



ASA

Agri-Services Agency
Leaders in Agricultural Insurance

P.O. Box 4910, Syracuse, NY 13221-4910 1-800-654-8840 Fax: 315-431-1310 www.Agri-ServicesAgency.com

Agrisurance, Inc.

Workers' Compensation



Claim Kit

2012

REDUCE THE COST OF YOUR CLAIMS & REDUCE YOUR PREMIUMS: CLAIMS REPORTED WITHIN 5 DAYS COST 30% LESS THAN CLAIMS REPORTED 21 - 30 DAYS AFTER INJURY.

Edition 10/11 (NY)



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Claim Forms Enclosed:

- A. Form C-2 (1-11) – Employer’s Report of Work Related Injury/Illness
- B. Form C-3.1 (3-04) – Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider

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I. Mandatory Claim Reporting Requirements

- A. Claims **MUST** be reported **within 24 hours** of the accident to **PMA Management Corporation** (see Page 4 of this Claim Kit for contact information)
- B. **Claim Form C-2 (1-11)** enclosed **MUST** be completed by the Employer (or, if necessary, a Third Party on Behalf of the Employer) in accordance with Section 110
 - 1. **Section 110 Requirements** [Please see the reverse side of Page 3 of Form C-2 (1-11) for the specific wording of Section 110.]
 - a. Form C-2 (1-11) has to be completed for any injury or illness incurred by one of its employees in the course of employment
 - b. A copy of Form C-2 (1-11) **must** be maintained by the employer **for at least 18 years**
 - c. Form C-2 (1-11) **must** be filed with the appropriate New York State Workers' Compensation Board (NYS WCB) District Office any time any accident resulting in personal injury caused or will cause a loss of time from regular duties of one day beyond the working day or shift on which the accident incurred, or which has required or will require medical treatment beyond ordinary first aid or more than two treatments by a person rendering first aid.

NOTE: If the above conditions apply, this form **must be filed with the NYS WCB District Office within 10 days** after the occurrence of the accident. An employer who refuses or neglects to make a report or to keep records as required above shall be guilty of a misdemeanor, punishable by a fine up to \$2,500.00

- 2. When required to file Form C-2 (1-11) with the NYS WCB, two copies must be made. One copy, for your records, and one copy has to be mailed to PMA Management Corporation (see Page 4 of this Claim Kit for address)
- 3. **If you feel a claim is not work related**, please complete a Form C-2 (1-11), indicate **“Negative Claim”** across the top of the claim form; please attach a narrative describing why you feel the claim is not work related and note names and contacts of any witnesses that may be able to corroborate your report; keep a copy for your records and mail a copy to PMA Management Corporation (See Page 4 of this Claim Kit for address)
- 4. Instructions, provided by the NYS WCB, are enclosed to assist you with completing Form C-2 (1-11) as required
 - a. Please refer to Page 3 of this Claim Kit to be sure you are providing the correct Company Name on this Form.
- 5. The bottom of Page 3 of Form C-2 (1-11) provides a reference to determine the appropriate NYS WCB District Office

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II. Insurance Carrier Information

Please refer to your new Workers' Compensation policy or the Form C-105 (1-11) (Your bulletin board posting notice) to obtain your Insurance Carrier name.

Your Insurance Carrier Name will be one of the following:

- A. United States Fidelity & Guaranty Insurance Company (USF&G)
- B. Fidelity & Guaranty Insurance Underwriters, Inc. (FGIU)
- C. Discover Property & Casualty (DP&C)
- D. Fidelity & Guaranty Insurance Company (FGIC)

Please Note: Agri-Services Agency, LLC (or ASA) should not be listed as the Insurance Carrier. ASA administers the Program, it is NOT the Insurance Company

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III. Claims Administration

Report Claims Within 24 Hours: Prompt reporting is required for any injury, accident or first aid claim. **Providing this information to PMA within 24 hours ensures timely assistance for your injured worker and will reduce your claim expense. Claims reported within 5 days cost 30% less than claims reported 21 to 30 days after injury.** (According to the Workers' Compensation Research Institute.)

PMA Management Corporation

If you are required to file a Form C-2 (1-11) (see Page 2 of this Claim Kit), please submit a copy via fax or mail using the information provided below;

If you are not required to file a Form C-2 (1-11) (see Page 2 of this Claim Kit) and wish to file a claim with PMA electronically, please refer to pages 5 – 9 in this Claim Kit for instructions. (Please remember you still have to complete a Form C-2 (1-11) to document the accident/injury/illness and maintain with your records for up to 18 years.)

