RPS Atlas Workers' Compensation Program 040997

Gallagher Bassett Nevada WC Claims Kit for Endurance Assurance Corporation Claims

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Accident Reporting Instructions

FOR SERIOUS OR LIFE-THREATENING INJURIES, CALL 911 OR TAKE EMPLOYEE TO NEAREST EMERGENCY ROOM IMMEDIATELY

Effective 7/1/2025 forward, Gallagher Bassett is the claims administrator for RPS Atlas's workers' compensation Endurance Assurance Corporation claims. Claims should be reported via one of the following methods:

1) **Telephonic reporting:** 833-378-4031
2) **Fax:** 866-668-7780
   - Please use the attached claim reporting form
3) **Email reporting**: Atlasworkcompclaims@gbtpa.com
   - Please use the attached claim reporting form

- Report all accidents/injuries immediately. Delays in reporting can significantly increase claim costs.
- Reporting a claim is NOT an admission that the claim is compensable. GB will investigate all accidents and determine if workers' compensation benefits are due.

Helpful information to have on hand when reporting new incidents:

CLIENT INFORMATION

- Client Number: Your GB client number is **040997**

INJURED EMPLOYEE INFORMATION

- Name
- Employee ID number
- Social security number
- Date of Birth
- Address and home phone number
- Personal email address
- Date of hire
- Marital Status
- Number of dependents
- Policy number (if known)
- Policy effective date (if known)

ACCIDENT INFORMATION

- Date and time of injury
- Location (city and state) of employer location
- Specific description of injury (i.e., employee slipped and fell on wet floor in warehouse)
- Any unsafe behavior that contributed to the accident
- Name and address of injured employee's physician or facility, if treatment already obtained for the injury

Gallagher Bassett Customer Support

GB Toll Free 833-707-6338

Obtaining medical care for your injured employee:

FOR SERIOUS OR LIFE-THREATENING INJURIES, CALL 911 OR TAKE EMPLOYEE TO NEAREST EMERGENCY ROOM IMMEDIATELY

To locate in-network providers near your locations at:

www.talispoint.com/cvty/gbppo

Through this site you can choose from several options to request the providers. Searches can be done by address, name, region, as well as a quick search which is a preformatted search using a limited number of specialties for providers who provide initial treatment of WC injuries only. Outcome Based Network (OBN) providers are identified by a rainbow circle design before their name. The site also provides you with the capability of creating your own preformatted worksite posters. There is also a selection to look up state rules which gives you a brief description of the state rules that apply to your direction of medical care for each state.

GB Care Pharmacy Benefit Management Program

First Fill Program – this program allows the injured employee to obtain their first fill of medication with no out-of-pocket expense to the employee. When filling a prescription, injured workers simply present the First Fill information to the pharmacy. Once the pharmacy verifies eligibility, injured employees are enrolled.

With over 68,000 contracted pharmacies, including all major pharmacy chains, our unique program design enables injured workers to receive prescriptions without incurring out of pocket expenses and ensures appropriate medications are dispensed during each stage of recovery. The injured employee can also call 1.844.276-2515 to find participating pharmacies.

Benefits of the program include:

- No out-of-pocket expense for injured workers. Injured employees can fill their prescriptions on demand (up to 30-day supply of medical) simply by presenting their myMatrixx information to the pharmacy.
- Home Delivery Programs – for qualified injured employees, myMatrixx offers home delivery of medications. Depending upon past use and type of injury, the system automatically identifies those who might benefit, providing added convenience and promoting their recovery.

Occupational Injury Temporary Prescription ID Card

GBCARE | myMatrixx by Evernorth

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved work-related injury prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 844-276-2515.

Atención Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 844-276-2515.

To the Pharmacist:

myMatrixx, an Express Scripts company administers this occupational accident prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of $500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 844-276-2515.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

myMatrixx, an Express Scripts Company

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ / _____ / _____
MM/DD/YYYY

Group #: NZEA

Employee Date of Birth: _____ / _____ / _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor:

Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

RPS Atlas Workers Compensation Program

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

GBGO Mobile App

- Your injured employee will receive an acknowledgement letter giving them their claim number and resolution manager contact information, along with information on accessing GBGO, our mobile app:

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

gbgo

gbgo
mygbclaim

GBGO® — Taking claims management mobile

In a world that keeps moving, GB delivers the best possible claim experience to both clients and injured workers. Through GBGO, a mobile suite that provides faster and better communication, GB keeps all parties engaged throughout the claims process and improves overall satisfaction with the claim experience.

