CATHOLIC MUTUAL GROUP

REVISED

Church Mutual INSURANCE COMPANY
Listening. | Learning. | Leading

TO: All Locations in the Diocese of Memphis

FROM: Catholic Mutual Group Service Team

DATE: January 29, 2016

RE: Workers' Compensation Coverage

In order to provide the Catholic Church with superior coverage, service and risk management at a fair price, Catholic Mutual has entered into a strategic alliance with Church Mutual Insurance Company. **Effective 1/1/2016**, Church Mutual Insurance Company will be replacing PPIC as your workers' compensation provider.

If one of your employees should suffer a work injury, the steps listed below should be followed:

- If your employee suffers an injury that is a **life threatening emergency**, call 911.
- **If your employee suffers an injury that is not life threatening and the employee has not yet received any outside medical care**, the supervisor/manager (with the employee present) should contact the Church Mutual Nurse Hotline at (844) 322-4662. (Please see attached information regarding the Church Mutual Nurse Hotline). The Nurse Hotline should be utilized anytime the injury likely requires "more than a Band Aid but less than an ambulance ride".
- **If an employee notifies you of an injury after they have already sought outside medical care** you should not call the Nurse Hotline number above, but should instead submit a First Report of Injury form (FROI), Accident Report and Medical Waiver to:
  - Church Mutual Insurance Company at claims@churchmutual.com or via fax (715) 539-4651, **and,**
  - Jhonna Ghrigsby at Vericlaim jghrigsby@vericlaiminc.com or via fax (615) 590-0094
- **If outside medical care has been sought at *any* point,** forms should be submitted as noted above.

Make sure your employees get the care they need with the
Church Mutual Nurse Hotline (844) 322-4662

A VALUE-ADDED SERVICE FOR OUR WORKERS' COMPENSATION POLICYHOLDERS AND THEIR EMPLOYEES

Learn what to do before you report a workers' compensation claim and before your employee sees a doctor.

Church Mutual®
INSURANCE COMPANY

Listening. | Learning. | Leading.®

Here's what the hotline can do for your employees.

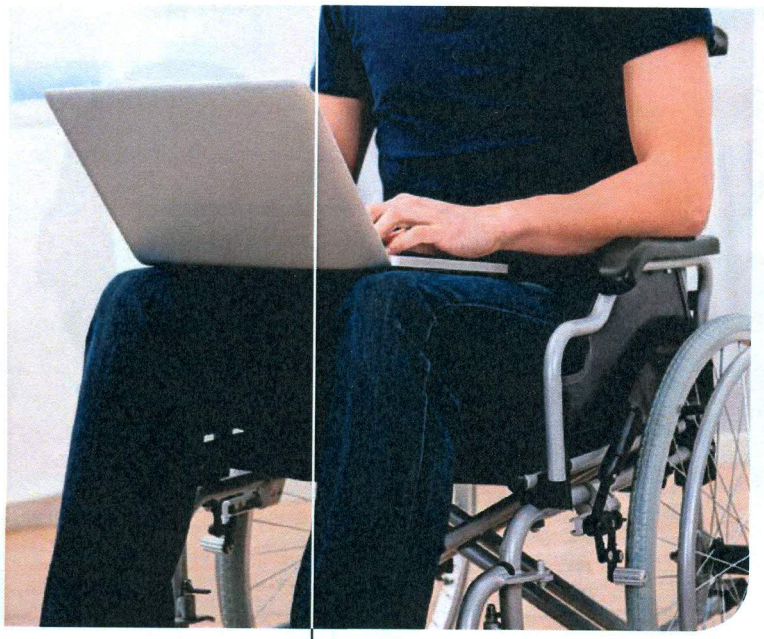
Even in the safest of workplace environments, injuries can happen. Supervisors, who usually aren't trained medical professionals, often don't know how to properly deal with an injury. As a result, employees with minor injuries are often sent for unnecessary and expensive off-site care when first aid would have sufficed. Conversely, employees with more serious injuries might not get the care they need.

Our no-cost Nurse Hotline provides you with 24/7 access to medical professionals who can help you appropriately manage work-related injuries.

You and your employees will benefit from:

- Sound clinically based decisions about when first aid is appropriate and when outside care referrals are necessary
- Consistent treatment decisions and documentation of injuries
- Off-site referrals to preselected providers
- Lower frequency and severity of workers' compensation claims
- Potential for reduced experience modification
- Greater confidence on the part of employees and less confusion for the employer

In addition to getting your employees the treatment they need in a timely manner, the Nurse Hotline also helps ensure that if you need to file a claim, you do so in a timely manner, which helps reduce costs, confusion and, potentially, litigation.