Fax first report of injury to:

1-888-329-2721

(If you fax it, you do not have to mail it.)

or

Mail first report of injury to:

PMA Management Corporation
PO Box 25250
Lehigh Valley, PA 18002

If you have questions regarding a claim or workers' compensation benefits, please call the primary contact for PMA Management Corporation or one of the following contacts:

Primary Contact:

Art Hellinger, Senior Account Claim Representative
1-800-329-6185, ext. 7214
e-mail: Art_Hellinger@pmagroup.com

Additional Contacts:

- | | |
|---|--|
| 1. Georgianna Burdick, Senior Account Claim Representative
1-800-329-6185, ext. 0174
e-mail: Georgianna_Burdick@pmagroup.com | 4. Chuck Bolesh, Business Development
1-800-329-6185, ext. 0168
e-mail: Chuck_Bolesh@pmagroup.com |
| 2. Colleen Zielinski, Claims Administrator
1-800-329-6185, ext. 7204
e-mail: Colleen_Zielinski@pmagroup.com | 5. Lisa Blair, Administrative Assistant
1-800-329-6185, ext. 294
e-mail: Lisa_Blair@pmagroup.com |
| 3. Bill Halligan, Asst. Claims Manager
1-800-329-6185, ext. 7209
e-mail: William_Halligan@pmagroup.com | |

Faxes other than First Report of Injury to: 1-800-432-9762

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IV. Electronic Workers' Compensation Claim Reporting

1. Go to PMA's website: www.pmagroup.com
2. Click on the icon "Report a Claim".
3. Enter the **User Name (your 7 digit company code)**:
0042754 – United States Fidelity & Guarantee (USF&G)
0042739 – Fidelity & Guaranty Insurance Underwriters (FGIU)
0045997 – Discover Property & Casualty (DP&C)
0042747 – Fidelity & Guaranty Insurance Company (FGIC)
4. Enter the **Password - newclaim** (use lower case).

The **Location Information** window will display:

The screenshot shows a web browser window titled "The PMA Group - Risk Management Information System - Microsoft Internet Explorer". The address bar shows "https://claims.pmagroup.com/rmis/RMISframeset.asp". The page has a blue header with navigation links: Home, New Claim Entry, Help, and Exit. Below the header is a section titled "Enter Location Information" with a "Next" button. The main content area contains two input fields: "Ten Digit Location Number:" with the value "1111111110" and "Location Address / Name:". A red arrow points to the "Ten Digit Location Number" field.

5. Enter your **FEIN with a zero at the end** in the **Ten Digit Location Number** field.

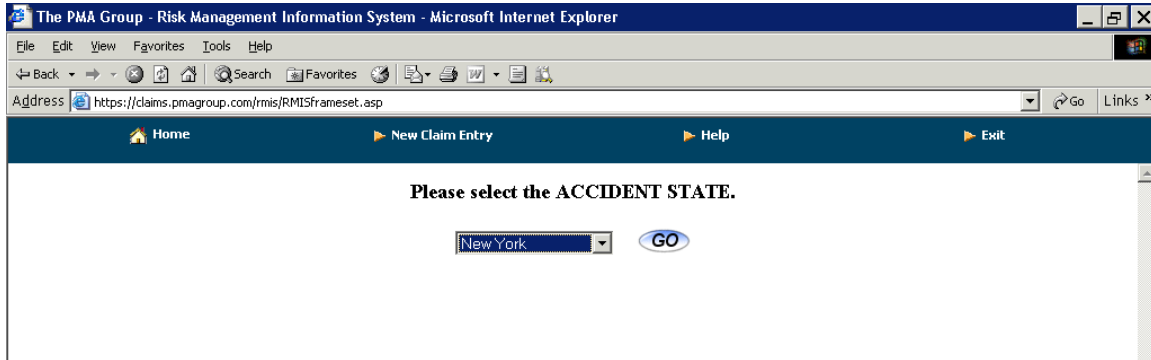
Note: YOU MUST ENTER YOUR FEIN.

Please call 1-800-654-8840 for help if you do not know your FEIN.

6. Select the **Next** button to navigate to the next window.

IV. Electronic Workers' Compensation Claim Reporting (cont'd)

The **Accident State** window will display:



