



## Employer's Comp Associates, Inc.

May 13, 2002

### **ATTENTION: Lexington "EPIC" Agents**

We are pleased to announce that effective **June 1, 2002**, Freeman Administrative Solutions, Inc. ("FAS") of Addison, Texas will assume claims administration responsibilities for the Lexington Insurance Company Employer's Primary Indemnity Coverage ("EPIC") program. We are confident FAS will provide excellent service in assisting you with the administration of your on-the-job injury claims.

Each of your "EPIC" Policyholders will receive:

1. A notice of the change and a **Policy Amendment** naming FAS as Claims Administrator
2. A Claims Kit containing **ACCIDENT REPORTING PROCEDURES** and **ACCIDENT REPORTING FORMS**.

For all questions regarding "EPIC" claims, please contact FAS at:

**FAS, Inc.  
16801 Addison Road  
Ste. 255  
Addison, Texas 75001**

**Toll Free: 1-866-930-9493  
Office Number 972-930-9493  
FAX Number: 972-930-9479**

16801 Addison Rd. / Suite 325 / Addison, TX 75001-5163  
(972) 931-2026 / FAX (972) 931-2126 / 1-800-299-5250

# ***FAS, Inc.***

## **Claims Kit**

***Includes:***

***Accident Reporting Procedures***

***REPORT NOTICES:***

- ✓ **EMPLOYEE STATEMENT OF INJURY**
- ✓ **SUPERVISOR'S INCIDENT REPORT**
- ✓ **WITNESS STATEMENT**
- ✓ **MEDICAL TREATMENT AUTHORIZATION &**
- ✓ **DRUG / ALCOHOL SCREEN**
- ✓ **PHYSICIANS REPORT**
- ✓ **MEDICAL AUTHORIZATION**

***FAX AND MAIL REPORT NOTICES TO:***

***FAS, INC.  
P O BOX 2309  
ADDISON, TEXAS 75001-2309  
FAX: (972) 930-9479***

***QUESTIONS:***

***Should you have any questions regarding any of these forms please contact our office at (866) 930-9493 between 8:00 a.m. and 5:00 p.m., Monday through Friday.***

# SUPERVISORS INCIDENT REPORT

**IF INJURY OCCURS:**

1. Immediately fax all completed forms to:
2. Mail originals to:

FAS, Inc (972) 930-9479  
P O BOX 2309, Addison, TX 75001-2309

**EMPLOYER INFORMATION**

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ FAX \_\_\_\_\_ Policy # \_\_\_\_\_

**EMPLOYEE INFORMATION**

NAME \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
DEPARTMENT \_\_\_\_\_ JOB TITLE \_\_\_\_\_ DATE OF HIRE \_\_\_\_\_  
SCHEDULED HRS/DAY \_\_\_\_\_ HRLY RATE \_\_\_\_\_ SCHEDULED DAYS PER WEEK \_\_\_\_\_ WKLY RATE \_\_\_\_\_  
TIME LOST FROM WORK: YES \_\_\_\_\_ NO \_\_\_\_\_ FIRST DAY MISSED: \_\_\_\_/\_\_\_\_/\_\_\_\_  
DATED RETURNED TO WORK: \_\_\_\_/\_\_\_\_/\_\_\_\_ RETURNED TO: FULL DUTY \_\_\_\_\_ MODIFIED DUTY \_\_\_\_\_

**LOCATION (if different from above)**

NAME \_\_\_\_\_ LOCATION NO. \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_ FAX \_\_\_\_\_

**CAUSE**

DATE OF INCIDENT \_\_\_\_/\_\_\_\_/\_\_\_\_ TIME OF INCIDENT \_\_\_\_ A.M. \_\_\_\_ P.M. DATE REPORTED \_\_\_\_/\_\_\_\_/\_\_\_\_ TIME REPORTED \_\_\_\_ A.M. \_\_\_\_ P.M.

WAS THE INCIDENT REPORTED IMMEDIATELY?  YES  NO TO WHOM WAS IT REPORTED? \_\_\_\_\_

EXACT LOCATION/AREA WHERE THE INCIDENT HAPPENED: \_\_\_\_\_

FULLY DESCRIBE THE INCIDENT \_\_\_\_\_

WAS INJURY CAUSED BY FAILURE TO USE OR OBSERVE SAFETY RULES OR REGULATIONS?  YES  NO

IF YES, EXPLAIN \_\_\_\_\_

**INJURY**

DESCRIBE THE INJURY AND PART OF BODY AFFECTED \_\_\_\_\_

**MEDICAL PROVIDER**

NAME OF CLINIC/HOSPITAL/PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

IF NOT A DESIGNATED PROVIDER, PLEASE COMPLETE THE FOLLOWING -

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

**WITNESSES**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ HAS WITNESS STATEMENT BEEN COMPLETED?  YES  NO

I CERTIFY that the foregoing statements and answers on this form are complete and true, and that no information has been omitted.

