CLAIMANT'S AUTHORIZATION TO RELEASE INFORMATION

Form 206

(To Be Completed By Employee)

To whom it may concern:

I, _____, a resident of _____, whose signature appears below, do hereby authorize Moylan's Insurance Underwriters, Inc., or any of its duly authorized representative, to secure any and all information relative to my workers compensation claim for injury/illness sustained while at work on or about _____, 20__,

Such information may include my medical records, police records, employment records, immigration documents, date of birth, civil status, etc.

I hereby expressly waive the privilege of confidentiality and right of privacy set forth by law that may be applicable to me.

_____ _____

DATE SIGNATURE OVER PRINTED NAME

_____ _____

DATE WITNESS

EMPLOYEE'S CLAIM FOR COMPENSATION

Form 203

(To Be Completed By Employee)

INSTRUCTIONS: *This form should be completed by the EMPLOYEE when filing a CLAIM FOR COMPENSATION. The policy requires the filing of a claim within one year after the date of injury or the date of last payment of compensation.*

1. Name of Injured Employee: SS No:	2. Name of Employer: Fed ID No.
3. Employee's Address & Phone No.:	4. Employer's Address:
5. Date and Time of Alleged Injury/Illness:	6. Date of Employer's first knowledge of injury/ilnness:
7. Date & hour Employee first lost time because of injury or illness:	8. Date & hour Employee returned to work:
9. Date & hour pay stopped:	10. Check box atop days usually worked per week:

Sun	Mon	Tues	Wed	Thu	Fri	Sat

11. Employee's occupation:	12. Employee's Wages/Earnings (overtime, etc.):		
	Hourly	$	Daily	$
	Weekly	S	Yearly	$
13. Is another person (not your fellow employee) the cause of the accident/injury? ☐ Yes ☐ No	14. If you answered yes to item 13, will you file a suit against the other person? ☐ Yes ☐ No			

15. DESCRIBE IN FULL HOW THE ACCIDENT OCCURRED. (Relate the events which resulted in the injury/illness. Tell what the Employee was doing at the time of the accident. Tell what happened and how it happened. Name any object or substance involved and tell how they were involved. Give full details on factors which led or contributed to the accident.)

(Use additional sheets if necessary and attach to this Notice.)

16. NATURE OF CLAIM FOR COMPENSATION: ☐ Temporary Disability (wage/salary lost) ☐ Permanent Disability (Physical loss/loss of use of) ☐ Facial Disfigurement (Serious head/facial) ☐ Other	EXPLAIN:
17. Have you received medical attention for your injury? ☐ Yes ☐ No	18. If yes, give name and address of treating physician/clinic:
19. Name and Signature of Employee:	20. Date:

NOTICE OF EMPLOYEE'S INJURY OR ILLNESS

Form 201

(To Be Completed By Employee)

INSTRUCTIONS: *This form may be used by the EMPLOYEE to file a NOTICE OF INJURY or ILLNESS, or in the case of death, by the EMPLOYEE's representative. No benefits need to be paid without this notice. Notice shall be given to the Employer by delivery or mail to the last known address.*

THIS IS NOT A CLAIM FOR COMPENSATION

1. Name of Injured Employee: SS No.	2. Name of Employer: Fed ID No.
3. Employee's Address & Phone No.	4. Employer's Address:
5. Date and Time of Alleged Injury/Illness:	6. Did employee stop work? ☐ Yes (Date Stopped - __/__/__) ☐ No
7. Employee's Occupation:	8. Name of Supervisor at the time of injury:
9. Place where injury occurred.	
10. Is another person (not your fellow employee) the cause of the accident/injury? ☐ Yes ☐ No	11. If you answered yes to item 10, will you file a suit against the other person? ☐ Yes ☐ No
12. DESCRIBE IN FULL HOW THE ACCIDENT OCCURRED. (Relate the events which resulted in the injury/illness. Tell what the Employee was doing at the time of the accident. Tell what happened and how it happened. Name any object or substance involved and tell how they were involved. Give full details on factors which led or contributed to the accident.) (Use additional sheets if necessary and attach to this Notice.)	
13. Effects of the injury. (Indicate parts of the body affected and how affected.)	
14. Employee's Signature	15. Print Name of Person Completing this Form:
16. Signature of Person completing this Notice	17. Date of this Notice

PHYSICIAN'S REPORT FOR SUBSEQUENT TREATMENT

Form 204

(To Be Completed By the Authorized Physician)

