Compensation Treatment Authorization Form. This Form is not a guarantee of eligibility or compensability for Workers' Compensation Benefits.

To be completed by employer (please print)

Account Number: F45

Employer Name: Nova Southeastern University

Employer Address: 3301 College Avenue, Ft. Lauderdale, Florida 33314

Employee Name: _____

Social Security Number: _____ Date of Injury: _____

Type of Injury: _____

Body Part Injured: _____

Supervisor issuing form: Charmaine Beckford (T) 954-262-5404* 954-262-6860-(F)

Supervisors: Please give this completed form to the injured employee to take with them to the physician.

This form is for one time use, only on this date _____.

Providers: You must call Cannon Cochran Management Services, Inc. toll free at 1-866-291-0194 prior to any additional treatment/admission or referral, other than an emergency. In an emergency, notification to CCMSI is required within 24 hours.

Send Medical Bills To:
Cannon Cochran Management Services, Inc.
PO Box 948399 | Maitland | FL 32794-8399
1-866-291-0194 | 407-660-5600 | Fax: 217-477-6946 | FICURMAmail@ccmsi.com



AUTHORIZATION FOR MEDICAL RECORDS AND COMMUNICATION RELEASE

Name: _____ Date of Birth: _____ Social Security #: _____

I hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of my mental or physical health, history, condition or wellbeing, to supply such information to my employer or its insurance carrier, claims administrator or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer or its insurance company, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment, and as to any other issues including diagnosis, prognosis, causal connection of care and treatment to my work injury or duties, and ability to work. I hereby waive my physician-patient privilege. In conjunction with this, I also authorize any treating physician or medical provider to review any additional materials provided to them.

A photocopy of this authorization shall be as valid as the original. This release shall remain valid for the length of my claim.

Note: Workers' Compensation Requests Are Exempt From HIPAA. Pursuant to 45 CFR, Sect. 164.512(1) a covered entity may without penalty under HIPAA disclose protected health information to the extent necessary to comply with the law relating to workers' compensation.

NAME-PLEASE PRINT

SIGNATURE

DATE

Cannon Cochran Management Services, Inc.
PO Box 948399 | Maitland | FL 32794-8399
866-291-0194 | 407-660-5600 | Fax: 217-477-6946 | FICURMAmail@ccmsi.com



False and Fraudulent Claim Warning

Please read the following information carefully. This form must be signed and returned within 30 days of the date it was received, stating that you have reviewed, understand and acknowledge the statement of benefits and/or payments shall be suspended until such signature obtained.

Workers' Compensation fraud includes but is not limited to the following:

- Requesting and/or receiving temporary total, temporary partial, permanent total disability or impairment benefits while working for gain as an employee of a business, independent contractor, yourself or a business and not reporting that income to the insurance company.
- Making a false or written statement and/or submitting false documents to your employer, your physician and/or the insurance company or their representatives for the purpose of filing or supporting a claim for workers' compensation benefits.
- Misrepresenting facts concerning an industrial accident, injury or illness to your employer, your physician and/or the insurance company or their representatives.
- Failing to report earnings when requested to do so by the insurance company.
- Selling your personal information to third parties for use of misrepresenting facts to any medical provider or insurance company.

Florida

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 Florida Statute 817.234.

I have reviewed, understand and acknowledge the above. This information is true and correct to the best of my knowledge.

Workers Name:

Please type or print

Claim #: _____ Employee: _____

Employer: _____

Employees' Address: _____

Phone: _____

Workers' Signature: _____ Date: _____

Cannon Cochran Management Services, Inc.
PO Box 948399 | Maitland | FL 32794-8399
866-291-0194 | 407-660-5600 | Fax: 217-477-6946 | FICURMAmail@ccmsi.com



FICURMA Workers' Compensation Prescription Information

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

	 
Employee Name:	
Group#:	P2KA
Member ID (SSN):	
Date of Injury:	
Processor:	<u>myMatrixx</u>
Bin#:	003858
Day supply is limited to 14 days for a new injury.	
<u>myMatrixx</u> Help Desk: (877) 804-4900	

Employee:

FICURMA has partnered with myMatrixx to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (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.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

Workers' Compensation Witness Report Form **(To be completed by witness only)**

Name of injured employee: _____

Name of witness: _____

Telephone # of Witness _____

Location where incident occurred: _____

Date of incident: _____ Time of incident: _____

1. What were you (the witness) doing at the time of the incident?

2. How and when did you become aware of the incident?

3. What did you hear at the time of the incident?

4. Describe what you saw at the time of the incident:

5. Who else was present?

6. Please relate any additional information you have pertaining to the incident:

Witness's signature: _____ Date signed: _____

Employee Information Section D

NSU Workers' Compensation Quick Facts

Reporting Period: An employee who suffers an injury/illness arising out of and in the course of employment must advise his/her supervisor, Risk Management or OHR contact of the injury immediately, but no later than within 30 days after the date of or initial manifestation of the injury. **The law requires that you report the accident or your knowledge of a job-related injury within 30 days of your knowledge of the accident or injury.** Failure to report the injury/illness in the noted timeframe could result in the denial of the claim under certain circumstances.

However, if the employee reports the injury after the 30 day period the information must be reported to Risk Management immediately using the pertinent forms found online at

http://www.nova.edu/cwis/fop/risk/forms/workers_comp.pdf.