**SIGNATURE OF SUPERVISOR/MANAGER COMPLETING REPORT**

Supervisor/Manager Name Printed \_\_\_\_\_

X  
Supervisor/Manager Signature \_\_\_\_\_

Date \_\_\_\_\_

# WITNESS STATEMENT

Fax this completed form to FAS, Inc. (972) 930-9479

<b>EMPLOYER INFORMATION</b>			
Name	_____		
Address	City	State	Zip
Phone	FAX	Policy #	

NAME OF WITNESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
TITLE \_\_\_\_\_ DEPT. \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
DATE OF INCIDENT \_\_\_\_\_ TIME OF INCIDENT \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. \_\_\_\_\_

**THIS STATEMENT CONCERNS MY KNOWLEDGE OF THE ALLEGED INCIDENT.**

1. Name of injured employee: \_\_\_\_\_
2. If not employee, reason for presence at location: \_\_\_\_\_  
\_\_\_\_\_
3. Are you related to injured employee? \_\_\_\_\_ How? \_\_\_\_\_
4. How long have you known this employee? \_\_\_\_\_
5. Please explain in detail what you know about this incident: (Name specific individuals, objects or equipment)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Did you actually see the incident? \_\_\_\_\_ If not, how did you hear about it? \_\_\_\_\_  
\_\_\_\_\_
7. Do you know of any other injury, incident or illness that this employee has had? \_\_\_\_\_ If so, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Give the names and addresses of any other persons who might know about this incident:  
\_\_\_\_\_  
\_\_\_\_\_
9. Additional Comments: \_\_\_\_\_  
\_\_\_\_\_

I CERTIFY that the foregoing statements and answers on this form are complete and true, and that no information has been omitted.

Witness: _____ Signature	Verified by: _____ Signature
Date: _____	Date: _____
Translated By (if Applicable): _____	Date: _____

*Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.*

# EMPLOYEE STATEMENT OF INJURY

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYEE  
Fax this completed form to FAS, Inc. (972) 930-9479

## EMPLOYER INFORMATION:

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
PHONE \_\_\_\_\_ FAX \_\_\_\_\_

## EMPLOYEE INFORMATION:

NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

FACILITY \_\_\_\_\_ OCCUPATION \_\_\_\_\_

DATE OF INCIDENT \_\_\_\_\_ DAY OF \_\_\_\_\_ TIME WORKSHIFT \_\_\_\_\_

INCIDENT \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ TIME OF \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. WEEK \_\_\_\_\_ STARTED \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

DATE INJURY REPORTED TO MANAGER \_\_\_\_\_ TIME REPORTED \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

EXACT LOCATION/AREA WHERE INJURED \_\_\_\_\_

DESCRIBE APPLIANCE/EQUIPMENT INVOLVED \_\_\_\_\_

DESCRIBE WHAT YOU WERE DOING AT TIME OF INCIDENT \_\_\_\_\_

DESCRIBE FULLY HOW THE INCIDENT OCCURRED \_\_\_\_\_

WAS A SAFETY DEVICE APPLICABLE?  YES  NO WAS IT USED?  YES  NO

WAS INJURY CAUSED BY FAILURE TO USE OR OBSERVE SAFETY RULES OR REGULATIONS?  YES  NO IF YES, WHICH RULE \_\_\_\_\_

DESCRIBE NATURE OF INJURY \_\_\_\_\_

BODY PART (S) INVOLVED \_\_\_\_\_

HAVE YOU HAD A SAME OR SIMILAR INJURY BEFORE?  YES  NO IF YES, GIVE DETAILS \_\_\_\_\_

## WITNESSES - Complete Witness Statement(s)

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

I, \_\_\_\_\_ (Employee), the undersigned herewith CERTIFY that the foregoing statements and answers on this form are complete and true, and that no information has been omitted, and that I made such statements and answers of my own free will. I understand that my Employer does not carry Workers' Compensation Insurance, and furthermore, that any payments to me or anyone else for expenses in connection with this incident and resulting in injury is not an admission of liability on the part of my Employer.

Employee Signature: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize direct payment to medical providers and others rendering services in connection with this claim.

Employee Signature \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Translated by (if applicable) \_\_\_\_\_ Date: \_\_\_\_\_

**Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.**

# *Freeman Administrative Solutions, Inc.*

## *ACCIDENT REPORTING PROCEDURES*

When an accident (or alleged accident) occurs:

1. See that the injured employee receives prompt medical attention.
  - Complete *Employee Statement of Injury* immediately upon notification of incident.
  - Complete initial *Medical Treatment Authorization & Drug Alcohol Screen* and send with employee to medical provider.
  - Send the employee to an approved occupational accident medical facility.
2. Obtain pertinent information about the claim.
  - To assist you with this, we suggest that you have the supervisor fill out a *Supervisor's Incident Report*.
  - Have all witnesses complete a *Witness Statement*.
3. Complete an injury report and mail or fax immediately to:

***Freeman Administrative Solutions, Inc.***  
**P O BOX 2309**  
**Addison, TX 75001-2309**  
**FAX: (972) 930-9479**

4. Accidents resulting in death or severe injury should be reported immediately by telephone.  
**Call 972-930-9493 or Toll free 1-866-930-9493.**
5. After we have received the accident report, you will be contacted to assist us in the investigation of the claim.

Submitting medical bills:

1. Submit all medical reports and bills from medical care providers to Freeman Administrative Solutions, Inc.

***If you should have any questions concerning a claim, do not hesitate to call us at 1-866-930-9493 between 8:00 A.M. and 5:00 P.M. Monday through Friday.***

***Coverage Underwritten By:***  
**Lexington Insurance Company**