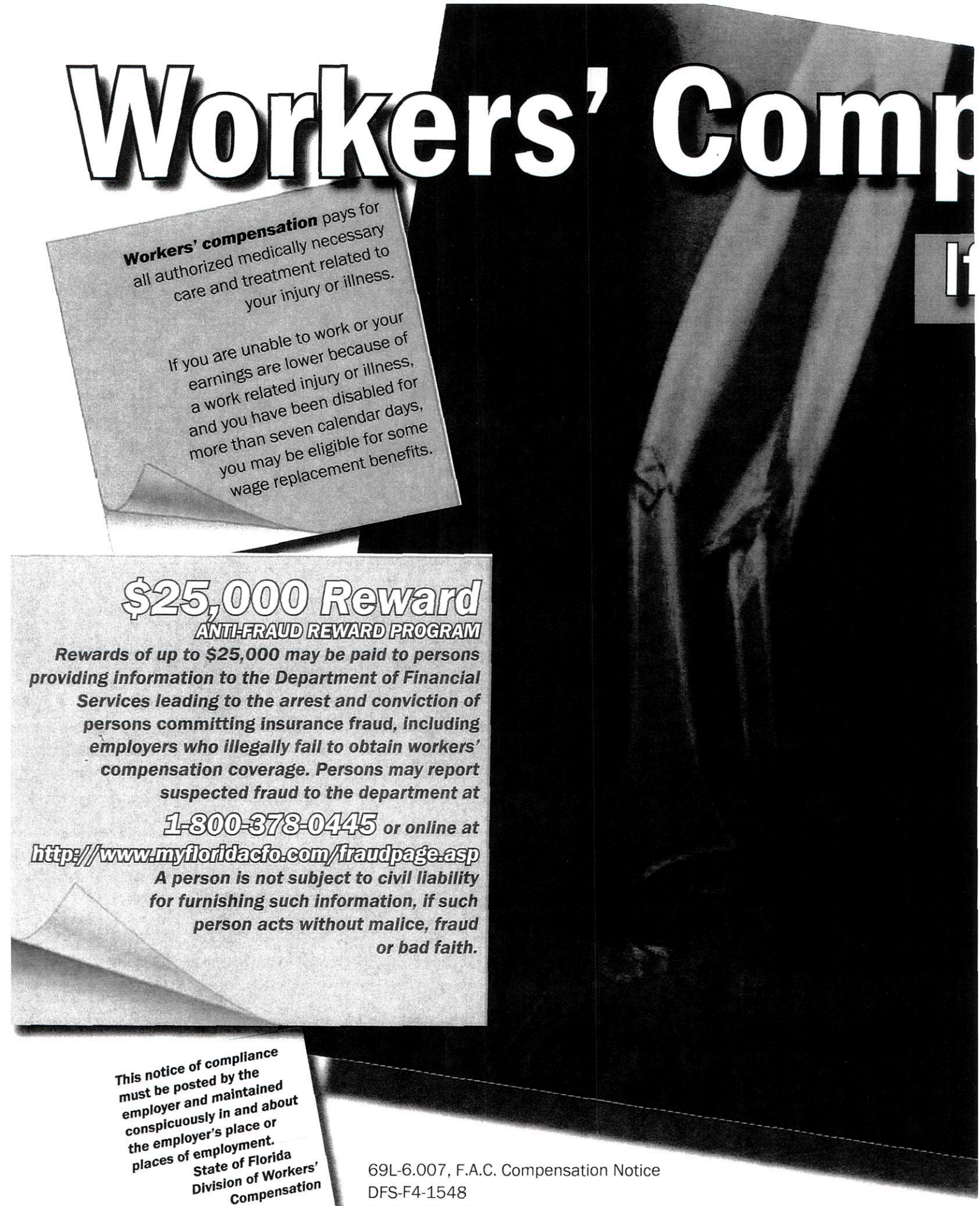
Workers' Comp



Workers' compensation pays for all authorized medically necessary care and treatment related to your injury or illness.

If you are unable to work or your earnings are lower because of a work related injury or illness, and you have been disabled for more than seven calendar days, you may be eligible for some wage replacement benefits.