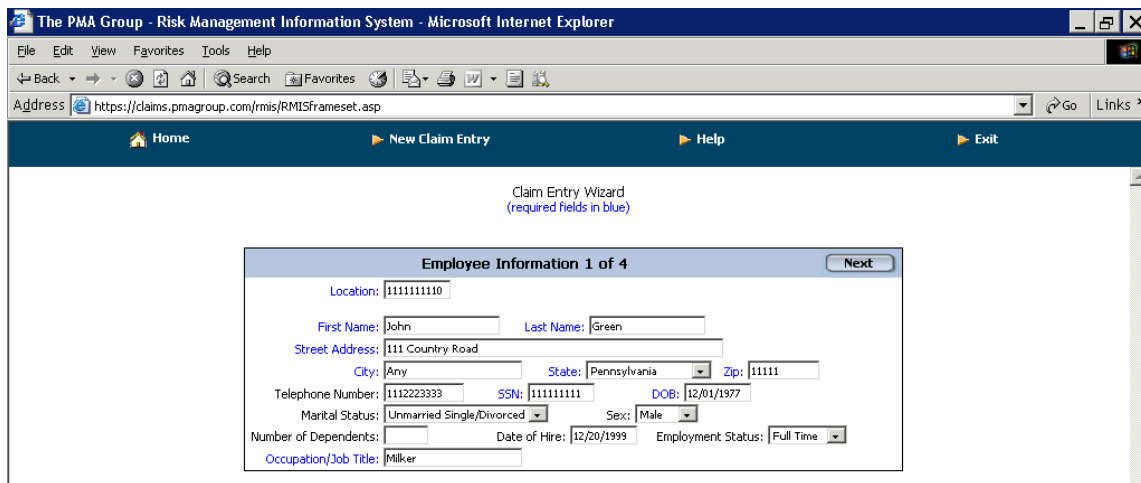
The screenshot shows a web browser window titled "The PMA Group - Risk Management Information System - Microsoft Internet Explorer". The address bar shows "https://claims.pmagroup.com/rmis/RMISframeset.asp". The page has a navigation bar with "Home", "New Claim Entry", "Help", and "Exit". The main content area displays the text "Please select the ACCIDENT STATE." followed by a dropdown menu currently set to "New York" and a "GO" button.

7. Select the **state where the accident occurred** from the drop-down menu

Tips for entering information in the following windows:

- Complete **all** fields. (The mandatory fields are in **BLUE**.)
- **Tab** to navigate from field to field.
- For date formats use: **MM/DD/YYYY**.

The **Employee Information** window will display:



The screenshot shows a web browser window titled "The PMA Group - Risk Management Information System - Microsoft Internet Explorer". The address bar shows "https://claims.pmagroup.com/rmis/RMISframeset.asp". The page has a navigation bar with "Home", "New Claim Entry", "Help", and "Exit". The main content area displays the text "Claim Entry Wizard (required fields in blue)". Below this is a form titled "Employee Information 1 of 4" with a "Next" button. The form contains the following fields:

Location:	1111111110		
First Name:	John	Last Name:	Green
Street Address:	111 Country Road		
City:	Any	State:	Pennsylvania
Zip:	11111		
Telephone Number:	1112223333	SSN:	111111111
DOB:	12/01/1977		
Marital Status:	Unmarried Single/Divorced	Sex:	Male
Number of Dependents:		Date of Hire:	12/20/1999
Employment Status:	Full Time		
Occupation/Job Title:	Milker		

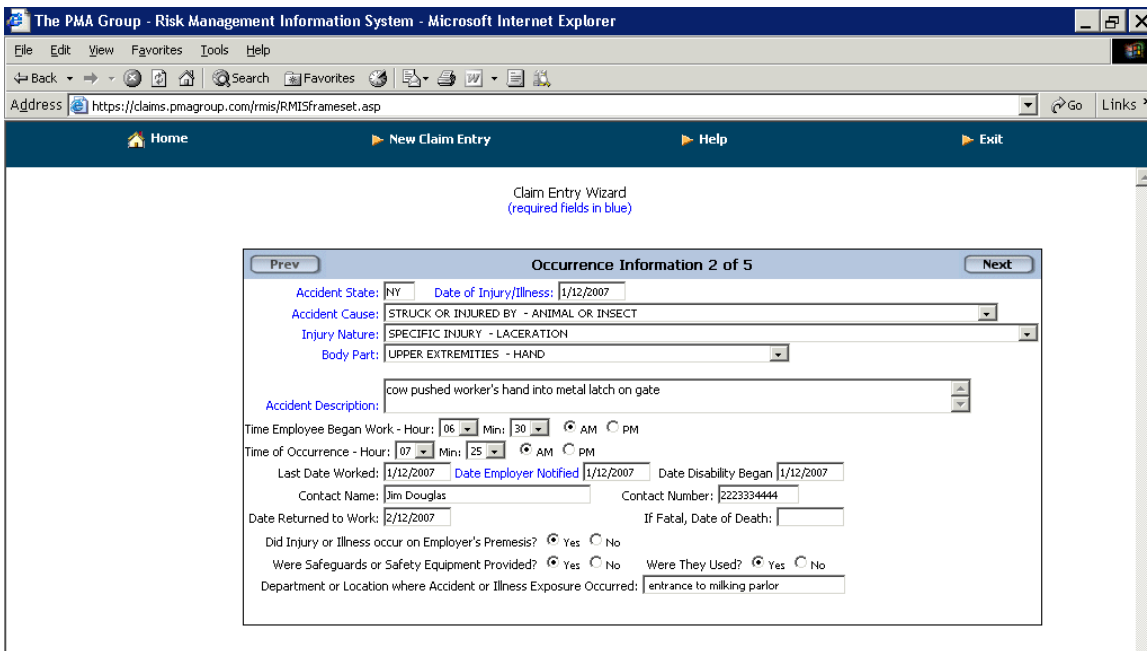
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IV. Electronic Workers' Compensation Claim Reporting (cont'd)