Waiting Period for Comp Benefits after Injury: 7 days

Wage Replacement Benefits: If an authorized treating physician places an injured worker off work the workers' compensation benefits for lost wages will start on the eighth day that the employee is unable to work. No wage replacement benefits are paid for the first 7 days of work missed, unless the employee is out of work for more than 21 days due to the work-related injury. The wage replacement benefits will equal two-thirds (66-2/3%) of the employee's pre-injury regular weekly wage, but the benefit will not exceed Florida's Maximum Compensation Rate for the year of the accident and is on a paid bi-weekly basis. An injured worker who is receiving wage replacement can use 2.5 hours or equivalent hours of his/her own accrued sick, personal, or vacation hours towards full wage compensation (based on a 7.5 hour daily scale).

Compensation is retroactive if disability continues for what period of time from the date of injury? If an authorized treating physician places an injured worker off in excess of 21 days, the 7 days is paid by the 4th week of disability.

Choice of Physician: You must see a doctor authorized by your Risk Management office (ext. 25404) or the insurance company (407-660-5637 or 866-291-0194). If it is an emergency and you cannot reach the Risk

Management office or adjuster, to tell you where to go for treatment, go to the nearest emergency room and let Risk Management and the adjuster know as soon as possible what has happened.

If it is after hours and you cannot reach the Risk Management office or adjuster, to tell you where to go for treatment and your PCP is not available go to the nearest emergency room and let Risk Management and the adjuster know as soon as possible what has happened.

Per Florida Statute 440.13(2) (f), an injured worker is entitled to a one time change per accident. The insurance company will authorize an alternative physician within five days of receiving a written request from the injured worker. If medical care is provided outside an authorized approved network, the employer chooses the physician.

Transportation during Disability Period: Medical transportation is available if the injured worker needs it. If the injured worker uses his/her vehicle for transportation to medical providers, they are reimbursed at the current rate of 44.5¢ per mile. The carrier/servicing agent can supply mileage forms or the employee can retrieve same online at http://www.nova.edu/cwis/fop/risk/forms/workers_comp.pdf. Call Cannon Cochran Management Services, INC. immediately at 407-660-5637 or 866-291-0194 if you need transportation or cannot make an appointment.

Prescription Benefit: Medications can be dispensed at any pharmacy (see MyMatrixx listing). The injured worker pays no co-pay (prior to MMI) for Rx. if an authorized medical provider prescribes medical services, devices, appliances, etc., as it relates to the injury/illness. Please contact your claim adjuster at CCMSI (407-660-5637 or 866-291-0194) for authorization prior to receiving service or Risk Management for assistance.

Notification from Insurance Company: Within 3-5 business days after you or the Office of Risk Management report the accident, you should receive an informational brochure explaining your rights and obligations, and a Notification Letter explaining the services provided by the Employee Assistance Office of the Division of Workers' Compensation. These forms may be part of a packet which may include some or all of the following:

- A copy of your accident report or "First Report of Injury or Illness," which you should read to make sure it is correct;
- A fraud statement, which you would have already read, signed and returned to the Office of Risk Management for forwarding to the insurance company. If you have not done so, then you must read, sign and return it as soon as possible, or benefits may be temporarily withheld until you do so;

- A release of medical records, which you would have already read, signed and returned to the Office of Risk Management for forwarding to the insurance company. If you have not done so, then you must read, sign and return it as soon as possible; and

Medical mileage reimbursement forms that you should fill out, after seeking medical treatment, and send to your claims adjuster for reimbursement. You may forward a copy to the Office of Risk Management to be placed on your file.

I am injured. Now What?

FAQ's regarding Workers' Compensation



How long do I have to report a claim to my employer?

All injured workers must contact their supervisor/employer immediately to notify them of any on-the-job injury. Claims reported after 30 days could be denied.

Which forms do I need to complete?

All injured workers should complete a First Report of Injury form, NSU Employee Statement Regarding Cause of Accident, CCMSI. NSU/CCMSI Workers' Compensation Treatment Authorization form, CCMSI False and Fraudulent Claim Warning form and CCMSI Authorization for Medical Records and Communication Release form, NSU Workers' Compensation Witness Report form when filing.

It is important that all injured workers complete the fraud statement. Benefits might become suspended if said injured workers refuse to provide the requested signature.

What doctor can I go to?

Your Workers' Compensation Risk Management Specialist (employer) or insurance company (CCMSI), upon becoming aware of your injury will direct you to a health care provider for such period as the nature of the injury or the process of recovery may require. Medical care must be authorized by the Workers' Compensation Risk Management Specialist or insurance company.

Why can't I go to the doctor of my choice?

Per Florida Statute 440.13(2) (a), the law requires that the employer/insurance company provide the appropriate medical care.

Can I go to my own personal physician?

No. You must go to an authorized physician provided by FICURMA or the insurance company (CCMSI).

The doctor is not helping me. Can I request a different doctor for my treatment?

Yes. Per Florida Statute 440.13(2) (f), you are entitled to a one time change per accident. The request for a change in physician must be in writing and provided to the insurance company (CCMSI). Upon receipt of the request, the insurance company will select and authorize an alternative physician within five days of receipt of the written request. The injured worker or insurance company (CCMSI) may also select a one-time Independent Medical Examination (IME), per accident. Please note, if your accident occurred on or after 10/1/03, the party requesting the IME is responsible for payment.

Will I have to pay any medical bills?

No, all authorized medical bills should be submitted by the medical provider to CCMSI for payment until you reach maximum medical improvement. Once you reach Maximum Medical Improvement you will be required to pay \$10.00 co-pay per visit.

If prescribed, how do I get my prescription filled?

If your authorized physician prescribes a prescription, please take the prescription to your pharmacist along with the information from **MyMatrixx** to ensure your prescriptions are billed directly to the insurance company. In rare cases you may be asked to pay for your medications: if this happens, you will be reimbursed any money you have to advance once receipts are provided to the insurance company.

What is my responsibility when the doctor places me on restricted duty?

It is your responsibility to communicate with your Supervisor and Workers' Compensation Risk Management Specialist following your appointments. If you are given restrictions or placed out of work any time during your treatment, please ensure they are communicated to your Supervisor and Workers' Compensation Risk Management Specialist immediately. Please remember, the doctor gives you restrictions until your next visit to help you recover from your injury. It is extremely important that you observe your restrictions at work as well as in your daily life.

If you are placed on medical leave please contact your Human Resources Total Rewards team for information pertaining to filing a request for medical leave due to your workers' compensation status. The contact extensions information can be had online at <http://www.nova.edu/hr/staff.html>.

Do I have to attend my appointments?

Yes. Time, effort and expense are put into providing your medical care. If you do not follow the doctor's direction and attend all medical appointments your case may be terminated for non-compliance and all benefits suspended.

If a medical bill comes to my house, what do I do?

Fax or mail the medical bill to the Risk Management Office (fax # 954-262-6860/3814). The Workers' Compensation Risk Management Specialist relates it to the claim and forwards it to your adjuster. CCMSI will pay all authorized invoices for your claim. Otherwise, you can elect to forward the bill to your CCMSI adjuster (fax. 217-477-6623) or by email to the adjuster.

Will I get paid mileage to my medical appointments?

If you, a family member or friend drives you to an authorized appointment, physical therapy, hospital, diagnostic testing or pharmacy you are entitled to mileage reimbursement @ 45 cents per mile or current rate. A form is available to document the appropriate mileage.

What do I do if I can't make my appointment or do not have transportation?

Call CCMSI immediately at 407-660-5637 or 866-291-0194.

When do I get my first check?

You should receive the first check within three (3) weeks after reporting your injury to FICURMA/CCMSI and have been off work by an authorized treating physician beyond the waiting period.

All injured workers must report any wages (from all employment) earned to the insurance carrier.

How much will I be paid?

In most cases, benefits are calculated at 66 2/3 percent of your average weekly wage up to the state max for the year of your accident. If you were injured on or after October 1, 2003, your average weekly wage is calculated using wages earned 13 weeks prior to your injury, not counting the week in which you were injured

Will I be paid if the doctor takes me off work?

In most cases, your first check will be from the 8th day of disability through the time your authorized treating physician releases you to return to work. Under Florida law, you are not paid for the first seven days of disability, unless you are out more than 21 days.

Will the check come to my house?

If you are entitled to benefits, your check will be mailed to your home. Please make sure we have the most up to date information regarding your address and phone number.

Can I receive unemployment compensation and workers' compensation benefits at the same time?

No, not if you are receiving temporary total or permanent disability benefits, you must be medically able and available to work to qualify for unemployment benefits.

Will I get fired because of my injury?

No. It is against the law to fire you because you have filed or attempted to file a workers' compensation claim.

If I choose to have Legal Representation how would this affect my claim?

Injured workers are not required to have an attorney but are free to retain one if they so desire. If an injured worker elects to hire an attorney to represent him or her with his or her workers' compensation claim -

- (a) Fees and costs may come out of benefits received, unless his or her employer or workers' compensation carrier is held responsible for paying the attorney fees and other costs which may occur under certain limited circumstances.
- (b) All communication, whether written or verbal, pertaining to an injured worker's claim, must be between the injured worker's attorney and NSU's Third Party Administrator. Consequently, the injured worker cannot communicate with NSU representatives/employees pertaining to his/her claim while represented by an attorney.

If my claim is based on Mental or nervous disorders how is it covered?

Mental or nervous injuries (440.093): A mental or nervous injury due to stress, fright or excitement only is not an injury by accident arising out of the employment (see 440.02(1), Definitions.) Section 440.093 addresses mental or nervous injuries. It states that the physical injury must be and remains the major contributing cause and limits the payment of permanent benefits for mental or nervous injury to six months following date of maximum medical improvement for the physical injury.

Who do I contact if I have any questions concerning my benefits?

CCMSI.: @ 407-660-5637 or 866-291-0194 . Their mailing address is CCMSI., 2600 Lake Lucien Dr. Suite 225, Maitland, FL 32751; Tel. 3407-660-5637 or 866-291-0194 and/or the Risk Management Office at 954-262-5404.

- (a) All injured workers must complete and return forms to the insurance carrier when asked.
- (b) All injured workers must notify the insurance carrier of any address changes.

Disclaimer: The above represents a summary of information pertaining to Nova Southeastern University's Worker's Compensation Benefit. Please note that worker's compensation law can be complex and these laws and policies are subject to amendment at any time. If you need help with a workers' compensation issue, please consult your CCMSI and/or Workers' Compensation Risk Management team.



69L-3.0036, F.A.C. Employer Informational Brochure

[https://www.myfloridacfo.com/docs-sf/workers-compensation-libraries/workers-comp-documents/employers/informational-brochure-for-employers-\(english\).pdf](https://www.myfloridacfo.com/docs-sf/workers-compensation-libraries/workers-comp-documents/employers/informational-brochure-for-employers-(english).pdf)

Workers' Compensation Exemptions

Construction Industry

An employer in the construction industry who employs one or more part-time or full-time employees, including the owner, must obtain workers' compensation coverage.

Corporate officers or members of a limited liability company (LLC) in the construction industry may elect to be exempt if:

- The officer owns at least 10 percent of the stock of the corporation, or in the case of an LLC, a statement attesting to the minimum 10-percent ownership.
- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.

