# CIRSA Claims

## Property Casualty & Workers Compensation

Presented By: Mike Wagner, Claims Manager and

Marla Myers, WC Claims Supervisor

# Submitting Claims To CIRSA

## CIRSA Website (Preferred)

Quicker claim set up

Auto generated claim number and email back to Member

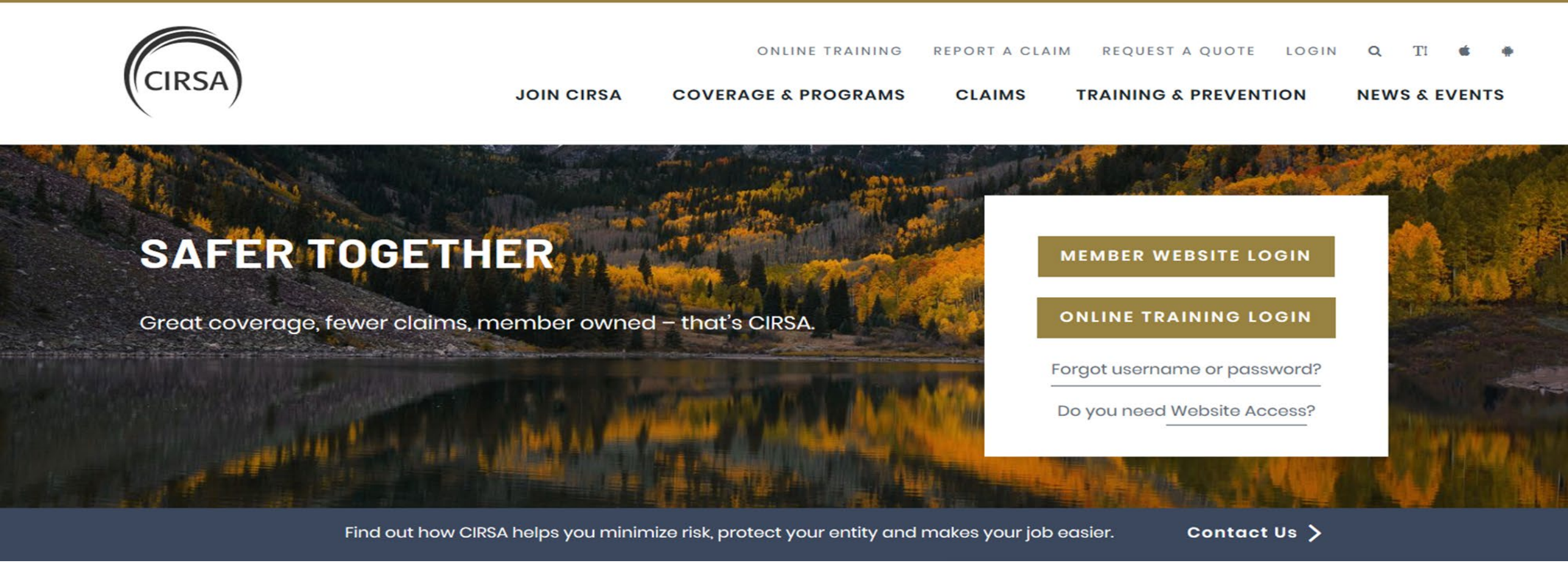
Automated claim acknowledgement letter upon adjuster assignment