INSTRUCTIONS TO PHYSICIAN: *This form is to be used for subsequent treatment, to make progress reports and final report when the patient is discharged. All questions must be answered fully. Write "NA" if not applicable. The exact point of amputation and other permanent partial disabilities must be know in order to determine compensation due the injured employee according to the benefit schedule shown on the policy. The back of this form may be used if needed. The physician may submit a narrative report covering all the questions and information asked for in this form on separate sheets.*

1. Name of Injured employee:		2. Date of Injury:	
3. Employee's Address:		4. Date of Birth: __/__/__	5. Sex:
6. Name of Employer:		7. Employer's Address:	
8. Date of First Visit: __/__/__	9. Date of Discharge: __/__/__	10. Who authorized treatment?	
11. Nature of Treatment:		12. Dates of your treatment:	
13. Was employee hospitalized? ☐ Yes (Go to item 15) ☐ No	14. Were X-rays taken? ☐ Yes (Go to item 17) ☐ No		
15. Give names, addresses, and dates of treatments provided by hospitals or other doctors for this injury.			
16. Employee's account of how injury or exposure to occupational disease occurred.			
17. Findings upon examination. (Include results of X-rays, laboratory studies, etc. Note prior injuries and existing conditions and any remarks and recommendations on the reverse side of this form).			
18. Diagnosis:		19. Is diagnosed condition due to occurrence described in item 16? ☐ Yes ☐ No (Please explain on reverse side of this form)	
20. Was there disability for work? ☐ Yes (Go to A, B & C) ☐ No	A. Date disability began: __/__/__	B. Date able to return to light work: __/__/__	C. Date able to return to regular work: __/__/__
21. Will there be permanent defect, or facial or head disfigurement? ☐ Yes (describe briefly and estimate loss in % terms.) ☐ No			
22. Name of Attending Physician:		23. Address:	
24. Signature of Attending Physician		25. Date of this Report: __/__/__	

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Form 202

(To Be Completed By Employer)

INSTRUCTIONS: *This form may be used by the EMPLOYER to report an injury or illness to the addressee shown in item 13 and 14 of Form 101A. The Insurance Carrier requires the employer to report within 10 days from the date of or knowledge of any injury or illness. Failure or refusal to file this report on a timely basis may serve as grounds for denial of the claim under the workers compensation policy.*

1. Name of Injured Employee: SS No:	2. Name of Employer: Fed ID No.
3. Employee's Address & Phone No.:	4. Employer's Address:
5. Date and Time of Alleged Injury/Illness:	6. Date of Employer's first knowledge of injury/ilnness:
7. Date & hour Employee first lost time because of injury or illness:	8. Date & hour Employee returned to work:
9. Date & hour pay stopped:	10. Check box atop days usually worked per week:

Sun	Mon	Tues	Wed	Thu	Fri	Sat

11. Employee's occupation:	12. Employee's Wages/Earnings (overtime, etc.):		
	Hourly	$	Daily	$
	Weekly	S	Yearly	$
13. Is there another person not of your employment who caused the accident? If yes, please provide name and address in 13.A	13.A		

14. DESCRIBE IN FULL HOW THE ACCIDENT OCCURRED. (Relate the events which resulted in the injury/illness. Tell what the Employee was doing at the time of the accident. Tell what happened and how it happened. Name any object or substance involved and tell how they were involved. Give full details on factors which led or contributed to the accident.)

(Use additional sheets if necessary and attach to this Notice.)

15. NATURE OF INJURY/ILLNESS (Name part of body affected, i.e., fractured leg, bruised arm, etc.) Note any amputations.

16. Has medical attention been authorized? ☐ Yes ☐ No	17. Date authorized: __/__/__	18. Has Insurance Company been notified: ☐ Yes ☐ No	19. Date Notified: __/__/__
20. Name of treating physician:		21. Name of Insurance Carrier	
22. Name of treating facility:		23. Name and Title of Person Completing this Report:	
24. Signature:		25. Date:	

ATTENDING PHYSICIAN'S INITIAL REPORT OF INJURY AND TREATMENT

Form 101B

(To Be Completed By the Authorized Physician)

INSTRUCTIONS TO PHYSICIAN: *This initial report should be completed and mailed within 20 days, the original to the address shown on item 13 (Form 101A), with a copy to the Company shown in item 14 of the same form. Subsequent reports should be made regularly on Form 201 or in narrative form while employee is in your care. Please read item 9 on Form 101A.*

15. What history of injury or disease did Employee give to you?

16. Is there any history or evidence of PRE-EXCISTING injury, disease or Physical Impairment?
    - ☐ Yes
    - ☐ No

17. What are your findings?

18. What is your diagnosis?

19. Do you believe the condition found was caused or aggravated by the employment activity described?
    - ☐ Yes
    - ☐ No

If answer to 19 is No, please explain.