No more than three corporate officers per corporation or limited liability member are allowed to be exempt. A \$50 fee is required for each application submitted to obtain an exemption. Construction exemptions are valid for a period of two years or until a voluntary revocation is filed or the exemption is revoked by the Division.

For copies of the exemption form, contact the Division's Bureau of Compliance at (850) 413-1609 or go to <https://www.MyFloridaCFO.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm> and click on Rule 69L-4 and Form number DWC-250, Notice of Election to Be Exempt.

Non-Construction Industry

An employer in the non-construction industry, who employs four or more part-time or full-time employees, must obtain workers' compensation coverage.

Sole proprietors and partners in the non-construction industry are automatically exempt from the law, but can elect to be covered.

Non-construction industry corporate officers may elect to be exempt if:

- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.

There is no limit to the number of corporate officers who can be exempt and there is no application fee. Non-construction exemptions are valid until a voluntary revocation is filed or the exemption is revoked by the Division.

What Your Employee Can Expect From the Insurance Carrier

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of the employee's claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of the employee's claim. This information should be provided to the injured worker by mail on either a Notice of Action/Change form (DWC-4) or a Notice of Denial form (DWC-12)

Questions about workers' compensation?

Please visit our Web site at www.MyFloridaCFO.com/Division/WC where you will find extensive information such as publications, databases, rules and forms that will give you a better understanding of workers' compensation.

Employee Assistance and Ombudsman Office Hotline
1-800-342-1741

Injured worker e-mail inquiries
wccase@myfloridacfo.com

Customer Service
(850) 413-1601

Employer e-mail inquiries
WorkCompCostServ@MyFloridaCFO.com

Workers' Compensation Fraud Hotline
1-800-378-0445

Frequently Asked Questions

Q) How many days do employees have to report work-related injuries or illnesses?

A) Employers should encourage employees to report accidents as soon as the work-related injuries or illnesses occur. By law, however, employees are required to report work-related injuries or illnesses within 30 days.

Q) To whom should I report the work-related injury?

A) You should report the accident to your insurance company as soon as you have knowledge of the injury. By law, you have seven days from your first knowledge of the work-related injury.

Q) Do I have to report a claim if I do not believe it is a work-related injury or illness?

A) Yes. You should report all claims of work-related injuries or illnesses to your workers' compensation insurance carrier. This includes claims in which there are no witnesses of the injury or illness. It is your workers' compensation insurance carrier's responsibility to investigate all claims and determine if employees are entitled to benefits under Florida's Workers' Compensation Law.

Q) Does the employee pay any part of my workers' compensation insurance premium?

A) No. The law is very specific on this point. It is the employer's responsibility to pay the entire premium for workers' compensation.

Employers who secure workers' compensation coverage can also apply to become a drug-free workplace and may receive a premium discount. To learn more about the Drug-Free Workplace Program, please call the Division of Workers' Compensation Customer Service Office at 850-413-1609.

Q) Who should I call if my employees have questions or concerns regarding their workers' compensation claims?

A) You should first contact your insurance carrier. If your carrier is unable to answer the question or resolve the problem, you or your employees should call the Employee Assistance and Ombudsman Office at 1-800-342-1741.

Disclaimer:

This publication is being offered as an informational tool only and complies with s. 440.185 (4) F.S., with the understanding that this is not official language of the Florida Statutes. In no event will the Division of Workers' Compensation be liable for direct or consequential damages resulting from the use of this printed material.

EMPLOYER FACTS



IMPORTANT

WORKERS' COMPENSATION
INFORMATION FOR
FLORIDA'S EMPLOYERS



**DIVISION OF
WORKERS' COMPENSATION**
Florida Department of Financial Services

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 69L-3.005, F.A.C. Forms
DPS-F2-DWC-05
Revised March 2010

69L-3.0036, F.A.C. Employer Informational Brochure cont'd

Your workers' compensation insurance policy covers medical and partial wage-replacement benefits for any employee who sustains a work related injury or illness.

This brochure will give you a better understanding of your role and responsibilities under the workers' compensation system.

Workers' Compensation Notice

The law requires that every employer who has secured workers' compensation coverage post in conspicuous place(s) a notice that contains the employer's insurance carrier information, the expiration date of the policy and an anti-fraud statement. The Division of Workers' Compensation has developed this notice, in poster form, for carriers to provide to their policyholders. Your carrier is required by law to provide you with the poster(s).

Even if employers have purchased workers' compensation policies, they shall be deemed to have failed to secure workers' compensation coverage if they have committed any of the following actions:

- materially understated or concealed payroll,
- materially misrepresented or concealed employee duties to avoid proper classification for premium calculations, or
- materially misrepresented or concealed information pertinent to the computation and application of an experience modification factor.

Employers who fail to secure workers' compensation coverage or fail to update information on their workers' compensation insurance application are subject to stop work orders and civil and criminal penalties.

First Report of Injury

As soon as you become aware of a work-related injury or illness, immediately contact your workers' compensation insurance carrier. If you do not report the injury or illness to your insurance carrier within seven days of the date you were informed, you may be subject to an administrative fine not to exceed \$2,000 per occurrence. Most insurance companies have a toll-free number to report work-related injuries. If you report the injury or illness to the insurance carrier by telephone, the carrier will complete the form and

send a copy to you and the employee within three business days. You can also fill out the First Report of Injury or Illness form (DWC-1) and send it to the insurance carrier. The form contains employer, employee and accident information and can be obtained on the Division of Workers' Compensation Web site at <https://www.MyFloridaCFO.com/Division/WC/pdf/DFS-F2-DWC-1.pdf>. You must also provide a copy of the First Report of Injury or Illness form to the employee. The employee's signature on the form is preferred, but if the employee is not able or available to sign it, then write "not available" in the employee signature box.

