UCONN HEALTH

Workers' Compensation Forms

Kindly read each page carefully!

Please complete this packet and return completed copies to Human Resources within 72 hours. Failure to do so may result in delays of workers' compensation benefits and inaccurate paychecks received from UConn Health.

The following pages of this packet include forms that are **required** for your claim to be processed. Please read and fully complete each form. Some forms include irrevocable decisions that may impact benefits for the entirety of your claim. **Please review all forms carefully.**

Employees must comply with the following:

- Contact your manager immediately after each re-evaluation to discuss full duty or light duty work options. It is the responsibility of the employee to report to work when s/he is medically cleared to do so. Failure to do so may result in unpaid workdays and may lead to disciplinary action, up to and including termination.
- Fax a copy of your Work Status Report to Human Resources immediately after each medical appointment (860-679-4660).
- Absences under workers' compensation must be prescribed by your treating physician or an emergency department/walk-in clinic following an in-person visit. If you are unable to report to work, or must leave work due to a workers' compensation incapacity, you must seek in-person treatment with an authorized medical provider.

Signature:_____

Printed Name:_____

Date of Injury:_____

Today's Date:_____

Questions regarding any of the following pages may be directed to the Employee Resource Center (860-679-2426) or HR-EmployeeResource@uchc.edu

Claim specific questions may be directed to Deddie Garvey, HR Workers' Compensation Associate (860) 679-4589 or belnavisgarvey@uchc.edu

Workers' Compensation Claim Filing Packet Cover Sheet

As part of the workers' compensation claim filing process, the forms below must be completed and returned by fax to Human Resources at (860) 679-4660.

Instructions: Please enter the fields below in order to pre-populate standard fields on the following forms (if completed electronically). Enter remaining fields as appropriate:

Date of Injury	
First Name	
Last Name	
Date of Birth	
Social Security Number	N/A
Employee ID	
Home Street Address	
City	
State	
Zip	
Phone	

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 7-13-2009

1A

Filing Status and Exemption

This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER October 1, 1991, and must be completed in its entirety.

WCC File #

Date filed in District

(for WCC use only)

EMPLOYEE

Name _____ Date of Birth *(required)* _____

Address _____

City/Town _____ State _____ Zip Code _____

DATE OF INJURY:

_____

FILING STATUS AND EXEMPTIONS — In order to determine your weekly benefit rate, as per Sec. 31-310 C.G.S.,we need the following information:

1. Select your Federal tax filing status based upon your **ACTUAL filing status as of the date of injury**, listed at right: *(Must match your tax return, as if you were filing with the IRS on the date of your injury.)*

   ❑ Single ❑ Head of Household ❑ Married filing jointly ❑ Married filing separately

2. Number of exemptions *(including yourself)* as of the date of injury listed at right = _____

3. FICA withheld for the above-named employee? ..... ❑ YES ..... ❑ NO — ***If NO, insurer must manually calculate weekly benefit rate.***

4. Check all appropriate boxes:

   ❑ Employee 65 years of age or older ❑ Employee legally blind ❑ Spouse 65 years of age or older ❑ Spouse legally blind

5. List name *(yourself first)*, date of birth, and relationship to you for all exemptions included in question #2, above:

Name	*Date of Birth*	*Relationship*
		SELF

CONCURRENT EMPLOYMENT — To be certain you receive all the benefits to which you are entitled, provide the following information *if you were working for more than one employer on the date of injury indicated above*:

Name of Employer	*Address*	*Date of Hire*

NOTE: Wage information for each concurrent employer must be supplied by the claimant.

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

I hereby attest that the above information is correct to the best of my knowledge.

Employee's Signature _____ Date _____

DAS
Concurrent Employment Third Party Liability Form

Per WC-211 Rev. 2/05

EMPLOYEE TO COMPLETE

Employee Name (last) (First) (MI)	Social Security Number N/A
Address (No. and Street)	Telephone Number
City or Town	Date of Injury
Employing State Agency UConn Health	Date of Birth
Address of Employing Agency (No. and Street) 263 Farmington Ave Farmington, CT 06030 Zip	Date First Employed by State

EMPLOYEE INSTRUCTIONS

The information requested on concurrent employment below is necessary to determine your Workers' compensation benefit rate:

1. You must complete this form for every Workers' Compensation claim you file.
2. You must keep the information contained in this form current while you are receiving Workers' Compensation benefits.
3. You must return this form to your personnel office within three days.