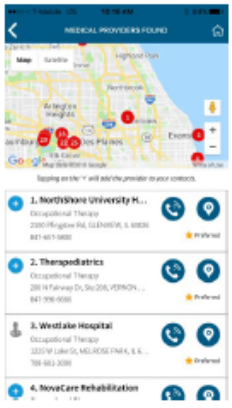
The GBGO MYGBCLAIM App lets injured workers manage their claim anytime, anywhere from their Apple or Android smartphone. The app is secure, easy to use and reliable. The following is a list of features currently supported.

Existing Features

- GBGO SMART bar – Access personalized messages, notifications, reminders, FAQs, and more
- Payments - View benefit payments history and get notifications related to payment updates, enroll in Direct Deposit
- Doctor Appointments - Input your next doctor appointment and let the app track it and remind you.
- Medical Cards - Access digital versions of the Medical Card and the Pharmacy card (Rx Card) with 'one click'.
- Connect with your RM - Phone or email your GB RM (Resolution Manager) with 'one click'.
- Report Release to Return to Work and request your RM (Resolution Manager) to update your contact information from the app.
- FAQs - Access answers to frequently asked questions 24 x7
- App feedback - Tell us what you think
- Experience the app in Spanish
- Pre-Claim Access – Access your Medical Awareness Card (MAC) after your call with the PC365 Nurse
- Claim Contacts – Add, Manage and Access Claim Contacts from one screen – RM, Providers and Pharmacies. Call or get directions to the provider location with one click
- Provider and Pharmacy Search – Search for a Preferred medical provider or pharmacy near you
- Attachments – Send attachments (Doctor Notes, Mileage Reimbursement requests etc.) to your RM directly from the App

Upcoming New Features

- Messaging capabilities



How to:

- Download the app from the Apple or Google app store by following the links below or search for GBGO mygbclaim
- Click on "Register" link at the top of the home screen. Follow the instructions and create an account to start accessing information about your claim
- In case of questions do not hesitate to email or call-us using the links at the bottom of the home page

For Apple devices:

Download on the App Store

For Android Devices:

GET IT ON Google Play

WHEN PEOPLE ARE EMPOWERED THEY CAN ACHIEVE AMAZING THINGS. THAT'S THE POWER OF GBGO.

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

gbgo

mygbclaim

GBGO®— Llevando la administración móvil de reclamos

En un mundo que sigue en movimiento, GB ofrece la mejor experiencia de reclamo posible tanto para clientes como para trabajadores lesionados. A través de GBGO®, una suite móvil que brinda una comunicación más rápida y mejor, GB mantiene a todas las partes involucradas a lo largo del proceso de reclamos y mejora en general la satisfacción con la experiencia del reclamo.

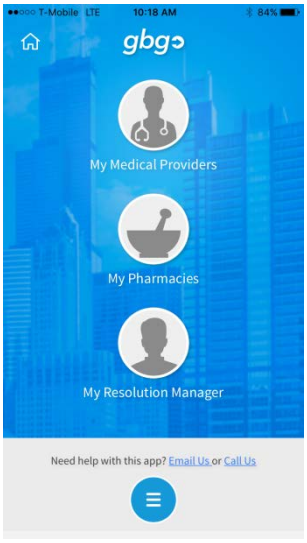
La aplicación GBGO MYGBCLAIM permite a los trabajadores lesionados gestionar su reclamo en cualquier momento y en cualquier lugar desde su teléfono inteligente Apple o Android. La aplicación es segura, fácil de usar y confiable. La siguiente es una lista de las funciones actualmente soportadas.