Workplace Fatalities

Employers must also report deaths resulting from work-related injuries or illnesses to the Division of Workers' Compensation within 24 hours. To report a workplace fatality, call 1-800-219-8953 (in Florida) or 850-413-1611, or fax the First Report of Injury or Illness form containing the fatality information to 850-354-5100.

To access the form, go to <https://www.MyFloridaCFO.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm> and click on DWC-1.

Medical Benefits

As soon as you notify your carrier about your employee's work-related injury, the carrier will:

- Determine the compensability of the injury
- Provide an authorized doctor
- Pay for all authorized medically necessary care and treatment related to the injury or illness
- Provide a one-time change of physician within five business days of receipt of your written request

Authorized treatment and care may include:

- Doctor's visits
- Hospitalization
- Physical therapy
- Medical tests
- Prescription drugs
- Prosthesis
- Travel expenses to and from authorized providers or pharmacies.

Upon reaching maximum medical improvement (MMI), the employee is required to pay a \$10 copayment per visit for medical treatment. MMI occurs when the treating physician determines that the employee's injury has healed to the extent that further improvement is not likely.

Wage Replacement Benefits

Workers' compensation benefits for lost wages will start on the eighth day that the injured employee is unable to work. The injured employee will not receive wage replacement benefits for the first seven days of work missed, unless he or she is out of work for more than 21 days due to the work-related injury. In most cases, the wage-replacement benefits will equal two-thirds of the employee's pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. If the employee qualifies for wage replacement benefits, he or she can expect to receive the first benefit check within 21 days after the carrier becomes aware of the injury or illness, and bi-weekly thereafter. The injured employee will be eligible for different types of wage replacement benefits, depending on the progress of the claim and the severity of the injury.

- **Temporary Total Benefits:** These benefits are provided as a result of an injury that temporarily prevents the employee returning to work and the employee has not reached MMI.
- **Temporary Partial Benefits:** These benefits are provided when the doctor releases the employee to return to work, and the employee has not reached MMI and earns less than 80 percent of the pre-injury wage. The benefit is equal to 80 percent of the difference between 80 percent of the pre-injury wage and the post-injury wage. The maximum length of time the injured employee can receive temporary benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.
- **Permanent Impairment Benefits:** These benefits are provided when the injury causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole. If you return to work at or above your pre-injury wage, the permanent impairment benefit is reduced by 50%.
- **Permanent Total Benefits:** These benefits are provided when the injury causes the employee to be permanently and totally disabled according to the conditions stated in law.
- **Death Benefits:** Compensation for deaths resulting from work-related injuries or illnesses include payment of funeral expenses and dependency benefits (each are subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

Wage Statement Form

You must complete and provide a wage statement form (DFS-F2-DWC-1a) to your carrier for any employee who is entitled to wage replacement benefits, within 14 days after knowledge of the accident. You must also complete this form upon the termination of the employee or upon termination of fringe benefits for any employee who is collecting wage replacement benefits within seven days of such termination. To access the form go to, <https://www.MyFloridaCFO.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm> and click on DWC-1a.

Employee Assistance Office

If you have any questions or concerns about your employees' workers' compensation benefits, call your workers' compensation insurance carrier. If the insurance carrier does not provide the information that you have requested, you can call the Division of Workers' Compensation, Employee Assistance Office (EAO) at 1-800-342-1741. This office helps prevent and resolve disputes between injured workers and employers/carriers.

EAO specialists are knowledgeable about the workers' compensation system and may be able to answer your questions. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at www.MyFloridaCFO.com/Division/WC/Employee/eao_offices.htm.

In addition, the Division of Workers' Compensation has a Web site section on "Frequently Asked Questions for Employers," which can be accessed at <https://www.MyFloridaCFO.com/Division/wc/Employer/faq.htm>.

Petition for Benefits

To begin the judicial procedure for obtaining benefits that you believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Office of Judges of Compensation Claims. The form can be accessed at www.jcc.state.fl.us/JCC/forms/.

Anti-Fraud Reward Program

Workers' compensation fraud occurs when any person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program, files false or misleading information. Workers' compensation fraud is a third degree felony that can result in fines, civil liability and jail time. Rewards of up to \$25,000 may be paid to individuals who provide information that led to the arrest and conviction of persons committing insurance fraud. To report suspected workers' compensation fraud, call 1-800-378-0445.

Certificado de elección para exenciones

Industrias dedicadas a la construcción

Empleadores en las industrias de la construcción con un (1) empleado o más a jornada completa o jornada parcial, incluyendo el dueño, debe obtener la cobertura de seguro por accidentes de trabajo.

Oficiales o miembros de una sociedad de responsabilidad limitada (LLC) de una corporación en la industria de la construcción pueden elegir ser exentos si:

- Poseen un mínimo de diez por ciento (10%) de titularidad de acciones de la corporación o en el caso de un LLC hay una declaración que da testimonio a la propiedad del 10 por ciento mínima.
- El oficial de la compañía aparece como oficial de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación aparece activa en el registro del Departamento del Estado de la Florida, División de Corporaciones.

Solamente tres oficiales de una corporación o sociedades de responsabilidad limitada pueden elegir ser exentos. Se requiere pagar \$50 por cada aplicación presentada para obtener una exención. Exenciones en las industrias que participan en la construcción son válidas por dos años o hasta que se registre una revocación voluntaria o si la exención es revocada por la división.

Para conseguir copias de la notificación de elección para ser exento [en inglés Notice of Election to Be Exempt] llame al (850) 413-1609 o vaya a nuestro sitio Web en <http://www.myfloridacfo.com/WC/forms.html>, y haga clic en la regla 69L-6 y número del formulario DWC-250 Elección de ser exento.