Here's how it works:

Step one: Make the call at the time of injury

Employees should be trained to notify their supervisor immediately in the case of an injury. At that time, the supervisor will make the call to the Church Mutual Nurse Hotline (844) 322-4662. Once the supervisor provides the nurse on call with pertinent facts, the injured employee will get on the phone so the nurse can ascertain the severity of his or her injuries. If the supervisor is not available, the injured employee can make the call directly.

Step two: The nurse recommendation

The nurse on call will provide the employee and supervisor with next steps for treating the injury. This could be anything from going to the emergency room, to making an appointment with a specialist to simple first aid. If the employee will self-treat, the nurse will forward patient follow-up care instructions in writing, directly to the employee.

Step three: Debrief with manager, if present

The nurse will confirm the treatment plan with the manager.

If self-care/first-aid is all that is needed, the nurse will advise the manager of this, and also will explain the specific recommendations provided to the employee. The nurse may fax follow-up instructions to the employee to reinforce the recommended steps for self-care/first-aid.

If outside care is recommended or sought, the nurse also will notify the manager of this (if available), along with the name of any specific provider for possible evaluation and treatment.

Step four: Timely record distribution

All calls will be documented in some way.

If self-care/first-aid is all that is needed, the nurse will provide Church Mutual Claims an incident report, but no formal claim will be established within the claims system, and the incident will not appear on any loss runs.

If outside care is recommended or sought, the nurse will send a report to the Claim Reporting Center, and a formal claim will be created within the claims system, and an appropriate claim handler will be assigned to manage the file. The claim will appear on loss runs.

If an injury is serious or life threatening, call 911

These include, but aren't limited to, the following conditions:

- Choking
- Unconsciousness or severe disorientation
- Severe bleeding
- Lack of balance or inability to walk
- Hot, dry skin
- Seizures or convulsions
- Difficulty breathing
- Chest pain or discomfort
- Profuse sweating
- Severe abdominal pain
- Any other problem you feel might be an emergency

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)

CLAIMS ADM CLAIM # (INSURER CLAIM #)

OSHA LOG CASE #

NAME OF INSURANCE CARRIER

CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)

CLAIMS ADJUSTER NAME

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2

CLAIM TYPE CODE
- ☐ MED ONLY
- ☐ INDEMNITY
- ☐ BECAME LOST TIME
- ☐ BECAME MED ONLY
- ☐ NOTIFY ONLY
- ☐ TRANSFER

CARRIER FEIN

FEIN OF CLMS ADM

CLMS ADJ PHONE #

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE TENNESSEE WORKERS' COMPENSATION LAW AND MUST BE COMPLETED AND FILED WITH YOUR INSURANCE CARRIER IMMEDIATELY AFTER NOTICE OF INJURY.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS' COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

IF YOU HAVE QUESTIONS, THE STATE NOW HAS A BENEFIT REVIEW SYSTEM WHERE A WORKERS' COMPENSATION SPECIALIST CAN PROVIDE ASSISTANCE. CALL 1-800-332-2667 (TDD).

CITY | STATE | ZIP

EMPLOYER

EMPLOYER NAME

EMPLOYER FEIN

SIC CODE

PHONE NUMBER

EMPLOYER ADDRESS LINE 1 AND LINE 2

NATURE OF BUSINESS

CITY | STATE | ZIP

INSURED REPORT #

EMPLOYER LOCATION

POLICY

INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)

POLICY NUMBER

SELF INSURED? ☐ YES ☐ NO

EFF DATE

EXP DATE

EMPLOYMENT STATUS CODE
- ☐ FULL TIME/REGULAR
- ☐ PART TIME
- ☐ PIECE WORKER
- ☐ SEASONAL
- ☐ VOLUNTEER
- ☐ APPRENTICE FULL TIME
- ☐ APPRENTICE PART TIME