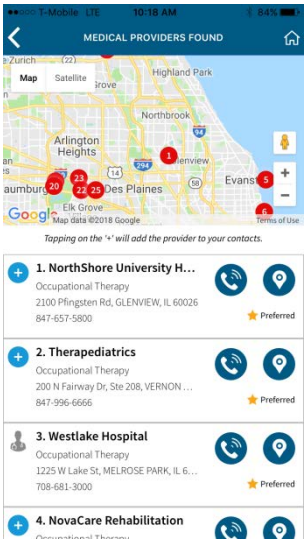
Funciones existentes

- GBGO® SMART bar - Acceder a mensajes personalizados, notificaciones, recordatorios, preguntas frecuentes y más.
- Pagos - Ver el historial de pago de prestaciones y recibir notificaciones relacionadas con las actualizaciones de pago.
- Citas Médicas - Ingrese su próxima cita con el médico y permita que la aplicación la rastree y le envíe un recordatorio.
- Tarjetas médicas - Acceda a las versiones digitales de la Tarjeta médica y la Tarjeta de la farmacia (Tarjeta Rx por sus siglas en Inglés) con 'un clic'.
- Conéctese con su Gerente de Resolución (RM por sus siglas en Inglés) - Por teléfono o envíe un correo electrónico a su GB RM con 'un clic'.
- Reporte la Alta de Regreso a Labores y solicite a su Gerente de Resolución (RM por sus siglas en Inglés) que actualice su información de contacto desde la aplicación.
- Preguntas frecuentes - Acceda a las respuestas a las preguntas frecuentes 24 x 7.
- Comentarios de la aplicación - Díganos lo que piensa.
- Experimente la aplicación en español

Nuevas funciones (serán liberadas el 14 de mayo)

- Acceso previo al reclamo - Acceda a su tarjeta de reconocimiento médico (MAC, por sus siglas en inglés) después de su llamada con la enfermera PC365.
- Contactos del Reclamo - Agregue, administre y acceda a los contactos del reclamo desde una pantalla - Gerente de Resolución, Proveedores y Farmacias. Llame u obtenga indicaciones sobre la ubicación del proveedor con un clic.
- Búsqueda de proveedores y farmacias - Busque un proveedor médico o farmacia preferida cerca de usted.
- Archivos Adjuntos - Envíe archivos adjuntos (notas del médico, solicitudes de reembolso de millas, etc.) a su Gerente de Resolución directamente desde la aplicación.





Cómo:

- Descargar la aplicación desde App Store o Google Play siguiendo los enlaces que se muestran en la parte inferior o busque GBGO® mygbclaim.
- Haga clic en el enlace "Registrarse" en la parte superior de la pantalla de inicio. Siga las instrucciones y cree una cuenta para comenzar a acceder a la información sobre su reclamo
- En caso de preguntas, no dude en enviarnos un correo electrónico o llamarnos usando los enlaces en la parte inferior de la página de inicio

Para dispositivos Apple:

Download on the App Store

Para dispositivos Android:

GET IT ON Google Play

CUANDO LAS PERSONAS ESTÁN EMPODERADAS, PUEDEN LOGRAR COSAS INCREÍBLES. ESE ES EL PODER DE GBGO.

Reset Form

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Name of Employer _____

Name of Employee		Social Security Number	Telephone Number
Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)	
What is the nature of the injury or occupational disease?		List any body parts involved:	
Briefly describe accident or circumstances of occupational disease: (Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)			
Names of witnesses:			
Did the employee leave work because of the injury or occupational disease? ☐ YES ☐ NO	If yes, when (date and time)?	Has the employee returned to work? ☐ YES ☐ NO	If yes, when (date and time)?
Was first aid provided? ☐ YES ☐ NO	If yes, by whom?	Name and address of treating physician, if applicable or known	
Did the accident happen in the normal course of work? (if applicable) ☐ YES ☐ NO			
Was anyone else involved? ☐ YES ☐ NO	Names of others involved		

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature Date

Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

For assistance with Workers' Compensation Issues you may contact the State of Nevada for Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov

Employee should sign, date and retain a copy.

Original to Employer, Copy to Employee

C-1 (Rev. 02/20)

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED

First Name	M.I.	Last Name	Birthdate	Sex ☐ M ☐ F	Claim Number (Insurer's Use Only)

Home Address	Age	Height	Weight	Social Security Number

City	State	Zip	Telephone

Mailing Address	City	State	Zip	Primary Language Spoken

INSURER	**THIRD-PARTY ADMINISTRATOR**	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred

Employer's Name/Company Name	Telephone

Office Mail Address (Number and Street)

Date of Injury (if applicable)	Hours Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported

Address or Location of Accident (if applicable)

What were you doing at the time of the accident? (if applicable)

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?	Witnesses to the Accident (if applicable)

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE, OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERAN ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHROIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date Place Employee's Original or * Electronic Signature

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place Name of Facility

Date / Hour	Diagnosis and Description of Injury or Occupational Disease	Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☐ No ☐ Yes (if yes, please explain)

Treatment:	Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from _____ to _____ ☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty If modified duty, specify any limitations/restrictions: _____
X-Ray Findings:	
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☐ Yes ☐ No	
Is additional medical care by a physician indicated? ☐ Yes ☐ No	