8. Enter the **injured employee's** information in **all** of the fields.

9. Select the **Next** button to navigate to the next window.

The Occurrence Information window will display:



10. Select the **Next** button to navigate to the next window.

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IV. Electronic Workers' Compensation Claim Reporting (cont'd)

The Treatment Information window will display:

The screenshot shows a web browser window titled "The PMA Group - Risk Management Information System - Microsoft Internet Explorer". The address bar shows "https://claims.pmagroup.com/rmis/RMISframeset.asp". The browser's menu bar includes "File", "Edit", "View", "Favorites", "Tools", and "Help". The browser's toolbar includes "Back", "Forward", "Home", "Search", "Favorites", "Print", "Stop", and "Go". The browser's status bar shows "Home", "New Claim Entry", "Help", and "Exit".

The main content area displays the "Claim Entry Wizard" with the instruction "(required fields in blue)". The wizard is titled "Treatment Information 3 of 5" and has "Prev" and "Next" buttons. The wizard contains three sections:

- Physician/Health Care Provider Name and Address:**
 - Name: Dr. David White
 - Address: 100 Main Street
 - City: Any
 - State: New York
 - Zip: 13021
- Hospital Name and Address:**
 - Name: General Hospital
 - Address: 110 Main Street
 - City: Any
 - State: New York
 - Zip: 13021
- Other Information:**
 - Witness Name: Anne Brown
 - Telephone Number: 4445556666
 - Date Prepared: 2/22/2007
 - Preparer's Name: John Smith
 - Telephone Number: 7778889999

11. Enter the applicable Physician, Hospital and "Other" information.

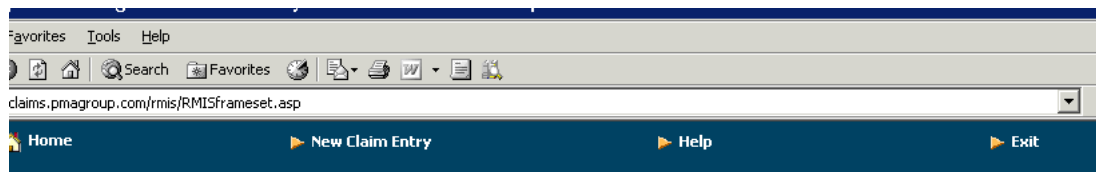
12. Select the **Next** button to navigate to the next window.

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IV. Electronic Workers' Compensation Claim Reporting (cont'd)

The Claim Submission window will display:



Claim Submission 4 of 4

The Claim Entry Wizard has been completed. You may add additional comments below and click the Submit button to send the data to PMA or click the "Prev" button to make additional changes.

Comments

Enter miscellaneous claim details including wage information or custom location codes in the comments box below.

Average weekly wage = 850

Record Only

Claim Information Email

Click on the checkbox below to receive an email copy of the claim information just entered.

Send Email copy to originator

Originator Email Address:

13. Enter any miscellaneous claim details in the **"Comments"** box.
14. Select the **"Send Email copy to the originator"** box to receive an email copy of the reported claim.
15. Enter your **Email address** in the **Originator Email Address Field**.
16. Select the **"Submit Claim"** button to transmit the claim information to PMA.

**For assistance with electronic claim filing, please call the PMA Call Center at:
1-888-476-2669**

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V. Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider – Form C-3.1 (3-04)

In New York State, the Third Party Administrator cannot direct the medical care of an injured employee to a specific doctor. In situations where the employer takes an

injured employee for urgent or non-urgent care, the New York State Workers' Compensation Board (NYS WCB) requires that the injured employee sign the C-3.1 (3-04) form at the time of treatment, except with severe injuries. In these cases, please have the form signed as soon as practicable. The signed form acknowledges that the injured employee can choose either the treating doctor or another doctor of his or her choice.

The NYS WCB requires the employer to provide a copy of the signed C-3.1 (3-04) form to the injured employee and shall maintain the original form in the employer's records where it may be inspected by the Workers' Compensation Board at any time. Keeping this form in your file protects you, as the employer, by providing proof that your injured worker realizes his or her right to select a health care provider.

Your continued emphasis on monitoring loss control activities to provide a safe place for your employees to work is important for the success of the program. Should you have an injury, please promptly report the claim to PMA Management Corp (instructions on pages 4 through 9 of this Claim Kit)

Remember, claims MUST be reported within 24 hours of the accident. This immediate reporting of a claim will assist with the initial investigation of the claim, reduce claim costs and can lead to a prompt return to work for the injured employee.