Service Lloyds
INSURANCE COMPANY

CLAIMS KIT

P.O. Box 26850 Austin, Texas 78755 1 800 299-6977 www.servicelloyds.com

Service Lloyds
INSURANCE COMPANY

CLAIMS REPORTING

You may report your claims by telephone, fax or through the mail.

Telephone: (800)-299-6977

In Austin: (512)-343-0600

Fax: Complete the loss report and fax to 512-231-8248

Mail: Send the completed loss report to:

P O Box 26850
Austin, Texas 78755

Service Lloyds
INSURANCE COMPANY

CLAIM REPORTING INSTRUCTIONS

Workers' Compensation Claims
Every accident involving lost time or medical treatment should be reported promptly using the **Employer's First Report of Injury**. Report death claims immediately by telephone.

Employee Returns to Work
Complete the Employer's Supplemental Report of Injury, in duplicate, on the same day employee returns to work and mail promptly. Once weekly compensation benefits are started, payments continue until notice is received that the employee has resumed work.

Weekly Benefits
There is a one-week waiting period for weekly compensation. Compensation is paid for the second week of lost time, beginning with the eighth day of disability, including weekends. If disability continues for 14 calendar days, the employee will then get compensation for the first week.

Medical Expenses
Medical expenses are paid in accordance with statutory provisions. The attending doctor will be requested to send their report and bill directly to Service Lloyds Insurance Company. Payments are made directly to the doctor.

Correspondence on Claims
Each claim is assigned a claim number; please refer to this number when corresponding.

Reordering Supplies or Forms
Request supplies by calling (800)-299-6977

Service Lloyds
INSURANCE COMPANY

CHECK LIST

WHEN AN ON-THE-JOB INJURY OCCURS:

1. Immediately fill out Employers First Report of Injury in its entirety and send in. **DO IT TODAY!**

2. If an injury has previously been reported as no lost time and the employee starts losing time from work, immediately fill out a Supplementary Report of Injury and send it in. **DO IT TODAY!**

3. If an injury has been reported as a lost time injury and the employee returns to work, immediately fill out a Supplementary Report of Injury, and send it in. **DO IT TODAY!**

4. Should medical bills be sent to you, please send them on to the insurance company. **DON'T HOLD THEM!!**

5. Fill in all applicable blanks.

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Service Lloyds
INSURANCE COMPANY

SUPERVISOR'S ACCIDENT/INCIDENT INVESTIGATION

(Should be completed within 24 hours of accident)

1. NAME OF EMPLOYEE:____________________
2. DEPARTMENT: __________________________
3. DATE/LOCATION OF ACCIDENT:__________________
   TIME:__________ A.M. P.M. (circle one)
4. WITNESSES: a. ______________________
   b. ______________________
5. BRIEFLY DESCRIBE ACCIDENT AND NATURE OF INJURY:

____

____

6. ACCIDENT CAUSES (check all factors)

PHYSICAL CAUSES

___Defective/improper tools or equipment
___Poor housekeeping (trash, slippery floor, etc)
___Unguarded/improperly guarded equipment
___Congested area
___Unstable/Improper piling or acreage
___Improper apparel
___Improper light, ventilation, temp, etc.
___External security doors, window, alarms, etc.
___Other

PERSONAL CAUSES

___ Not Properly Trained/Instructed
___ Failure to use personal protective equipment
__ Failure to follow rules or instructions
__ Using improper/defective tools or equipment
___ Horseplay
___ Using improper methods/procedures
___ Operating without authority
___ Physical limitations of work
___ Other (describe) ________________

7. SIGNATURES: Prepared By: __________________________
   (Supervisor)
   Reviewed By:__________________________
   (Person Responsible for Safety)

   ____
   (Manager)

8. FOLLOW UP: What HAS been done to prevent recurrence of this type accident?
   (Follow up within 30 days of accident, check progress at 30 day intervals until complete.)

____

____

SIGNATURES: ______________________________
(Person Responsible for Safety)

____
(Manager)

Date: ______________________________

NOTE: Record any additional information, diagrams, photos, etc. on reverse side.

