



sedgwick

Sedgwick Claims Kit South Carolina



FALLS LAKE
INSURANCE COMPANIES



P.O. Box 14779 | Lexington, KY 40512 | Toll Free: 866-738-9201 | Fax: 859-280-3275



Dear Insured:

We would like to welcome you as a policyholder of Falls Lake National Insurance Company. Sedgwick is your Claims Administrator and we are pleased to be able to provide you with workers' compensation claims handling services. Please follow the below instructions for filing a new claim and note the claim kit attachment.

Where do I report a claim?

- **Phone:** 855-728-5277 (855-7ATLAS7)
- **Email:** 6200AtlasGeneralInsurance@sedgwickcms.com
- **Fax:** 866-383-3296

Where do I send my injured employee for medical treatment?

- **Website:** www.sedgwickproviders.com/AG

Sedgwick Claim Kit Attachments:

- Workers' Compensation Compliance Poster
- Employer's First Report of Injury Form (WCC-12A)
- Wage Statement (WCC-20)
- Express Scripts First Fill Temporary Pharmacy Card

Need a loss run?

- **Email us:** Lossruns@atlas.us.com

Have more questions?

Contact the Atlas Customer Care Team at Sedgwick - One of our friendly Client Services Associates will be happy to assist you.

- **Phone:** 866-738-9201
- **Email:** AtlasTeam@Sedgwickcms.com

We appreciate your business and believe that communication is critical for successful claims administration. We encourage you to contact us if you have any questions.

www.Atlas.us.com/claims



South Carolina Workers' Compensation

Workers' Compensation Compliance Poster

We are operating under and subject to the South Carolina Workers' Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

Workers' Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

If you are injured on the job, you should:

1. Notify your employer at once. You cannot receive benefits unless your employer knows you are injured.
2. Tell the doctor your employer sends you to that you are covered by workers' compensation.
3. Notify the Workers' Compensation Provider listed on this poster or the South Carolina Workers' Compensation Commission at 803.737.5700 if you experience undue delays or problems with your claim.

South Carolina
 Workers' Compensation Commission
 P.O. Box 1715, 1333 Main Street, Suite 500
 Columbia, S.C. 29202-1715
 803-737-5700
www.wcc.sc.gov

Workers' Compensation Provider Name

Mailing Address

Claims Telephone Number

S.C. WORKERS' COMPENSATION COMMISSION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
INDUSTRY CODE EMPLOYER FEIN		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
	TO	
	CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE	
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	MARITAL STATUS <input type="checkbox"/> Unmarried/Single/Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	OCCUPATION/JOB TITLE	
			EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS	NCCI CLASS CODE		
RATE PER: <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
		DID SALARY CONTINUE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE (<input type="checkbox"/>) CANNOT BE DETERMINED <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED	
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE	
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL			CAUSE OF INJURY CODE	

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO
		WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 <input type="checkbox"/>
		1 <input type="checkbox"/>
		2 <input type="checkbox"/>
		3 <input type="checkbox"/>
		4 <input type="checkbox"/>
5 <input type="checkbox"/>	NO MEDICAL TREATMENT MINOR: BY EMPLOYER MINOR CLINIC/HOSP EMERGENCY CARE HOSPITALIZED > 24 HOURS FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	

OTHER

WITNESSES (NAME & PHONE #)			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER



South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500

P.O. BOX 1715

Columbia, SC 29202-1715

803-737-5722

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YYYY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:
Full-Time On Strike Unknown Volunteer
Part-Time Disabled Apprenticeship Full-Time Seasonal
Not Employed Retired Apprenticeship Part-Time Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (e.g. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (e.g. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.



South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

South Carolina Workers' Compensation Commission
 1612 Marion Street • P.O. Box 1715
 Columbia, SC 29202-1715
 (803) 737-5723



WCC File # _____
 Carrier File #: _____
 Carrier Code #: 1039
 Employer FEIN #: _____

Claimant's Name _____ SSN: _____ Employer's Name _____
 Address _____ Address _____
 City, State, Zip _____ City, State, Zip _____
 Home Phone: _____ Work Phone (_____ Insurance Carrier _____
 Preparer's Name _____ Law Firm _____ Preparer's Phone _____

Date of injury: _____
 (m/d/yyyy)

A. Total Wages Paid

1. Check Applicable Method:

- Report of earnings of injured employee based on four completed quarters.
- Report of earnings of injured employee who did not complete four quarters based on actual time worked.
- Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire Date: _____
- Report of earnings of injured employee based on alternative method because Form 20 results in a compensation (m/d/yyyy) rate that is not fair and just. (Attach documentation to show how average weekly wage and compensation rate were calculated.)