EMPLOYEE

EMPLOYEE LAST NAME

PHONE INCL AREA CODE

FIRST | MI

DEPARTMENT REGULARLY WORKED

ADRRESS LINE 1 & 2

GENDER
- ☐ MALE
- ☐ FEMALE
- ☐ UNKNOWN

OCCUPATION DESCRIPTION

CITY | STATE | ZIP

MARITAL STATUS
- ☐ UNMARRIED, SINGLE, DIVORCED
- ☐ MARRIED
- ☐ SEPARATED
- ☐ UNKNOWN

NCCI CLASS CODE

SSN | DATE OF BIRTH | DATE OF HIRE

WAGE

WAGE $

PERIOD
- ☐ HOURLY
- ☐ DAILY
- ☐ WEEKLY
- ☐ BI-WEEKLY
- ☐ MONTHLY

NUMBER OF DAYS WORKED PER WEEK

SALARY CONTINUED IN LIEU OF COMPENSATION ☐ YES ☐ NO

FULL WAGES PAID FOR DATE OF INJURY ☐ YES ☐ NO

ACCIDENT/INJURY

DATE OF INJURY

TIME OF INJURY ☐ AM ☐ PM ☐ COULD NOT BE DETERMINED

TIME EMPLOYEE BEGAN WORK ON INJURY DATE ☐ AM ☐ PM

DATE EMPLOYER NOTIFIED OF INJURY

BODY PART AFFECTED CODE

NATURE OF INJURY CODE

CAUSE OF INJURY CODE

DATE CLAIM ADM NOTIFIED OF INJURY

DATE LAST DAY WORKED

DATE DISABILITY BEGAN

RETURN TO WORK DATE (IF APPLICABLE)

HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.

DATE OF DEATH (IF APPLICABLE)

IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP
- ☐ WIDOW
- ☐ WIDOWER
- ☐ MOTHER
- ☐ FATHER
- ____ DAUGHTER
- ____ SON
- ____ SISTER
- ____ BROTHER
- ____ HANDICAPPED CHILD

TOTAL # DEPENDENTS

DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)

CITY | STATE | ZIP

COUNTY OF INJURY

TREATMENT

PHYSICIAN NAME

HOSPITAL OR OFF SITE TREATMENT NAME

ADDRESS LINE 1 AND 2

ADDRESS LINE 1 AND 2

CITY | STATE | ZIP

CITY | STATE | ZIP

INITIAL TREATMENT
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYER
- ☐ MINOR BY CLINIC/HOSPITAL
- ☐ HOSPITALIZED > 24 HRS
- ☐ EMERGENCY CARE
- ☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

DATE PREPARED | PREPARER'S NAME & TITLE | PREPARER'S COMPANY NAME | PHONE NUMBER

AUTHORIZATION FOR ACCESS BY PATIENT OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Medical Record #_____

Date of Birth: _____ Social Security # _____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name of Individual/Facility/Company to Receive PHI:

Vericlaim, Inc. on behalf of Catholic Mutual Group
and Church Mutual Insurance Company
131 Saundersville Rd., Suite 220
Hendersonville TN 37075

Name of Individual/Facility to Disclose PHI:

_____
_____
_____
_____

Information authorized for use or disclosure, or to be obtained:

- All medical information concerning this patient.
- Medical information of this patient compiled between _____ to _____
- Only: _____

The information will be obtained, used, or disclosed for the following purpose(s) only:

☐Insurance ☐Continued treatment ☐Legal ☐At the request of the patient's representative ☐Other (specify) _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Federal law may subject to redisclosure by the recipient and no longer protect information used or disclosed pursuant to this authorization.
- Federal law may subject to redisclosure by the recipient and no longer protect information used or disclosed pursuant to this authorization. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease

_____ _____
Signature of Patient or Representative Date

_____ _____
Representative's Relation to Patient Expiration Date of Authorization

_____ _____
Signature of Witness Date

NOTICE OF RIGHTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

ACCIDENT INVESTIGATION REPORT

I. Identification of the Accident:

Name of Injured: _____ Date of Accident: _____

Time of Accident: _____ Location of Accident: _____

II. Nature of Injury:

Exact part of body affected and type of injury: _____

_____

Description of HOW and WHY accident occurred:

_____

_____

_____

Names of witnesses: _____

III. Accident Prevention Information:

Equipment, tool, or item causing injury: _____

Was accident caused by failure to use or observe safety practices, policies, or regulations? _____

IV. Corrective Action:

What corrective action can be done to prevent a recurrence of this accident/injury?

_____

_____

Comments/Recommendations (by Safety Committee, Safety Director, or Supervisor):

_____

_____

Person(s) responsible for corrective action: _____

_____

Safety Director/Manager Review: _____

_____

_____ _____

Signed Date