## Email

Hard copy claim form that must be downloaded, completed, and then scanned back

Turn around time is not as quick, but does not require access to CIRSA website

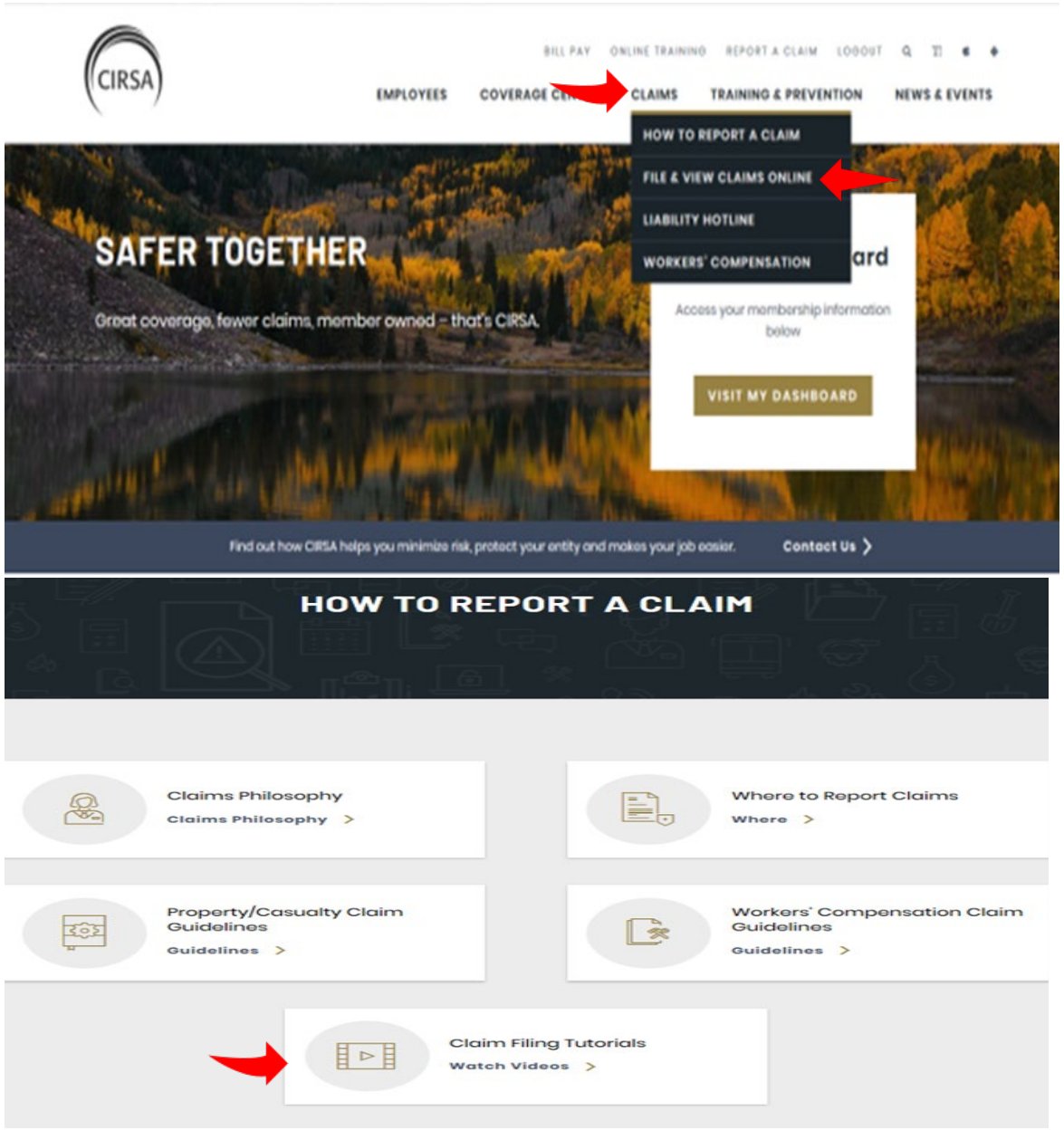
# Submitting WC/PC Claims via CIRSA Website



# Website Navigation & Help

Submit a new claim (event) by using the drop-down menu and choosing “File & View Claims Online”

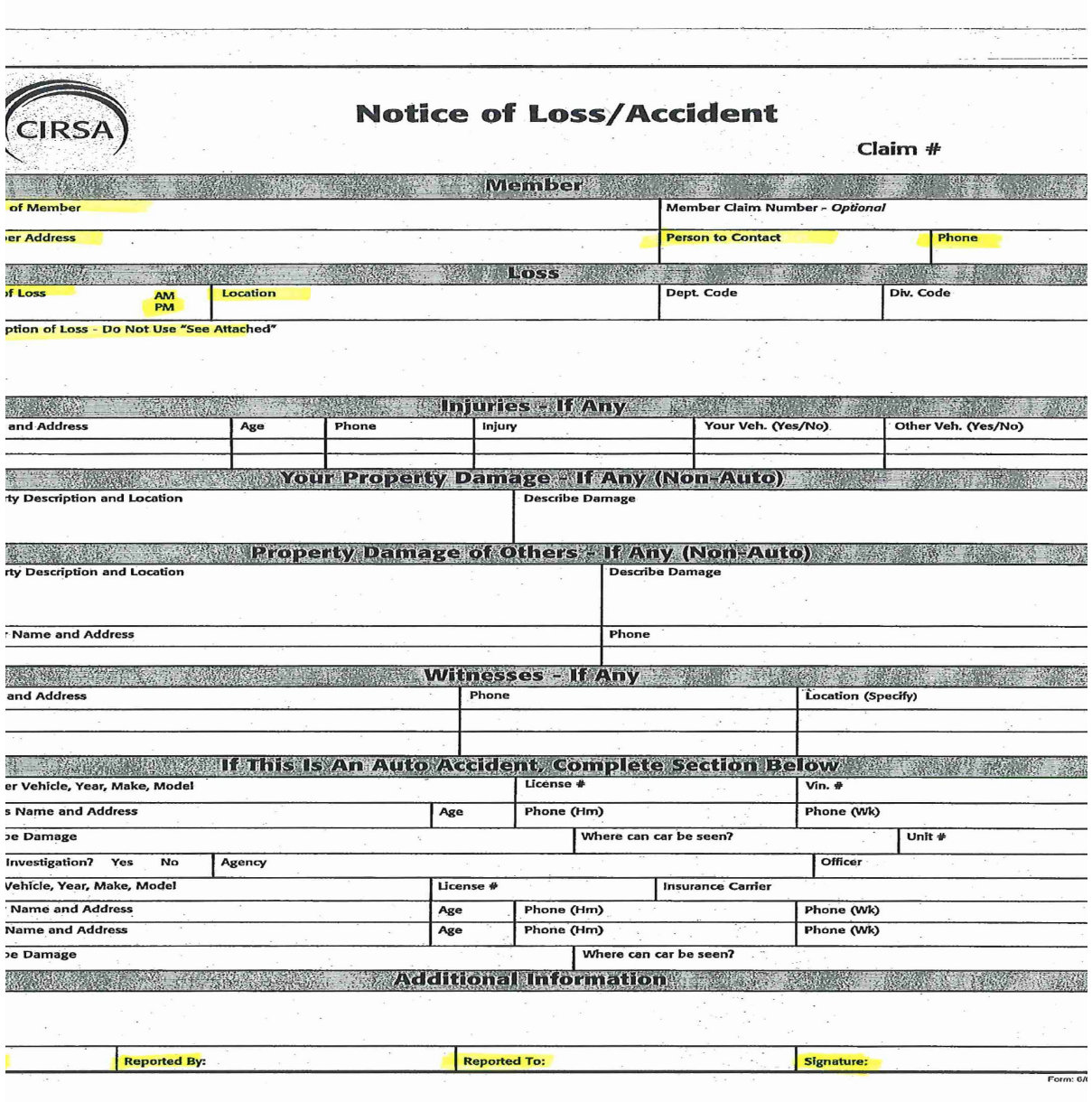
If you have difficulty, view “Claim Filing Tutorials” for training on submitting a new claim (event) to CIRSA.



# Property Casualty

**Notice of Loss / Accident**

- Form obtained from Claim Dept.
- Highlighted areas completed at a minimum
- Document needs to be emailed to Claim Manager Mike Wagner and PC Claims Supervisor Dianne Hall
  - mikew@cirsa.org
  - Dianneh@cirsa.org



CIRSA

Notice of Loss/Accident

Claim #

Member

of Member | Member Claim Number - *Optional*

er Address | Person to Contact | Phone

Loss

f Loss | AM PM | Location | Dept. Code | Div. Code

ption of Loss - Do Not Use "See Attached"

Injuries - If Any

and Address | Age | Phone | Injury | Your Veh. (Yes/No) | Other Veh. (Yes/No)

Your Property Damage - If Any (Non-Auto)

ty Description and Location | Describe Damage

Property Damage of Others - If Any (Non-Auto)

ty Description and Location | Describe Damage

Name and Address | Phone

Witnesses - If Any

and Address | Phone | Location (Specify)

If This Is An Auto Accident, Complete Section Below

er Vehicle, Year, Make, Model | License # | Vin. #

s Name and Address | Age | Phone (Hm) | Phone (Wk)

e Damage | Where can car be seen? | Unit #

Investigation? Yes No | Agency | Officer

Vehicle, Year, Make, Model | License # | Insurance Carrier

Name and Address | Age | Phone (Hm) | Phone (Wk)

Name and Address | Age | Phone (Hm) | Phone (Wk)

e Damage | Where can car be seen?

Additional Information

Reported By: | Reported To: | Signature:

Form: 6/

# Workers' Compensation

## Employer's First Report of Injury (aka FROI)

- Document should be emailed to WC Claims Supervisor
  - marla@cirsa.org

See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

**EMPLOYER'S FIRST REPORT OF INJURY**

| | | | | |
|---|---|---|---|---|
| Employee's name (first, middle, last) | Social Security # | ☐ Male ☐ Female | Employee's home phone # ( ) | OSHA Log # |
| Employee's street address | City | State | Zip code | |
| Birth date / / | Marital status ☐ Married ☐ Separated ☐ Single ☐ Unknown | Date of hire / / | Occupation | Employment status ☐ Full time ☐ Part time ☐ Other ☐ Unknown |
| Employer's name | Employer's Federal ID # | Employer's phone # ( ) | | For Division use only |
| Employer's mailing address | City | State | Zip code | SOI / POB / NOI / Coder |
| Average weekly wage at time of injury $_____ (see instructions on reverse side) | Check box if employee receives ☐ Tips ☐ Meals ☐ Room ☐ Health insurance | Check if these benefits are included in AWW ☐ Tips ☐ Meals ☐ Room ☐ Health insurance | | |
| Is the employer self-insured? ☐ Yes ☐ No | Were full wages paid for the DOI? ☐ Yes ☐ No | Are wages continued per C.R.S. 8-42-124? [1] ☐ Yes ☐ No | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Injury/Illness date / / (See instructions on reverse side) | Time employee began work ____ ____ ☐ a.m. ____ ____ ☐ p.m. | Injury time ____ ____ ☐ a.m. ____ ____ ☐ p.m. ☐ unknown | Last day worked / / | Date employer notified / / | Date disability began / / | Date returned to work / / |
| Did injury cause death? ☐ Yes ☐ No | If so, date of death / / | Name, relationship, and address of closest dependent if injury caused death | | | | Injury occurred because of ☐ Intoxication ☐ Safety violation ☐ Not applicable |
| Tell us the part of body that was affected | | | | Tell us the nature of the injury/illness [2] | | |
| What was the employee doing just before the accident occurred? [3] | | | | | | |
| Tell us how the injury occurred [4] | | | | What object or substance directly harmed the employee? [5] | | |
| Did injury occur on premises? ☐ Yes ☐ No | Injury site address/ 9-digit zip code | Initial treatment (check one) ☐ None ☐ Minor on-site ☐ Clinic/hospital ☐ Emergency room ☐ Hospital >24 hrs | | Was the employee hospitalized overnight as an in-patient? ☐ Yes ☐ No | | |
| Names of witnesses | | | | Name of employer representative notified | | |
| Name and address of treating doctor or other health care professional | | | | Name and address of facility where treated | | |
| Completed by (name) | Title | Phone # ( ) | | Date completed / / | | |

**The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.**

| | | | | |
|---|---|---|---|---|
| Name of insurance company | | Address | | |
| Name of third party administrator (if applicable) | | Address | | |
| Adjuster name | | Adjuster phone # | | |
| Policy # | Carrier claim # | Date insurer received first report / / | Block # | Adj. Code |

# Employee's Notice of Injury

**CIRSA**
Workers' Compensation Pool
3665 Cherry Creek North Drive
Denver, CO 80209

## EMPLOYEE'S NOTICE OF INJURY

**EMPLOYER: This form should be given by the employer to any employee who reports an occupational injury or illness to his/her employer. This form is used to provide written notice of an injury pursuant to §8-43-102 (1)(a).**