2. List total wages paid as reported to Employment Security Commission on the Employer Quarterly Contribution and Wage Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

Quarter	Ending Date (m/d/yyyy)	Total Wages Paid	
1 st	_____	\$ _____	
2 nd	_____	\$ _____	
3 rd	_____	\$ _____	
4 th	_____	\$ _____	Total Paid 2. _____

3. List total value of other allowances of any character made in lieu of wages during four quarters above. 3. _____

4. Add lines 2 and 3.

TOTAL WAGES PAID 4. _____

5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. _____

B. Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5).

AVERAGE WEEKLY WAGE 6. _____

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667.

Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. _____

8. The compensation rate is as follows (choose one):

- The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.
- When average weekly wage (line 6) is less than \$75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
- When the estimated compensation rate (line 7) is less than \$75.00 and average weekly wage (line 6) is more than \$75.00, the compensation rate is \$65.00. Enter \$75.00 on line 8.
- When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
- Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8. _____

WEEKLY COMPENSATION RATE 8. _____

Employees representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deduction. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ONLINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803) 737-5723.

Workers' Compensation Temporary Prescription ID Card

»» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 1-866-590-5882.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 1-866-590-5882.

»» To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 1-866-590-5882.

Pharmacy Processing Steps

- Step 1: Enter bin number 003858
- Step 2: Enter processor control A4
- Step 3: Enter the group number as it appears above
- Step 4: Enter the injured worker's nine-digit ID number
- Step 5: Enter the injured worker's first and last name
- Step 6: Enter the injured worker's date of injury

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____
MM/DD/YYYY

Group #: GJC6200 _____

Employee Date of Birth: _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

»» **To the Supervisor:** Please fill in the information requested for the injured worker.

Employee Information

First M Last

Street Address or PO Box

City State ZIP

Employer Name



Participating Retail Network Pharmacies

A & P	Drug Emporium	Major Value	Schnucks
Acme Pharmacy	Drug Fair	Marsh Drugs	Scolari's
Albertson's	Drug Town	Medic Discount	Sedano
Albertson's/Acme	Drug World	Medicap	Shaw's
Albertson's/Osco	Eckerd	Medistat	Shop 'N Save
Albertson's/Sav-On	Econofoods	Meijer	Shopko
Amerisource	EPIC Pharmacy	Minyard	ShopRite
Bergen	Network	NCS HealthCare	Snyder
Anchor Pharmacies	FamilyMeds	Neighborcare	Stop & Shop
Arrow	Farm Fresh	Network	Sun Mart
Aurora	Farmer Jack	Pharmaceuticals	Super Fresh
Bartell Drugs	Food City	Northeast	Super Rx
Bigg's	Food Lion	Pharmacy Services	Target
Bi-Lo	Fred's	Osco	Texas Oncology
Bi-Mart	Gemmel	P & C Food	Srvs
BJ's Wholesale	Giant	Markets	The Pharm
Club	Giant Eagle	Pamida	Thrifty White
Brooks	Giant Foods	Park Nicollet	Times
Brookshire Brothers	Hannaford	Pathmark	Tom Thumb
Brookshire Grocery	Harris Teeter	Pavilions	Tops
Bruno	H-E-B	Price Chopper	Ukrop's
Carrs	Hi-School	Publix	United Drugs
Cash Wise	Pharmacy	Quality Markets	United
Coborn's	Hy-Vee	Raley's	Supermarkets
Costco	Jewel/Osco	Randalls	Vons
Cub	Kash n Karry	Rite Aid	Waldbaums
CVS	Keltsch	Rosauers	Walgreens
D&W	Kerr	Rx Express	Wal-Mart
Dahl's	Kmart	RXD	Wegmans
Dierbergs	Knight Drugs	Safeway	Weis
Discount Drugmart	Kroger	Sam's Club	Winn Dixie
Doc's Drugs	LeaderNet (PSAO)	Sav-On	
Dominicks	Longs Drug Store	Save Mart	