20. Did injury require hospitalization. If so, please provide:
    - Hospital
    - Admission Date
    - Discharge Date

21. Is additional confinement required?
    - ☐ Yes
    - ☐ No

22. Surgery (if any, describe):

    Date Performed:

23. Other types of treatments:

24. What PERMANENT DEFECTS do you anticipate:

25. Date of First Examination:

26. Date of Treatments:

27. Dates of Discharge:

28. Period of TEMPORARY DISABILITY (Indicate if Unknown):
    Partial: From - __/__/__ To - __/__/__
    Total: From - __/__/__ To - __/__/__

29. Date Employee will be able to resume work:
    - ☐ LIGHT
    - ☐ REGULAR

30. If Employee is able to resume work, date when advised:

31. If Employee is able to resume only light work, indicate extent of PHYSICAL LIMITATIONS and type of work that could reasonably be performed with limitations.

32. General Remarks and Recommendations for future care, if indicated:

33. Do you SPECIALIZE?
    - ☐ Yes, please specify:
    - ☐ No

34. Name and Signature of Physician

35. Address:

36. Date of Report:

37. MEDICAL BILLS. Please attach your billing statement showing dates of treatment, itemized services and supplies provided.

MOYLAN'S INSURANCE UNDERWRITERS, INC.

AUTHORIZATION FOR MEDICAL EXAMINATION AND/OR TREATMENT

Form 101A

(To Be Completed By Employer)

INSTRUCTIONS TO EMPLOYER: *This side should be completed in full. It authorizes a physician (duly qualified physicians include surgeons, osteopathic practitioners, and acupuncturists within the scope of their practice as defined by law) of the employee's choice to examine and /or treat the employee for the injuries arising out of such accidental occupational injury, illness, or disease covered by your Workers' Compensation Insurance Policy.*

1. Name of authorized Physician:	2. Name of Medical Facility:	
3. Physician's Address:	4. Medical Facility's Address:	
5. Name of Injured Employee: Social Security No.:	6. Occupation	7. Date of Injury:
8. Description of Injury:		

9. YOU ARE HEREBY AUTHORIZED TO PROVIDE MEDICAL SERVICES TO THE EMPLOYEE AS FOLLOWS:

- ☐ If you believe the condition is related to the injury, furnish necessary treatment.
- ☐ If there is doubt as to whether the condition is related to the injury, you are authorized to examine the employee, using indicated non-surgical diagnostics studies, and promptly advise the carrier indicated in item 14 whether you believe the disability is due to the alleged injury. Pending further advice, you may provide the necessary conservative treatment.
- ☐ Other (specify)

YOU ARE REQUESTED TO SUBMIT A WRITTEN REPORT OF FIRST TREATMENT WITHIN 20 DAYS TO THE ADDRESS SHOWN IN ITEM 13 BELOW. (See succeeding page for the form for the medical report and your billing charges). The report is required for services to be paid.

10. Signature and Title of Authorizing Official	11. Name and Address of Employer:
12. Date:	
13. Send your Report to :	14. Name and Address of Insurance Carrier to whom copies of your report and bill are to be sent:

EMPLOYER'S SUPPLEMENTARY REPORT OF AN INJURY

Form 210

(To Be Completed By Employer)

INSTRUCTIONS: *This form should be completed by the EMPLOYER and filed promptly with the Insurance Carrier, within 10 days from the date the employee returned to work in every case in which that date is not indicated in Form No. 203.*

1. Name of Injured Employee: SS No:		2. Name of Employer: Fed ID No.
3. Employee's Address & Phone No.:		4. Employer's Address:
5. Date of Injury/Illness:		6. Date of Employer's first knowledge of injury/illness:
7. Initial Period of illness/disability. (Use inclusive dates for a and b.)		
a. From: (Month, Day, Year)	b. To: (Month, Day, Year)	c. Date returned to work: (Month, Day, Year)
8. If this report covers a period of illness/disability after the date shown on Item 7c, state each subsequent period of illness/disability. Use inclusive dates for a and b.		
a. From: (Month, Day, Year)	b. To: (Month, Day, Year)	c. Date returned to work: (Month, Day, Year)
9. Did employee receive medical attention? ☐ Yes. Give Dates, names and addresses of doctors and hospitals providing treatment		☐ No. Please explain
10. Was employee treated by his/her choice of physician? ☐ Yes ☐ No		11. Was Form 203 given to employee when the injury/illness was reported to employer? ☐ Yes ☐ No
12. Name and Signature of person completing this form.	13. Title	14. Date: