WORKERS' COMPENSATION CLAIM REPORTING PROCEDURES

1. In the event of a work related incident, complete the attached First Report of Incident **within 24 hours of notification of injury** and forward it to MBAdvisors. Have the employee sign the First Report of Injury to MBAdvisors Risk Management Department at 1.888.894.4622 or email it to wcinjuryreport@MBAdvisors.com. **Please note:** if the employee refuses to sign or is unable to sign, please note this on the First Report of Injury and Fax the completed First Report of Incident without the employee's signature. If available, please send any medical notes from the treating physician or hospital.

2. Complete the Workers' Compensation Claim Form (DWC 1). Fax or email the completed form to MBAdvisors Risk Management Department at 1.888.894.4622 or email it to wcinjuryreport@MBAdvisors.com.

3. Sign the Medical Authorization form and give it to the employee.
   The Medical Authorization form will ensure that the medical bills are processed properly and that they are not being sent to the employer or injured employee.

4. For weekday work related injuries:
   Send the injured employee to the nearest identified medical facility (on the approved provider list) with a signed Medical Authorization form and Fax the completed First Report of Injury to MBAdvisors Risk Management Department at 1.888.894.4622 or email it to wcinjuryreport@MBAdvisors.com.

5. For weekend, after hour or holiday work related injuries:
   Send the injured employee to the nearest identified medical facility (on the approved provider list) with a signed Medical Authorization form, Fax the completed First Report of Injury to MBAdvisors Risk Management Department at 1.888.894.4622 or email it to wcinjuryreport@MBAdvisors.com and follow up with MBAdvisors Risk Management Department at 1.888.622.6460 on the next business day.

6. For any EMERGENCY or SERIOUS work related injuries:
   Call 911 to have immediate treatment for the employee. Please be sure to provide the emergency medical technicians a signed Medical Authorization form. Call MBAdvisors Risk Management Department at 1.888.622.6460 and fax the completed First Report of Injury to 1.888.894.4622 or email it to wcinjuryreport@MBAdvisors.com.

7. The completed First Report of Injury will be transmitted to the appropriate claims handling office and a copy of the report will be kept on file by MBAdvisors for our records and claim auditing.

If you need additional help or information, please contact MBAdvisors Risk Management Department at

1.888.622.6460

MEDICAL AUTHORIZATION FORM

Employer:_____

Employee Name:_____

This is authorization for medical treatment arising from a job related injury being reported under Workers' Compensation Law. All billing and future authorizations should be directed to MBAdvisors at the location shown below.

Manager's Signature:_____ Date:_____

Employee's Signature:_____ Date:_____

MBAdvisors
Attn: Risk Management Department
9455 Koger Blvd.
Suite 200
St. Petersburg, FL 33702
1.888.622.6460

MB ADVISORS
POWERING THE PEO INDUSTRY

FIRST REPORT OF INJURY

FAX to 888.894.4622

1. Date of injury: _____ Time of injury: _____ am pm
2. Date injury reported to employer: _____/_____/_____
3. Injured worker Name: _____ SSN: _____
   Address: _____ City: _____ St: _____
   Zip: _____ Phone#: (____) _____
4. Date of Hire: ____/____/_____ Date of Birth: _____/_____/_____
5. Job Title: _____ w/c class code: _____
6. Did the employee return to work? Yes____ No____ Same Day____ Date Returned _____
7. Client name: _____ Client Number: _____
   Address: _____ City: _____ St: _____
   Zip: _____ County: _____ Phone #:(____)_____
8. Place of accident, *if different from client location*: _____
   Address: _____ City: _____ St: _____ Zip: _____
9. Describe what happened (be as specific as possible): _____
   _____
   _____
10. What was the employee doing at the time of injury: _____
    _____
11. Describe the injuries and body part(s) effected (be specific): _____
    _____
12. Did the employee receive medical treatment? Yes____ No____
    If Yes, please state the treating facility or physician: _____
    Address: _____ City: _____ St: _____
    Zip: _____ Phone#: (____) _____
13. Is employer aware of any pre-existing conditions that may apply? Yes____ No____
    If Yes, Please state what conditions apply; _____

14. Is there any doubt or question as to the validity of the injury? Yes____ No____
15. Was there any other person or equipment that may have been the cause of the injury?
    Yes____ No____
    If Yes, Please explain: _____
16. Were there any witnesses? Yes____ No____
    Please provide Name(s) and Job Title(s): _____
    _____
17. Was any personal protective equipment required? Yes____ No____
    If Yes, please list all personal protective equipment required (i.e. Slip resistant shoes, cut resistant gloves, etc.) _____
    _____
    If Yes, was the employee using the proper personal protective equipment?
    Yes____ No____
18. Was the proper safety training provided to the injured employee? Yes____ No____
    If no, please explain: _____
    _____
19. Describe corrective action to be taken to prevent future incidents: _____
    _____
    _____

Completed by: _____ Date:_____

I understand that 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 a criminal offense. I attest that the above information is true and correct.

Employee Signature: _____ Date:_____

Please fax completed form to: 1.888.894.4622 or email it to

wcinjuryreport@MBAdvisors.com

Acknowledgment of Refusal of Medical Treatment

I, _____, hereby acknowledge that I have refused to be medically evaluated for a work related incident on _____. I understand that by signing this document any future claims or treatment relating to this incident will require me to notify my supervisor immediately.

_____ _____
Employee Date

_____ _____
Direct Supervisor Date

_____ _____
Witness Date

Cc: Personnel File (MBA)