(Form furnished by Service Lloyds Insurance Company)

Service Lloyds INSURANCE COMPANY

SUPERVISOR'S ACCIDENT/INCIDENT INVESTIGATION

(Should be completed within 24 hours of accident)

1. NAME OF EMPLOYEE:____________________
2. DEPARTMENT: _________________________
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   TIME:__________ A.M. P.M. (circle one)
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___ Operating without authority
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   (Supervisor)
   Reviewed By: __________________________
   (Person Responsible for Safety)
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   (Manager)
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____

____

SIGNATURES: __________________________
(Person Responsible for Safety)

____
(Manager)

Date: __________________________

NOTE: Record any additional information, diagrams, photos, etc. on reverse side.

(Form furnished by Service Lloyds Insurance Company)

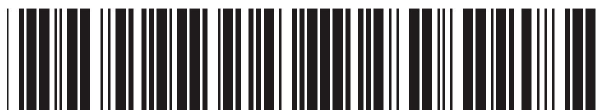
DWC FORM-1
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM -1 (Rev. 10/05)] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

[Workers' Compensation Rule 120.2]



INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-1)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM - 1 (Rev. 10/05) to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed $500.00. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Article 8308 -5.04. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Article 8308 - 7.03 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8: Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.

Item 4: If no home phone, please provide a phone number where the employee can be reached.

Items 5,15,17, 26,29,30: Enter data in month, day, year format. Example: 08-13-54.

Item 18: List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.

Item 19: List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.

Item 20: Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.

Item 22: State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.

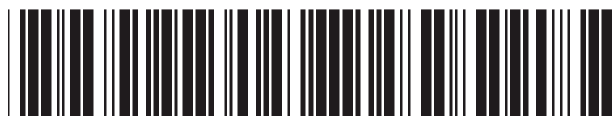
Item 24: List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.

Items 32,33: Enter date in month-year format. Example: 02-56.

Item 37: Enter the number of days or hours that make up a full work week for your employees.

Item 45: Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.

Item 46: For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.



Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # ____________________

CARRIER'S CLAIM # ____________________

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☐ M ☐

3. Social Security Number - -

4. Home Phone ( )

5. Date of Birth (m-d-y) - -

6. Does the Employee Speak English? YES ☐ NO ☐ If No, Specify Language

7. Race White ☐ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) - -

16. Time of Injury : am ☐ pm ☐

17. Date Lost Time Began (m-d-y) - -

18. Nature of Injury*

19. Part of Body Injured or Exposed*

20. How and Why Injury/Illness Occurred*

21. Was employee doing his regular job? YES ☐ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

Street or P.O. Box County

City State Zip Code

24. Cause of Injury(fall, tool, machine, etc.)*

25. List Witnesses

26. Return to work date/or expected (m-d-y) - -

27. Did employee die? YES ☐ NO ☐

28. Supervisor's Name

29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -

31. Was employee hired or recruited in Texas? YES ☐ NO ☐

32. Length of Service in Current Position Months ______ Years ______

33. Length of Service in Occupation Months ______ Years ______

34. Employee Payroll Classification Code

35. Occupation of Injured Worker

36. Rate of Pay at this Job $______Hourly $______Weekly

37. Full Work Week is: _____ Hours _____ Days

38. Last Paycheck was: $______ for ____ Hours or _____ Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form

41. Name of Business

42. Business Mailing Address and Telephone Number
Street or P.O. Box Telephone ( )

City State Zip Code

43. Business Location (If different from mailing address)
Number and Street

City State Zip Code

44. Federal Tax Identification Number

45. Primary North American Industry Classification System Code:(6 digit)

46. Specific NAICS Code (6 digit)

47. Texas Comptroller Taxpayer No.

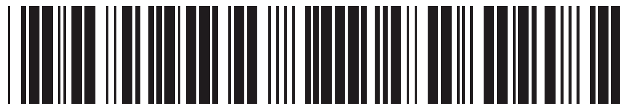
48. Workers' Compensation Insurance Company

49. Policy Number

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X ____________________ Date ____________________



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