**EMPLOYER AND EMPLOYEE: Please read the instructions on reverse side before completing this form.**

| | |
|---|---|
| **Name of City/Town/Entity:** | |

| | | | | | |
|---|---|---|---|---|---|
| **Employee's Name**: (First, middle, last) | | | | | |
| **Social Security Number:** | | **Date of Birth:** (MM/DD/YYYY) | | | |
| **Mailing Address:** | | | | | |
| **Email Address:** | | | | | |
| **Phone Number(s):** | Home: | | Work: | | Cell/Other: |

| | |
|---|---|
| **Occupation/Job Title:** | |
| **Briefly explain how injury/illness occurred:** | |
| **Body Part(s) Injured:** | |
| **Place of Accident:** | |
| **Date of Injury:** (MM/DD/YYYY) | **Time of Injury:** |

| | | |
|---|---|---|
| **Did you notify your employer/supervisor at the time of the injury/illness?** | Yes: | No: |
| **Did you seek medical treatment at the time of the injury/illness?** | Yes: | No: |
| **Were you provided information regarding your employer's designated workers' compensation medical provider(s)? (e.g. Designated Provider List)** | Yes: | No: |

| | | | |
|---|---|---|---|
| **Employee Signature:** | | **Date:** (MM/DD/YYYY) | |



**PLEASE READ CAREFULLY**

The Colorado Revised Statutes, Section 8-43-102 provides:

(1)(a) Every employee who sustains an injury resulting from an accident shall notify said employee's employer in writing of the injury **within four days of the occurrence of the injury**. If the employee is physically or mentally unable to provide said notice, the employee's foreman, superintendent, manager, or any other person in charge who has notice of said injury shall submit such written notice to the employer. Any other person who has notice of said injury may submit a written notice to the said person in charge or to the employer, and in that event the injured employee shall be relieved of the obligation to give such notice. Otherwise, **if said employee fails to report said injury in writing, said employee may lose up to one day's compensation for each day's failure to so report**. If, at the time of said injury, the employer has failed to display the notice specified in paragraph (b) of this subsection (1), the time period allotted to the employee shall be tolled for the duration of such failure.

**INSTRUCTIONS TO EMPLOYEE**

1. All injuries, no matter how trivial, must be reported on this form to your employer immediately, but in any event within four working days of the occurrence of the injury.
2. Type or print your responses legibly.

**INSTRUCTIONS TO EMPLOYER**

1. Complete an Employer's First Report of Injury (WC 1) and submit it along with this form to the CIRSA Claims Department.
2. Note the date and time of receiving this notice from the employee in the space provided below.
3. Provide a copy of this completed Employee's Notice of Injury to the injured employee within two (2) working days.

**EMPLOYER'S ACKNOWLEDGMENT OF RECEIPT**

The foregoing completed Employee's Notice of Injury was received by the undersigned employer representative on _____, 20___ at _____ a.m. / p.m.

A copy of the completed Employee's Notice of Injury was provided to the Employee on _____, 20___ at _____ a.m. / p.m.

| | | | |
|---|---|---|---|
| **Employer Representative Signature:** | | **Date:** (MM/DD/YYYY) | |



CIRSA SAFER TOGETHER

# Workers' Compensation

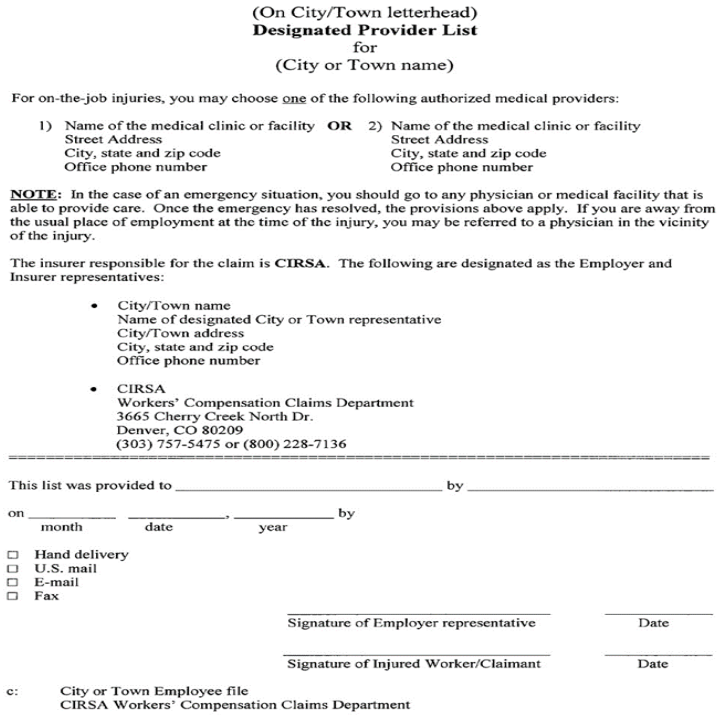
## Designating a Medical Provider

- The statute requires with some exceptions, that a list of **at least four (4) physicians, corporate medical providers, or a combination of both**, where available, be provided by the employer so as to afford the injured employee the opportunity to select a treating physician. At least one (1) of the four (4) designated providers or corporate medical providers offered must be at a distinct location from the other three (3) without common ownership.
- **If no physician is properly designated, the employee may attend the health care provider of his or her choice**.

# Worker's Compensation

## Designated Provider List (DPL)

**This must be given to the injured worker in a verifiable manner within seven (7) business days following the date the employer has notice of the injury.**



(On City/Town letterhead)
**Designated Provider List**
for
(City or Town name)

For on-the-job injuries, you may choose one of the following authorized medical providers:

1) Name of the medical clinic or facility **OR** 2) Name of the medical clinic or facility
Street Address — Street Address
City, state and zip code — City, state and zip code
Office phone number — Office phone number

**NOTE:** In the case of an emergency situation, you should go to any physician or medical facility that is able to provide care. Once the emergency has resolved, the provisions above apply. If you are away from the usual place of employment at the time of the injury, you may be referred to a physician in the vicinity of the injury.

The insurer responsible for the claim is **CIRSA**. The following are designated as the Employer and Insurer representatives:

- City/Town name
  Name of designated City or Town representative
  City/Town address
  City, state and zip code
  Office phone number
- CIRSA
  Workers' Compensation Claims Department
  3665 Cherry Creek North Dr.
  Denver, CO 80209
  (303) 757-5475 or (800) 228-7136

This list was provided to _____ by _____

on _____ _____, _____ by
month date year

☐ Hand delivery
☐ U.S. mail
☐ E-mail
☐ Fax

_____ _____
Signature of Employer representative Date

_____ _____
Signature of Injured Worker/Claimant Date

c: City or Town Employee file
CIRSA Workers' Compensation Claims Department

# WC & PC Claims Reporting

## What we need from you

Report claims timely, properly, and accurately

- Complete and accurate information when submitting a New Event through the Origami system, including date and time of loss, facts of the loss or injury
- Department and Division codes

Provide the designated Claim Contact's name, phone number, email address (including your City attorney's contact information, if needed)

Gather documentation and information to send to the claims adjuster once the claim is assigned. Documents can be attached to the "Incident" when submitting a New Event.

# You've Submitted a Claim

## What happens next?

We will make timely Member and claimant contacts

We will conduct timely investigations and request supplemental documents (e.g. police reports, Supervisor's Accident/Incident Investigation Reports, witness statements, estimates, photographs, Department reports and other pertinent documents)

We will discuss our findings with you and recommend future handling, which will include possible denial or payment of the claim.

# Lawsuits

## Don’t delay – These are urgent matters

Summons and Complaint

- **Send Summons and Complaint and any supporting documents to CIRSA immediately. Confirm receipt with CIRSA.**
- **Please include the name, phone number and email address of all involved parties and include your City or Town Attorney information.**

CIRSA will:

- Review the Complaint for coverage
- Assign defense counsel, if appropriate
- Send a reservation of rights or denial letter to all listed defendants explaining our coverage decision

# Other Important Stuff to Know

## After-hours emergencies

The Claims Department has an on-call, after hours representative in both WC and PC to assist our Members with emergencies after normal business hours

Please call the CIRSA Office at (303) 757-5475 or (800) 228-7136

## CIRSA Liability Hotline

CIRSA Members can contact our Liability Hotline (1-800-228-7136) for assistance with complex issues such as:

Disciplinary Issues

Hiring/Termination

Americans with Disabilities Act

Fair Labor Standards Act

Discrimination

# Questions?

Please contact us with any questions

CIRSA Office (303) 757-5475 or (800) 228-7136

Claims Manager Mike Wagner mikew@cirsa.org

PC Claims Supervisor Dianne Hall; dianneh@cirsa.org

WC Claims Supervisor Marla Myers; marla@cirsa.org