JOINT INDUSTRY BOARD EMPLOYEES AND JIB SERVICES LLC EMPLOYEES ONLY

Workers' Compensation Claims Process

Occupational Injury/ Illness

STEP 1 Report accident/incident within 24 hours

JIB employees must report the accident/incident to the JIB Department Supervisor/Director on duty within 24 hours from the date of occurrence.

STEP 2 Complete JIB Employee Incident Report - see attached

JIB Supervisor/Director must provide the employee with the Worker's Compensation incident form immediately.

Employee must complete Part A

Supervisor/Director must complete Part B

Competed form must be returned to JIB Human Resources within 48 hours

STEP 3 JIB HR Department

JIB Human Resources will complete and submit the C-2F and Additional Info for WRM form to Wright Risk Management along with the JIB Accident/Incident report electronically via email.

STEP 4 Wright Risk Management - Third Party Administrator ("TPA")

JIB worker's compensation TPA is Wright Risk Management. They are responsible for processing the claim and also contacting the injured worker. Wright Risk Management will contact JIB HR for any and all information related to claims.

Wright Risk Management will mail claim information packet to the injured worker which will include but not limited to injured employee rights, medical coverage and treatment. Injured worker must communicate directly with Wright Risk Management with regard to medical care, medical payment, bills, claim status, and authorization for treatment.

NOTE:
JIB employees must adhere to time and attendance policy per JIB Handbook. Report all time loss related to worker's compensation using our internal time slips to avoid overpayment, duplication of payment, recoupment etc.

DATE_____

I,_____ was given a worker's Compensation accident/incident form and necessary information to fill out for an occupational injury/illness sustained on _____ during working hours.

The worker's compensation accident/incident form was given to me by JIB Human Resources Department on_____

Employee Signature_____

Date _____

JOINT INDUSTRY BOARD
AND
JIB SERVICES LLC
WORKERS' COMPENSATION ACCIDENT/ILLNESS REPORT FORM
(For reporting work-related injuries/ illnesses)

The injured worker and supervisor m must complete and file this report with the Joint Board H u m a n Resources Department, WITHIN 24 HOURS of an on-the-·job injury .

PART A: INJURED WORKER'S STATEMENT OF ACCIDENT/ILLNESS		
Employee Name (Last Name, First Name):		SSN:
Home address:		Cell Phone:
Home phone:	Date of Birth:	Work phone:
Job Title/Position:	Department Name: JIB	
Date of occurrence: __/___/__	Time of accident: AM /PM	Address Where Accident Occurred:
How did injury occur? (please give details which led up the injury or illness):		What time did you start work?_____AM/PM What is your work schedule? Mon Tues Wed Thu Fri Sat
What were you doing when injured?		Body part(s) injured:

Employee's Signature: _____ **Date:**_____

Part B: SUPERVISOR'S/DIRECTOR'S STATEMENT		
Nature of Injury and Body Part Affected:		Was the injured worker with anyone at the time of injury? Yes /No
Did injured worker receive medical treatment? YES /NO If yes, When: _/_/_	Name and address of hospital or physician , If available:	Date & Time when employer first knew of injury: _/_/_ - _AM/PM
Object, equipment, or machinery causing injury:		
Was there contact with any other person's blood or body flu id: Yes / No If yes, name and address of source person:		
How could a similar occurrence be avoided inn the future:	Did weather conditions contribute to occurrence: Yes / No If yes, what were the weather conditions:	
Describe any unsafe practice/condition:		
Name and phone n umber of witnesses (if any):		

Did injured worker lose time from work: Yes/No	If yes, first day out due to disability:_____
Has the injured worker returned to work:	If yes, date returned :
Supervisor's /Director's Name:	Signature:
Phone ext.:	Date Completed:

IF THE INJURED WORKER RETURNS TO WORK OR BECOMES DISABLED AFTER THIS FORM HAS BEEN FILED, IT IS Imperative THAT YOU CONTACT JIB HUMAN RESOURCES.

**ALL TIME LOSS RELATED TO WORKER'S COMPENSATION MUST BE CLEARLY MARKED ON THE TIME SLIP.

Original to: JIB HUMAN RESOURCES

JIB HR USE ONLY NOTICE TO PAYROLL _____

SAFETY REVIEW _____

Joint Industry Board of the Electrical Industry

Worker's Compensation Leave Without Pay Status

It is the policy of the Joint Industry Board to remove an employee from active pay status to leave without pay status while on worker's compensation leave. In the event an employee is issued a check for regular wages and benefits for the worker's compensation covered period, the Joint Industry Board will automatically charge available leave credit, i.e., Personal Time and/or vacation for said period which can be up to two weeks or more.

Employees without any leave credit and subsequently receive regular wages and benefits must reimburse the Joint Industry Board through future payroll deduction upon return to work from worker's compensation leave. If the employment ends for any reason, prior to having reimbursed the Joint Industry Board in full, the outstanding balance will become immediately due and withheld from any funds owed to the employee from the Joint Industry Board or will pursue garnishment or other civil procedures.

Duplication of regular wages and worker's compensation benefits for the same period is not authorized.

It is the responsibility of the employee to keep track of the days out related to worker's compensation, and to notify JIB Human Resources and the worker's compensation benefits examiner of any use of paid vacation or personal time as a result of the work-related injury.

If you are absent for partial days due to workers' compensation incident, you will be charged personal time and/or vacation accruals to cover these absences.

WRIGHT™
Risk Management
900 Stewart Ave. • Suite 600 • Garden City, New York 11530
Phone • 516.227.2300
Fax • 516.794.5254

Joint Industry Board of the Electrical Industry Workers' Compensation Claim Information

Dear injured worker:

Workers' Compensation claims involving JIB employees are administered by Wright Risk Management.

All work related injuries must be reported to your supervisor immediately. You are not required to pay for any treatments, co-payments deductibles or make any partial payments for treatment due to a work-related injury.

Please present this information to all providers and medical facilities that treat you for a work- related injury to ensure that all bills are properly submitted for payment under our Workers' Compensation program.

Employer:	**Joint Industry Board of the Electrical Industry** **158-11 Harry Van Arsdale Jr. Avenue** **Flushing, New York 11365**
Carrier:	**Electrical Employers Self Insurance Safety Plan (EESISP)** **c/o Wright Risk Management** **900 Stewart Avenue Suite 600** **Garden City, NY 11530** **Phone: 516-227-2300** **Fax: 516-706-1850**
Carrier Code:	**W398002**

Wright Risk Claims Service Team

Name	Title	Phone #	Email
Sean Slaven	Claims Manager	516-750-9404	sslaven@wrightinsurance.com
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Carolann DeRosa	Medical Claims Adjuster	516-750-9434	CDeRosa@wrightinsurance.com