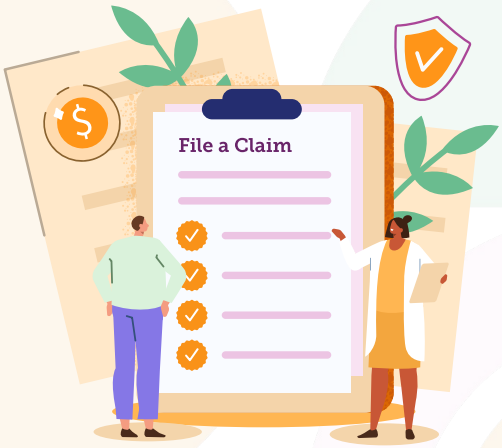
PIE INSURANCE



How to respond to a workplace injury:

For life-threatening medical emergencies, call 911.

For non-life-threatening injuries, call the 24/7 Nurse Line at (844) 581-0828 to report the incident and get your employee the right care

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Workers' comp claims
You can file your first report of injury for a workers' comp claim in three simple ways:
Call the 24/7 claim intake line within 24 hours of the incident: **(844) 581-0828**

Submit the claim information online here

Email the claims team within 24 hours of he incident: **claims@pieinsurance.com**

- **In your email, please include the following:**
- The name of your business
- The policy number
- Reporting party's contact information (name. phone, email)
- The name, phone, and email address of the injured employee
- Date of the injury or accident
- A description of the injury or accident

Thank you.

STATE OF DELAWARE FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

Department of Labor
Office of Workers' Compensation (OWC)
4425 N. Market Street
Wilmington, DE 19802
Telephone 302-761-8200

OWC Case File No. _____

ALL INFORMATION IS REQUIRED, unless not applicable where "if applicable" is noted.

1.EMPLOYEE: FIRST MIDDLE LAST		2. EMPLOYEE SOCIAL SECURITY NO.
3. **ADDRESS – INCLUDE COUNTY AND ZIP CODE**	4. **MALE** ☐ **FEMALE** ☐ **UNSPECIFIED** ☐	5. **EMPLOYEE PHONE NUMBER (INCLUDING AREA CODE)**

6. DATE OF BIRTH / /	7.AGE	8. WAGE	9. WEEKLY HOURS WORKED

10. OCCUPATION (REGULAR)	11. DEPARTMENT OR DIVISION REGULARLY EMPLOYED	12. HOW LONG EMPLOYED

13. **EMPLOYER:**	14. **PERSON MAKING OUT THIS REPORT**
15. ADDRESS - INCLUDE COUNTY AND ZIP CODE	16. EMPLOYER PHONE# (INCLUDE AREA CODE)
17. MAILING ADDRESS-IF DIFFERENT THAN ABOVE	18. NATURE OF BUSINESS -TYPE OF MFG., TRADE, CONSTRUCTION, SERVICE, ETC.

19. **WORKERS' COMPENSATION INSURANCE CARRIER**	20. **WORKERS' COMP INS. CARRIER PHONE # (INCLUDING AREA CODE)**
21. WORKERS' COMP. INSURANCE CARRIER ADDRESS	22. POLICY NUMBER/ CARRIER CASE NUMBER:
23. THIRD PARTY ADMINISTRATOR (TPA), IF APPLICABLE	24. TPA ADDRESS- INCLUDE CITY STATE AND ZIPCODE

DATES: 25. DATE OF REPORT / /	26. DATE OF INJURY / /	27. NORMAL STARTING TIME AM ☐ PM ☐	28. IF EMPLOYEE BACK TO WORK GIVE DATE / /	29. AT SAME WAGE? YES ☐ NO ☐

30. IF FATAL INJURY, GIVE DATE OF DEATH / /	31. DATE EMPLOYER KNEW OF INJURY / /	32. DATE DISABILITY BEGAN / /	33. LAST FULL DAY PAID-DATE / /

INJURY OR DISEASE:

34. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.

35. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.

OCCURRENCE:

36. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE USED WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.

37. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, E.G. LIFTING A PATIENT.

38. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED.

39. NAME OF PHYSICIAN (IF APPLICABLE)	40. PHYSICIAN'S ADDRESS
41. HOSPITAL (IF APPLICABLE)	42. HOSPITAL ADDRESS

DISTRIBUTION OF THIS REPORT (1 original and 3 copies)

1. ORIGINAL MUST BE SENT IMMEDIATELY TO THE WORKERS' COMPENSATION INSURANCE CARRIER.
2. COPY TO THE OFFICE OF WORKERS' COMPENSATION (use the address at the top left of this form)
3. EMPLOYER'S COPY - RETAIN AS RECORD
4. EMPLOYEE'S COPY

WORKERS' COMPENSATION

IMPORTANT THINGS TO DO IN CASE OF INJURY

THE EMPLOYER SHOULD:

1. Provide all necessary medical, surgical and hospital treatment from the date of accident.
2. Every employer shall keep a record of all injuries received by employees and make a report within 10 days thereof in writing to the Office of Workers' Compensation
3. Ascertain the average weekly wages of the employee and provide compensation in accordance with the provisions of the law, for disability *beyond the third day* after the accident. All agreements as to compensation must be submitted to the Office of Workers' Compensation for approval.

THE EMPLOYEE SHOULD:

1. Immediately notify the employer in writing of accidental injury or occupational disease and request medical services. Failure to give notice or to accept medical services may deprive the employee of the right to compensation.
2. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the law, file application with the Industrial Accident Board for a hearing on the matters at issue within two years of the date of accidental injury or one year of knowledge of the diagnosis of an occupational disease or an ionizing radiation injury. All forms can be obtained from the Office of Workers' Compensation.

Fox Valley Offices
4425 North Market Street- 3rd Floor
Wilmington, DE 19802
(302) 761-8200

Georgetown American Job Center
8 Georgetown Plaza, Suite 2
Georgetown, DE 19947
(302) 856-5230

Departamento de Trabajo de Delaware
División de Asuntos Industriales

Blue Hen Corporate Center
655 S Bay Road, Ste. 2H
Dover, DE 19901
(302) 422-1134

University Office Plaza
252 Chapman Road, 2nd Floor
Newark, DE 19702
(302) 761-8200

Correo electrónico: wages@delaware.gov | Correo electrónico: workpermits@delaware.gov | Sitio web: Labor.delaware.gov

INDEMNIZACIÓN POR ACCIDENTE LABORAL

MEDIDAS IMPORTANTES QUE LLEVAR A CABO EN CASO DE LESIONES

EL EMPLEADOR DEBE:

Tener una cobertura de seguro de indemnización por accidente laboral. Brindar todo tratamiento médico, quirúrgico y hospitalario necesario desde la fecha del accidente. Cada empleador debe llevar un registro de todas las lesiones sufridas por los empleados y presentar un informe dentro de los diez (10) días desde ese momento por escrito a la Oficina de Indemnización por Accidente Laboral. Determinar los salarios semanales promedio del empleado y brindar indemnización de acuerdo con las disposiciones legales por discapacidad después del tercer día luego del accidente. Todos los acuerdos en relación con la indemnización deben presentarse ante la Oficina de Indemnización por Accidente Laboral para su aprobación.

EL EMPLEADO DEBE:

Notificar de inmediato al empleador por escrito acerca de una lesión por accidente o enfermedad laboral y solicitar servicios médicos. El incumplimiento en la notificación o en la aceptación de servicios médicos pueden privar al empleado del derecho a recibir indemnización. Notificar al empleador de inmediato, de forma directa o a través de un supervisor, sobre cualquier reclamo de indemnización por el período de discapacidad luego del tercer día después del accidente. En caso de lesiones mortales, la notificación debe realizarla uno o más dependientes del fallecido o una persona en su nombre. En caso de no llegar a un acuerdo con el empleador en relación con la indemnización conforme a la ley, presentar una solicitud ante la Junta de Accidentes Industriales para tener una audiencia sobre los temas en cuestión dentro de los dos (2) años de la fecha de la lesión por accidente o de un (1) año del conocimiento de un diagnóstico de enfermedad laboral o una lesión de radiación ionizante. Todos los formularios pueden obtenerse en la Oficina de Indemnización por Accidente Laboral.

WORKERS' COMPENSATION

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252 Chapman Road, 2nd Floor
Newark, DE 19702
(302) 761-8200

DEPARTMENT OF LABOR
DIVISION OF INDUSTRIAL AFFAIR

Email: dol_dia_workcomp@delaware.gov | Email: dol_dia_wc_compliance@delaware.gov | Website: Labor.delaware.gov

WORKERS' COMPENSATION

IMPORTANT THINGS TO DO IN CASE OF INJURY

THE EMPLOYER SHALL:

Carry Workers' Compensation Insurance Coverage per Title 19, Chapter 23, 2303. Every employer shall keep of record of all injuries received by employees; and within 10 days, file a First Report of Injury with the Office of Workers Compensation as per Title 19, Chapter 23, 2313. In addition, the employer should notify their Workers' compensation Insurance carrier of said injury. First Report of Injury forms are available on our website listed above

THE EMPLOYEE SHALL:

Or someone on the employee's behalf, notify the employer as soon as possible of an accidental injury or occupational disease and request medical services if needed. Failure to give notice or to accept medical services may deprive the employee of the right to compensation. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf. In case of failure to reach an agreement with the employer in regard to compensation under the law, file a petition with the Industrial Accident Board for a hearing on the matters at issue within two (2) years of the date of accidental injury. All forms can be obtained from the Office of Workers' Compensation. (Email: dol_dia_workcomp@delaware.gov)

It is unlawful to retaliate against an employee because (s)he has made a complaint or given information to the Dept of Labor about possible labor law violations.

DELAWARE DEPARTMENT OF LABOR

Violations of Delaware Worker's Compensation Labor Laws could result in fines.

Revised 1/27/2023

PRINT

Official Print Size - 8.5" x 11"
Compliance Ready - Do Not Scale