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date	Print Health Care Provider's Name	I certify that the employer's copy of this form was delivered to the employer on:

Address			INSURER'S USE ONLY
City State Zip	Provider's Tax I.D. Number	Telephone	
Health Care Provider's Original or Electronic Signature		Degree (MD, DO, DC, PA-C, APRN) Choose (if applicable)	

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C 4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Office Mail Address	Location . . . If different from mailing address		Telephone
City State Zip	**INSURER**		**THIRD-PARTY ADMINISTRATOR**

EMPLOYEE

First Name M.I. Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Home Address (Number and Street)	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
City State Zip	Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No		How long has this person been employed by you in Nevada?	
In which state was employee hired?	Employee's occupation (job title) when hired or disabled		Department in which regularly employed:	
Telephone	Is the injured employee a corporate officer? ☐ Yes ☐ No . . . sole proprietor? ☐ Yes ☐ No . . . partner? ☐ Yes ☐ No		Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No	

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
Address or location of accident (Also provide city, county, state) (if applicable)			Accident on employer's premises? (if applicable) ☐ Yes ☐ No
What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)			
How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.			

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)		Witness	Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No
Part of body injured or affected	If fatal, give date of death	Witness	
Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)		Witness	
		Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No	Will you have light duty work available if necessary? ☐ Yes ☐ No
If validity of claim is doubted, state reason		Location of Initial Treatment	
Treating physician/chiropractor name		Emergency Room ☐ Yes ☐ No	Hospitalized ☐ Yes ☐ No

IMPORTANT How many days per week does employee work?	From ☐ am ☐ pm To ☐ am ☐ pm		Last day wages were earned
Scheduled days off S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐	Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No		

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
Was the employee hired to work 40 hours per week? ☐ Yes ☐ No	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know	

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	Emloyee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY	On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the State of Nevada Office of the Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title | Date

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

State of Nevada
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

A T T E N T I O N

Caution: The information below is general in nature and is not intended to be legal advice. If you have any questions regarding your status as an employer or employee or your rights and qualification for specific benefits under an industrial injury or occupational disease claim, you should consult with an attorney experienced in industrial insurance.

Brief Description of Whether the Employer is Required to Obtain Industrial Insurance and Whether a Person is a Covered Employee

Every employer … shall provide and secure compensation … for any personal injuries by accident sustained by an employee arising out of and in the course of the employment. See NRS 616B.612(1).

An **employer** is defined as, "Every person, firm, voluntary association and private corporation, including any public service corporation, which has in service any person under a contract of hire." See NRS 616A.230(2). "A person is not an employer …. if: (a) The person enters into a contract with another person or business which is an independent enterprise; and (b) The person is not in the same trade, business, profession or occupation as the independent enterprise." See NRS 616B.603(1).

An **employee** is broadly defined as, "… every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed" (See NRS 616A.105), but excludes casual employees not in the same trade, business, profession or occupation; persons engaged as a theatrical or stage performer or in an exhibition; musicians not lasting more than 2 consecutive days; household servants, farming and ranching employees; voluntary ski patrol; sports officials paid a nominal fee; clergy, rabbi or lay readers; real estate brokers or sales persons; and commissioned sales persons (See NRS 616A.110).

An **independent contractor** is a person who is hired and paid solely to produce a result. It is defined as, "… any person who renders service for a specified recompense for a specified result, under the control of the person's principal as to the result of the person's work only and not as to the means by which such result is accomplished." See NRS 616A.255.

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

Notice of Injury or Occupational Disease (Incident Report Form C-1) If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

Employee's Claim for Compensation/Report of Initial Treatment (Form C-4): If medical treatment is sought, the Form C-4 is available at the place of initial treatment. A completed Form C-4 must be filed within 90 days after an accident or OD. The treating physician, chiropractic physician, physician assistant or advanced practice nurse must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractic physician from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered a contract with an MCO or PPO, you may select a physician or chiropractic physician from the Panel of Physicians and Chiropractic Physicians. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractic physician to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation, your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractic physician as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a lump-sum PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeals Officer's decision. You may be represented by an attorney at your own expense, or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a Hearing Officer decision, you may request that NAIW represent you without charge at an Appeals Officer hearing. NAIW is an independent state agency and is not affiliated with any insurer. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact Workers' Compensation Section, 1886 East College Pkwy. Ste. 100, Carson City, NV 89706, telephone (775) 684-7270, or 3360 W. Sahara Ave., Suite 250, Las Vegas, NV 89102, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the State of Nevada Office for Consumer Health Assistance, 7150 Pollock Drive, Las Vegas, NV 89119, Toll Free 1-888-333-1597, Website: https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/, E-mail cha@govcha.nv.gov

The information in this publication is derived from Chapters 616A through 616D, inclusive, and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administrator:_____ Contact Person: _____

Address:_____ Telephone Number: _____
City State Zip

MCO/Health Care Provider:_____ Contact Person: _____

Address:_____ Telephone Number: _____
City State Zip

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

Notice of Injury or Occupational Disease (Incident Report Form C-1): If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the required forms.