$25,000 Reward

ANTI-FRAUD REWARD PROGRAM

Rewards of up to $25,000 may be paid to persons providing information to the Department of Financial Services leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the department at

1-800-378-0445 or online at

http://www.myfloridacfo.com/fraudpage.asp

A person is not subject to civil liability for furnishing such information, if such person acts without malice, fraud or bad faith.

This notice of compliance must be posted by the employer and maintained conspicuously in and about the employer's place or places of employment.

State of Florida
Division of Workers' Compensation

69L-6.007, F.A.C. Compensation Notice
DFS-F4-1548
Revised March 2010

Works For You

you are injured on the job:

1. Notify your employer immediately to get the name of an approved physician. Workers' comp insurance may not pay the medical bills if you don't report your injury promptly to your employer.

2. Notify the doctor and medical staff that you were injured on the job so that bills may be properly filed.

3. If you have any problems with your claim or suffer excessive delays in treatment, contact the State of Florida's Division of Workers' Compensation at 1-800-342-1741.

Employer: New Orleans Baptist Theological Seminary
NAME & ADDRESS
5400 College Dr. Graceville FL 32440-1831
is providing Worker's Compensation through
GuideOne Mutual Insurance Company
INSURANCE COMPANY, SELF-INSURANCE FUND, SELF-INSURANCE
Policy Number: 00-1295-106 **Effective Date:** 04/01/17
Local representative or agent : ISU Mid South Insurance Agency
4603 Bluebonnet Blvd. Baton Rouge LA 70809 (225)291-5060

POLICY NUMBER

FLORIDA WORKERS COMPENSATION MONTHLY CHANGE SHEET

THE FLORIDA RULES REQUIRE THAT AN EMPLOYER UPDATE AN APPLICATION MONTHLY TO REFLECT ANY CHANGE.

GuideOne Insurance

1111 Ashworth Road • West Des Moines, Iowa 50265-3538

Item 1. Named Insured (No., Street, Town, County, State)

ZIP

Agent's Name and Mailing Address

Agent No.
ZIP

POL. EFFECTIVE DATE	POL. EXPIRATION DATE

LOCATIONS If applicant is an employee leasing company, the client's company name should be included with the address.

CHANGE	LEASING COMPANY	LOC. #	STREET, CITY, STATE, ZIP CODE
☐ ADD ☐ DELETE	☐ YES ☐ NO		
☐ ADD ☐ DELETE	☐ YES ☐ NO		
☐ ADD ☐ DELETE	☐ YES ☐ NO		
☐ ADD ☐ DELETE	☐ YES ☐ NO		
☐ ADD ☐ DELETE	☐ YES ☐ NO		

RATING INFORMATION

CHANGE	STREET, CITY, STATE	LOC #	CLASS CODE	RATE	CATEGORIES, DUTIES, CLASSIFICATIONS	NO. OF EMPLOYEES	EST. REMUNER. FOR PRESENT POLICY PERIOD
☐ ADD ☐ DELETE ☐ CHANGE							
☐ ADD ☐ DELETE ☐ CHANGE							
☐ ADD ☐ DELETE ☐ CHANGE							
☐ ADD ☐ DELETE ☐ CHANGE							
☐ ADD ☐ DELETE ☐ CHANGE							
☐ ADD ☐ DELETE ☐ CHANGE							

REMARKS

CP-14300 (2/98)

PLEASE COMPLETE REVERSE SIDE

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)

CHANGE	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	RE-MUNERATION
☐ ADD ☐ DELETE ☐ CHANGE								
☐ ADD ☐ DELETE ☐ CHANGE								
☐ ADD ☐ DELETE ☐ CHANGE								
☐ ADD ☐ DELETE ☐ CHANGE								

EMPLOYEES NAMES ☐ Check if additional employee names are attached.

CHANGE	NAME	CHANGE	NAME
☐ ADD ☐ DELETE ☐ CHANGE		☐ ADD ☐ DELETE ☐ CHANGE	
☐ ADD ☐ DELETE ☐ CHANGE		☐ ADD ☐ DELETE ☐ CHANGE	
☐ ADD ☐ DELETE ☐ CHANGE		☐ ADD ☐ DELETE ☐ CHANGE	

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS (Please proide comments on changes in operations and the reason for the changes)

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING—RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT, CONTRACTOR—TYPE OF WORK, SUB-CONTRACTS, MERCANTILE—MERCHANDISE, CUSTOMERS, DELIVERIES, SERVICE—TYPE, LOCATION, FARM—ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