Note: If your claim is for Temporary Total or Temporary Partial disability benefits, you must advise your employer of any other earnings while receiving these benefits. Failure to do so may result in civil and/or criminal liability.

CONCURRENT EMPLOYMENT CHECK IF ANY OF THE FOLLOWING APPLY: ☐ NONE

☐ Employed by Another State Agency ☐ Employed Outside State Government

Name of Other Employer	Supervisor's Name	Telephone Number of Employer
Address of Employer (No. and Street)	City or Town	State Zip

THIRD PARTY LIABILITY INFORMATION

1. Was the cause of your accident/injury the result of the actions of a party other than you or your employer?

Yes ☐ No ☐

If you checked yes, please describe the facts.

Name the Third Party _____

Address _____

Insurance Carrier of Third Party _____

2. Were there any witnesses?

Yes ☐ No ☐

Name of witnesses _____

3. Have you initiated a claim against this responsible Third party?

Yes ☐ No ☐ Date _____

I DECLARE THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I AM AWARE THAT PROVIDING FALSE INFORMATION MAY RESULT IN CIVIL, OR CRIMINAL LIABILITY.

Signature _____ Date _____

Request for Use of Accrued Leave with Workers' Compensation

DAS WC-715

3-10

This form covers an employee election to utilize or not utilize accrued leave (existing balances and additional accruals as credited) during the interim period and/or to supplement lost wage benefits on an approved workers' compensation claim. The Agency Section shall be completed with the initial agency processing of the **LOST TIME** claim and provided to the injured employee with instruction to make an election and ***RETURN WITHIN 10 BUSINESS DAYS***. This form is to be maintained in the injured worker's agency workers' compensation file.

AGENCY SECTION

Agency Name	Department ID
UConn Health	UHC72000

Employee Name	Employee ID

Date of Injury	Daily Pay Rate	**LEAVE BALANCES** As of date of injury Denoted in Hours	Sick	Vacation	Personal	Holiday Comp	Comp

EMPLOYEE ELECTION SECTION - Please check your choice of the options available to you then sign and return to your agency Workers' Compensation office **within ten business days.** Failure to return the completed form to the agency will be administered as an election **not** to utilize accrued leave during the interim period and **not** to supplement the approved workers' compensation lost wage benefit.

USE OF ACCRUED LEAVE FOR INTERIM PERIOD

☐ I elect NOT to use accrued leave during the interim period (after the first day of my incapacity and continuing until such time as a determination of compensation is made).

☐ I elect to use accrued leave during this interim period. By choosing this option I will receive my full base pay while a determination of compensation is being made. I understand that, once a compensation award has been made, I must repay the State an amount equal to the net pay I would have received during such interim period in order for my leave balances to be restored. I further understand that sick leave must be used first, followed by my designated choice of vacation, personal, holiday compensatory time and/or compensatory leave, as designated below.

Indicate the order in which you wish to use leave balances (if any), upon the exhaustion of your sick leave, by entering the number 2,3,4,5 in each box:	Sick	Vacation	Personal	Holiday Comp	Compensatory
	1				

USE OF ACCRUED LEAVE WHILE RECEIVING WORKERS' COMPENSATION

☐ I elect NOT to use any of my accrued leave while I am receiving Workers' Compensation lost wage benefits.

☐ I elect to use accrued leave, which in addition to the lost wage benefits awarded to me under Workers' Compensation, will result in my receiving the equivalent of my full base pay while I am receiving Workers' Compensation lost wage benefits. I further understand that sick leave must be used first, followed by vacation and/or personal leave, as designated below.

Indicate the order in which you wish to use leave balances (if any), upon the exhaustion of your sick leave, by entering the number 2 or 3 in each box:	Sick	Vacation	Personal
	1		

STATEMENT OF APPLICANT

I have read and understand the above explanation of the choices available to me as a result of my application for workers' compensation. Once made, this election cannot be revoked and will remain in effect until all accrued leave (including any future accruals that may be credited to me) is exhausted or until I return to my pre-injury number of scheduled work hours. **I agree to the conditions applicable to the choices I have checked above.**

SIGNATURE OF EMPLOYEE **DATE SIGNED**