Lo que su empleado puede esperar de parte de la compañía de seguros:

- Provisión oportuna de tratamiento médico
- Provisión oportuna de beneficios de reemplazo de salario
- Pago oportuno de cuentas médicas
- Notificación oportuna de su reclamación a la División de Compensación por Accidentes de Trabajo
- Notificación oportuna de cualquier cambio del estado de su reclamación. Esta información se le será proveída por correo en un formulario titulado "Notice of Action/Change (DWC4) [Notificación de Acción o Cambio (DWC4)] o "Notice of Denial (DWC12) [Notificación de Negación (DWC12)]"

Industrias que no se dedican a la construcción

Un empleador que no participa en la industria de construcción y tiene cuatro (4) empleados o más de jornada completa o jornada parcial, tiene que obtener la cobertura de seguros por accidentes de trabajo.

Propietarios únicos y socios en industrias que no participan en la construcción están automáticamente exentos de la ley, pero pueden elegir ser cubierto.

Oficiales de una corporación que no se dedica a la construcción puede elegir ser exentos si:

- El oficial esta listado como oficial de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación esta listada activa en el registro del Departamento del Estado de la Florida, División de Corporaciones.

No hay limite de oficiales que pueden ser elegibles para ser exentos y no le cobrarán por llenar la aplicación para la exención. Exenciones en las industrias que no se dedican a la construcción son válidas por dos años o hasta que se registre una revocación voluntaria o si la exención es revocada por la división.

¿Tiene preguntas sobre el seguro por accidentes de trabajo?

Por favor, visite nuestra página Web en www.MyFloridaCFO.com/wc donde usted encontrará información extensa tal como publicaciones, un número de bases de datos, reglas, y formas que le dará un mejor entendimiento del seguro para accidentes de trabajo.

Oficina de Ayuda al Trabajador (Oficina de asistencia para el trabajador) 1-800-342-1741

Empleados lesionados pueden hacer preguntas por correo electrónico wceao@myfloridacfo.com

Servicio al cliente (850) 413-1601

Empleadores pueden hacer preguntas por correo electrónico
WorkCompCustServ@MyFloridaCFO.com

Preguntas sobre el programa contra el fraude
1-800-378-0445

Preguntas hechas con frecuencia

P) ¿Cuántos días tienen los empleados para reportar lesiones u enfermedades relacionadas con el trabajo?

R) Los patrones deben aconsejar a sus empleados que reporten accidentes tan pronto como ocurran lesiones o enfermedades relacionadas con el trabajo. Por ley, sin embargo, se requiere que empleados reporten lesiones o las enfermedades relacionadas con el trabajo en el plazo de 30 días.

P) ¿A quién le debo reportar la lesión relacionada con el trabajo?

R) Usted debe reportar el accidente a su compañía de seguros tan pronto usted tenga conocimiento de la lesión. Por ley, usted tiene siete días desde su primer conocimiento de la lesión relacionada con el trabajo.

P) ¿Tengo que reportar un reclamo si no creo que la lesión o enfermedad es relacionada con el trabajo?

R) Si. Usted debe reportar todas las demandas de lesiones o de enfermedad relacionadas con el trabajo a su compañía de seguros. Esto incluye las demandas de las cuales no hay testigos de las lesiones u de las enfermedades. Es responsabilidad de la compañía de seguros por accidentes de trabajo investigar todas las demandas y determinar si el empleado tiene derecho a recibir beneficios de acuerdo a la ley de seguros por accidentes de trabajo.

P) ¿El empleado paga parte de la prima de seguro por accidentes de trabajo?

R) No. La ley es muy específica en este punto. Es la responsabilidad del empleador pagar la prima entera del seguro por accidentes de trabajo.

P) ¿A quién debo llamar si mis empleados tienen preguntas o preocupaciones con respecto a sus reclamaciones?

R) Usted debe primero contactar a su compañía de seguro. Si la aseguradora no puede contestar la pregunta o resolver el problema, usted o sus empleados deben llamar la oficina de la ayuda al Trabajador en 1-800-342-1741.

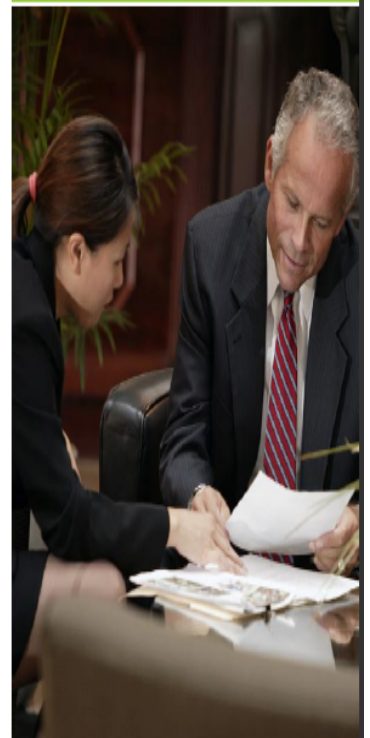
Empleadores que adquieran una póliza de seguros por accidentes de trabajo pueden también aplicar para ser un lugar de trabajo libre de drogas y pueden recibir un descuento de prima. Para aprender más sobre el programa, llame por favor a la División de Compensación por Accidentes, la oficina del servicio de atención al cliente al 850-413-1609.

Limitación de responsabilidad

Esta publicación esta siendo ofrecida sólo como una herramienta de información, acata s.440.185 (4) F.S. con el entendimiento que esto no es lenguaje oficial de los Estatutos de la Florida. Bajo ningunas circunstancias será la División de Compensación por accidentes de trabajo responsable de daños directos o resultantes del uso de ese material.