Employee's Claim for Compensation/Report of Initial Treatment (Form C-4): If medical treatment is sought, the Form C-4 is available at the place of initial treatment. A completed Form C-4 must be filed within 90 days after an accident or OD. The treating physician, chiropractic physician, physician assistant or advanced practice nurse must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractic physician from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractic physician from the Panel of Physicians and Chiropractic Physicians. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

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Claim Number _____

INJURED EMPLOYEE'S REQUEST FOR COMPENSATION
(Pursuant to NRS 616C.475(6))

ANSWER ALL QUESTIONS, DATE, SIGN AND RETURN TO YOUR CLAIMS AGENT

1. Name: _____ Social Security # _____ Phone No: _____

2. Physical address: _____
Street City State Zip

Mailing address: _____
Street/P.O.Box City State Zip

Is this a change of address? [ ] Yes [ ] No

3. Employer at time of injury: _____
4. Supervisor's name: _____
5. Name of your attending physician or chiropractor: _____
6. Date on which you were last examined by attending physician or chiropractor: _____
7. Date of next appointment with physician or chiropractor: _____
8. a. Have you been released to return to work by your attending physician or chiropractor? [ ] Yes [ ] No
   b. If so, give the date of release: _____
9. a. Have you returned to work with another employer? [ ] Yes [ ] No
   b. Are you receiving payment from any employer? [ ] Yes [ ] No
   c. Date on which you returned to work: _____
   d. Name of employer for whom you returned to work: _____
   e. Address: _____
10. Have you been disabled and unable to work in <u>any</u> <u>occupation</u> for at least 5 consecutive days, or 5 cumulative days within a 20 day period? [ ] Yes [ ] No
11. Date on which you last worked: _____ For Whom: _____
12. When do you expect to be able to return to your regular occupation? _____
13. Would you be able to work at a light duty type job now? [ ] Yes [ ] No
    Comment: _____
    _____
    _____
14. Has your employer offered you a light duty type job? [ ] Yes [ ] No
    a. If yes, when was the light duty job offered? _____

Per NRS 616D.300, I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits. Further, I understand falsification may subject me to civil and criminal penalties. I certify the above information is correct to the best of my knowledge.

_____ _____
Date Signature

_____
CITY COUNTY STATE

NOTE: An explanation of the methods used to calculate your average monthly wage and compensation benefits should accompany your first compensation check. If you did not receive this, please contact your claims agent.

FOR CLAIMS AGENT'S USE ONLY

PAY: From _____ To _____ Rev. date _____
From _____ To _____ TT Final TT TP

_____ _____
Date Signature D-6 (Rev. 7/99)

EXPLANATION OF WAGE CALCULATION
Pursuant to NAC 616C.520(1)

The amount of disability compensation payable to an injured employee is based on his average monthly wage at the time of the accident. The compensation due is calculated on a calendar day basis, and paid at the rate of 66 2/3% of the average monthly wage, subject to the statutory limitation that creates a maximum average monthly wage benefit that is 150% of the state-calculated average monthly wage. If disabled for at least five consecutive days, or five cumulative days within a 20-day period, each day of disablement, including and following the five days, is compensable. When a doctor releases the injured employee to work or he returns to work on his own, the eligibility for disability ceases.

ITEMS INCLUDED IN THE AVERAGE MONTHLY WAGE
Pursuant to NAC 616C.423

The calculation of your average monthly wage includes the following: wages or salary; commissions which are prorated over the period used to calculate the AMW; incentive pay; payment for sick leave; bonuses which are prorated over the period used to calculate the average monthly wage; termination pay; tips which are collected and disbursed by the employer and are not paid at the discretion of the customer; tips you report pursuant to NRS 616B.227; payment for piecework, tool allowance, vacation, holidays, overtime, and travel time; and value of room and/or board. Concurrent employment with another employer may be included.