REMARKS

I understand that as the employer,

I must update the application monthly to reflect any change in the required application information;

If I file an application or application update containing false, misleading, or incomplete information with the purpose of avoiding or reducing the amount of premiums for Worker's Compensation coverage it is a felony of the third degree;

I shall submit to the carrier, a copy of the quarterly earnings report and self-audits supported by the quarterly earnings reports, as required by chapter 443, at the end of each quarter. If I omit the name of an employee from this quarterly earnings report, Florida statutes state that I will remain liable and will reimburse the carrier for any worker's compensation benefits paid to this omitted employee;

I agree to make available, all records necessary for the payroll verification audit and permit the auditor to make a physical inspection of our operations. I understand failure to do this shall result in a $500 payment to the carrier to defray the cost of the audits;

If I intentionally understate payroll or misrepresent employee duties so as to avoid proper classification for premium calculations, I shall pay the carrier, in addition to any additional premium due resulting from an audit, a 12 percent penalty on the amount underpaid.

I hereby swear that the information contained in this application is accurate and acknowledge that I have read the above statements.

APPLICANT'S SIGNATURE	PRODUCER'S SIGNATURE

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)	Social Security Number	Date of Accident (Month-Day-Year)	Time of Accident ☐ AM ☐ PM

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION	INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED

DATE OF BIRTH _____ / _____ / _____

SEX ☐ M ☐ F

EMPLOYER INFORMATION

COMPANY NAME: _____

D. B. A.: _____

Street: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

FEDERAL I.D. NUMBER (FEIN)

NATURE OF BUSINESS

DATE FIRST REPORTED (Month/Day/Year)

POLICY/MEMBER NUMBER

DATE EMPLOYED _____ / _____ / _____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED _____ / _____ / _____

RETURNED TO WORK ☐ YES ☐ NO
IF YES, GIVE DATE _____ / _____ / _____

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP _____ / _____ / _____

PLACE OF ACCIDENT (Street, City, State, Zip)

Street: _____

City: _____ State: _____ Zip: _____

COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable) _____ / _____ / _____

AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK

$ _____ PER ☐ DAY ☐ MO

Number of hours per day _____

Number of hours per week _____

Number of days per week _____

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 insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.

I have reviewed, understand and acknowledge the above statement.

_____ EMPLOYEE SIGNATURE (If available to sign) _____ DATE

_____ EMPLOYER SIGNATURE _____ DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case - DWC-12, Notice of Denial Attached

☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)

Employee's 8TH Day of Disability _____ / _____ / _____

Entity's Knowledge of 8TH Day of Disability _____ / _____ / _____

☐ 3. Lost Time Case - 1st day of disability _____ / _____ / _____ Full Salary in lieu of comp? ☐ YES Full Salary End Date _____ / _____ / _____

Date First Payment Mailed _____ / _____ / _____ AWW _____ Comp Rate _____

☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH ☐ SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:

INSURER NAME

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #	**CLAIMS-HANDLING ENTITY** FILE #

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

GuideOne Insurance

Injured Worker's First Fill Prescription Form

Administered by CorVel (800) 563-8438

Injured Worker's Name: _____

SS#: _____ ***Date of Injury:*** _____

INJURED WORKER INSTRUCTIONS:

On your first Pharmacy visit, **please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Workers' Compensation prescriptions, based on the parameters established by GUIDE ONE**. With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Information Sheet to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a **14** day supply of medications.

PHARMACIST INSTRUCTIONS:

Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:

CORVEL CVS CAREMARK

BIN:	**004336**
PCN:	**ADV**
RxGroup:	**RXFFWC491**
Member ID:	**See below to generate ID**

To Generate Member ID: The Injured Worker's nine digit Social Security Number plus 8 digit Date of Injury will be used as their 17 digit **Member Identification number** when processing their First Fill Prescription: **XXXXXXXXXMMDDYYYY**

Please contact CorVel **Pharmacy Solutions** at (800) 563-8438 for assistance with claims processing

There are over 70,000 Participating Pharmacies in the CorVel Network. Below is a sample listing. Call (800)563-8438 to locate a Pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Dominick's Finer Foods	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy
Giant Food Stores, LLC	Medicine Shoppe	Shoprite Supermarkets	Winn Dixie Pharmacy

CORVEL