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-66
Revised March 2010

Información Para Empleadores



INFORMACIÓN IMPORTANTE DEL SEGURO DE INDEMNIZACIÓN POR ACCIDENTES DE TRABAJO PARA LOS EMPLEADORES DE LA FLORIDA



DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

Su póliza de seguro por accidentes de trabajo cubre beneficios médicos y reemplazo parcial del salario para cualquier empleado que sostenga lesión o una enfermedad relacionada con su trabajo.

Este folleto le dará una mejor comprensión de su papel y responsabilidades bajo el sistema de seguro por accidentes de trabajo.

Aviso de seguro por accidentes de trabajo

La ley requiere que cada empleador que ha adquirido una póliza de seguro por accidentes de trabajo coloque en un lugar o lugares conspicuo(s) un aviso que contenga información sobre la compañía de seguros, la fecha de vencimiento de la póliza, y una declaración en contra de fraude. La División de Compensación por Accidentes de Trabajo ha desarrollado este aviso en forma de cartel, para que las compañías de seguro se las proporcionen a sus asegurados. Su compañía de seguros tiene obligación legal de proveerle los carteles.

Aunque el empleador adquiera una póliza de seguros por accidentes de trabajo, se consideran no haberlo hecho si han cometido cualquiera de las siguientes acciones:

- subestimar u ocultar nómina de pago,
- falsificar u ocultar las responsabilidades del empleado para evitar la clasificación apropiada para los cálculos de la prima de seguro
- falsificar u ocultar información pertinente al cálculo y aplicación de un factor de modificación de experiencia.

Los empleadores que tienen obligación de proveer seguro por accidentes de trabajo pero no lo hacen o no actualizan la información reportada en la solicitud de seguro por accidentes de trabajo, son sujetos a recibir una orden de suspensión de trabajo y penas civiles y criminales.

Primer reporte de la lesión o enfermedad

Tan pronto usted se entere de una lesión o enfermedad relacionada con un accidente en el lugar de trabajo, contacte inmediatamente a su compañía de seguro por accidentes de trabajo. Si usted no reporta la lesión o la enfermedad a la compañía de seguro en un plazo de siete días después de la fecha que usted fue informado, usted puede estar sujeto a una multa administrativa que no exceda \$2,000 por ocurrencia. La mayoría de las compañías de seguros tienen un número gratis para reportar lesiones relacionadas con el trabajo. Si usted reporta la lesión o la enfermedad a la compañía de seguros por teléfono, la compañía de seguros llenará el formulario y le enviará una copia al empleado dentro de tres días laborales.

Usted también puede completar el primer reporte de la lesión o enfermedad (DWC-1) y enviarlo a la compañía de seguros. El formulario contiene información sobre el empleador, el empleado, y el accidente y se puede obtener en la página Web de la División de Compensación por Accidentes de Trabajo en www.MyFloridaCFO.com/WC/pdfs/F2-DWC-1a.pdf. Usted debe también proveer una copia del primer reporte del accidente o enfermedad al empleado. Se prefiere la firma del empleado en el formulario, pero si el empleado no puede o no está disponible para firmarlo, escriba "no disponible" en la caja donde se pide la firma del empleado.

Fallecimientos relacionados con el trabajo

Empleadores también tienen que reportar muertes que resulten por lesiones o enfermedades relacionadas con el trabajo a la División de Compensación por Accidentes de Trabajo en un plazo de 24 horas. Para reportar una fatibilidad en el lugar de trabajo, llame al 1-800-219-8963 (en la Florida) o al 850-413-1611, o envíe el primer reporte de la lesión o enfermedad con la información sobre la muerte por fax a 850-413-1980. Para tener acceso al formulario, vaya a la página web <http://www.MyFloridaCFO.com/WC/forms.html>. Haga clic en DWC-1.

Beneficios médicos

Tan pronto usted le notifique a la compañía de seguro sobre la lesión que sufrió su empleado en el trabajo, la compañía:

- Determinará si la lesión es compensable
- Proveerá un médico autorizado
- Pagará para todo el cuidado autorizado que sea médicamente necesario y este relacionado con la lesión o enfermedad.
- Proporcionará un solo cambio de médico dentro de cinco jornadas laborales del recibo de la petición de su empleado por escrito.

Atención médica y tratamientos autorizados pueden incluir:

- Consultas médicas
- Hospitalización
- Terapia física
- Exámenes médicos
- Medicamentos recetados
- Prótesis
- Gastos de ida y vuelta por viajes a consultas médicas o farmacias autorizadas.

En cuanto usted alcance la máxima mejoría médica (MMI) por su sigla en inglés) usted tendrá que pagar un copago de \$10.00 por cada consulta para tratamiento médico. La máxima mejoría médica ocurre cuando el médico que lo (a) atiende determina que la lesión o enfermedad del empleado se ha curado al grado que mejoría adicional no es probable.

Beneficios de reemplazo de salario

Los beneficios de reemplazo de salario comenzarán al octavo día que el empleado no pueda trabajar. El empleado lesionado no recibirá beneficio de reemplazo de salario por los primeros siete días que no pudo trabajar a menos que ha estado incapacitado por más de 21 días debido a su lesión o enfermedad relacionada con su empleo. En la mayoría de los casos, los beneficios de reemplazo de salario igualarán a dos tercios (2/3) del salario semanal regular del empleado antes de sufrir la lesión o enfermedad, pero el beneficio no excederá el promedio de los salarios semanales en la Florida. Si el empleado califica para los beneficios de reemplazo de salario, él o ella puede esperar recibir el primer cheque dentro de 21 días después de que la compañía de seguros se entere de la lesión o enfermedad. Los siguientes cheques se le enviarán cada dos semanas. El empleado lesionado será elegible para diversos tipos de beneficios de reemplazo de salario dependiendo del progreso del reclamo y de la severidad de la lesión.