Items which cannot be included are: employment not subject to coverage under NRS 616A to 616D, inclusive or chapter 617 of NRS, or elective employment which has not been elected; reimbursement for job related expenses, including per diem and travel, and allowances for laundry or uniforms.

In certain instances, wages are determined by statute. Compensation will be based on that wage.

If your average monthly wage exceeds the State Average Monthly Wage, compensation will be based on the State Average Monthly Wage.

CALCULATION OF THE AVERAGE MONTHLY WAGE

A wage history of a period of 12 weeks must be used to calculate the average monthly wage. If a 12-week period is not representative of your average monthly wage, the following methods are to be used.

A period of one year, or the full period of employment if less than one year, may be used. It **must** be used if the average monthly wage would be increased; or pursuant to NAC 616C.435(3), if employee is a member of a labor organization and regularly employed by referrals from that office, wages from all employers for one year must be used if the average monthly wage would be increased.

If employed less than 12 weeks, but for a period not less than four weeks, wages are averaged for the available period; or earnings based on piecework or a period of less than four weeks must be based on the rate of pay and projected working schedule, or on an average equal to other employees doing the same work.

The period used to calculate the AMW must consist of consecutive days immediately preceding your accident. Each day must be counted, with the following exceptions: A certified illness or disability; institutionalized in a hospital, or other; enrollment as a full-time student and not employed on days of attendance; military service other than weekend duty; an officially sanctioned strike; or absence due to approved leave pursuant to the Family and Medical Leave Act of 1993.

Concurrent wages for employment by two or more employers may also apply. NAC 616C.447 provides that the insurer shall advise an injured employee in writing of his eligibility for compensation for concurrent employment at time of the initial payment of compensation.

IF IT APPEARS THAT AN ERROR HAS BEEN MADE IN THE WAGE DETERMINATION, PLEASE CONTACT YOUR CLAIMS AGENT. AN EXPLANATION OF THE CALCULATION WILL BE PROVIDED. THE WAGE WILL BE REVISED UPON PRESENTATION OF DOCUMENTATION (CHECK STUBS, INCOME TAX FORM W-2, WAGE STATEMENT FROM THE EMPLOYER) WHICH SHOWS THE ORIGINAL WAGE DETERMINATION TO BE IN ERROR. A REVISED WAGE WILL BE USED TO RECALCULATE AND ADJUST COMPENSATION FOR PERIODS ALREADY PAID, AS WELL AS FUTURE COMPENSATION.

Request for Additional Medical Information And Medical Release

(Pursuant to NRS 616C.177 & 616C.490(5))

Injured Employee's Name: _____

Claim Number: _____ Social Security Number: _____

Injured Employee's Address: _____

Injury/Occupational Disease Date: _____ Date this Notice Printed: _____

Insurer's Name: _____ Employer: _____

Insurer's Address: _____ Employer's Address: _____

Please provide the information requested below, sign and date the form, and return it to your insurer. Your signature on this form also acts as a release to acquire information affecting your claim from other entities. Failure to fully complete and return this form to your claims agent in a timely manner could affect your benefits or delay the resolution of your claim.

Prior History Information

Please check the appropriate box below and provide the information requested.

☐ **I have no prior conditions, injuries or disabilities of which I am aware, that might affect the disposition of the claim referenced above. Note - if you checked this box, no further information is needed at this point.**

☐ **I have a prior condition, injury or disability that could affect the disposition of the claim referenced above. This can include birth defects, prior surgeries, injuries, etc., whether work-related or not. Note - if you checked this box, indicating a pre-existing condition, please explain in detail in the space below. Please attach additional sheets of paper to this form if necessary to fully explain the condition.**

I have provided this information to obtain the benefits of the Nevada Industrial Insurance Act and/or the Nevada Occupational Diseases Act (NRS 616A to 616D, inclusive, and/or NRS 617). I hereby authorize any physician, chiropractor, surgeon, practitioner, or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any insurance company, or other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to diagnosis, treatment and/or counseling for AIDS, psychological conditions, alcohol or controlled substances, for which I must give specific authorization.

1. If executed in Nevada: Pursuant to Nevada Revised Statutes ("NRS") 53.045, I declare under penalty of perjury that the foregoing is true and correct.

   Executed on _____ _____
   (date) (signature)

2. Except as otherwise provided in NRS 53.250 to 53.390, inclusive, if executed outside of Nevada: I declare under penalty of perjury under the law of the State of Nevada that the forgoing is true and correct.

   Executed on _____ _____
   (date) (signature)