- Beneficios Por incapacidad total temporal (TTD por su sigla en inglés): Estos beneficios son proveídos como resultado de una lesión o enfermedad que temporalmente prohíbe que el empleado vuelva a trabajar, y el empleado no ha alcanzado la máxima mejoría médica.
- Beneficios Por incapacidad parcial temporal (TPD por su sigla en inglés): Estos beneficios son proveídos cuando el médico le permite al empleado volver a trabajar, el empleado no ha alcanzado la máxima mejoría médica, y gana menos del 80% del salario que ganaba antes de sufrir la lesión o enfermedad. El beneficio es igual al 80% de la diferencia entre el 80% del salario de antes de la lesión y del salario después de la lesión. El periodo máximo que el empleado lesionado puede recibir beneficios temporales es 104 semanas o hasta que la fecha del MMI sea determinada, lo que ocurra primero.
- Beneficios por daños permanente (IB por su sigla en inglés): Estos beneficios son proveídos cuando la lesión o enfermedad causa cualquier pérdida física, psicológica o funcional y el impedimento existe después de la fecha de la máxima mejoría médica. [MMI] Un médico asignará una valoración de incapacidad permanente a la lesión que será expresada como un porcentaje.
- Beneficios por incapacidad total permanente (PTD por su sigla en inglés) Estos beneficios son proveídos cuando la lesión causa que el empleado sea permanente y totalmente incapacitado(a) según las estipulaciones de la ley.
- Indemnizaciones por fallecimiento: Compensación por accidentes de trabajo que resulten en la muerte del trabajador incluye pago de gastos para el funeral y beneficios para los dependientes del fallecido (estos son sujetos a límites definidos por ley). Un cónyuge dependiente puede ser elegible para entrenamiento vocacional.

Formulario de la declaración del salario

Usted debe llenar el formulario de la declaración del salario (DFS-F2-DWC-1a) para cualquier empleado que tenga derecho a recibir beneficios de reemplazo de salario y proveérselo a su compañía de seguros dentro de 14 días después del conocimiento del accidente. Usted también debe llenar el formulario al despedir o al dejar

de proveer beneficios a cualquier empleado que esté recibiendo beneficios de reemplazo del salario. Esto se debe hacer en un plazo de 7 días de tal terminación. Para tener acceso a la forma vaya a la página web (<http://www.MyFloridaCFO.com/WC/forms.html>) y haga clic en DWC-1a.

Oficina de ayuda al trabajador

Si usted tiene algunas preguntas o preocupaciones sobre los beneficios que ofrece el seguro por accidentes de trabajo, llame a su compañía de seguros. Si la compañía de seguros no ofrece la información que usted ha pedido, usted puede llamar la División de Compensación por Accidentes de Trabajo, oficina de Ayuda al Empleado (EAO) al 1-800-342-1741. Esta oficina ayuda a prevenir y a resolver disputas entre los trabajadores y los empleadores/las compañías de seguros.

Los especialistas de la EAO poseen conocimiento sobre el sistema de seguro por accidentes de trabajo(y pueden contestar sus preguntas. EAO tiene oficinas por todo el estado que puede llamar o visitar. Usted puede localizar el lugar donde están estas oficinas visitando el sitio: www.MyFloridaCFO.com/WC/organization/eao_offices.html.

Además, la División de Compensación por Accidentes de Trabajo tiene una sección en el Web, "Preguntas hechas con frecuencia por empleadores," que puede alcanzar en <http://www.MyFloridaCFO.com/WC/faq/emplyrs.html>.

Petición para beneficios

Para comenzar el proceso judicial para solicitar beneficios que se le deben según la ley pero la compañía de seguros no lo ha proveído, se debe presentar el formulario "Petition for Benefits" [Petición para beneficios] a la Oficina de los Jueces de las Reclamaciones de compensación. Se puede conseguir el formulario visitando el sitio Web: www.jcc.state.fl.us/jcc/forms/asp.

Programa de recompensación contra fraude

El fraude en el seguro por accidentes de trabajo ocurre cuando cualquier persona a sabiendas y con intención de hacer daño, defrauda o engaña a cualquier empleador o trabajador, compañía de seguros, o auto compañía de seguros, presenta información falsa o engañosa. El fraude del seguro por accidentes de trabajo es un delito mayor de tercer grado que puede resultar en multas, responsabilidad civil, o encarcelamiento. Recompensas de hasta \$25,000.00 se les puede pagar a personas quienes proveen información que resulte en la detención y la condena de personas que han cometido fraude de seguros. Llame al 1-800-378-0445 para reportar sospechas de fraude de seguros por accidentes de trabajo.

Resources

Nova Southeastern University

Risk Management Office
3301 College Ave
Suite 226
Fort Lauderdale, FL 33314
Tel: (954) 262-5404 * (954) 262-3814 (fax)
E-Mail: risk@nova.edu

Claims-Handling Entity

Cannon Cochran Management Services, Inc.
PO Box 948399 | Maitland | FL 32794-8399
Tel: 407-660-5637 | 1- 866-291-0194 | 217-477-6623 (fax) | FICURMAmail@ccmsi.com
After Hours: 1-877-253-5169



For more information regarding prevention of risk visit our website at <http://www.nova.edu/cwis/fop/risk/>