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.

VERMONT

DEPARTMENT OF LABOR

Employer's Liability and Workers' Compensation

NOTICE TO EMPLOYEES

This employer, _____ , has complied with the provisions of Title 21 of the Vermont Statutes, Annotated §687, by obtaining Workers' Compensation Insurance coverage through:

Pie Insurance (844) 581-0828

(Insurance Carrier)

Workers' Compensation benefits for lost time, medical expenses, disability or death because of a work-related injury are available through the above named company.

- **An injured employee MUST immediately notify his/her employer of an injury.**
- **The employer MUST file an Employee Claim and Employer's First Report of Injury (Form 1) with the Vermont Department of Labor within 72 hours of the notice of an injury that requires medical attention or results in time lost from work. The employer must also provide a copy of the Form 1 to the injured worker and to the insurance carrier.**
- **If the employer fails to file a First Report, an employee may file a Notice of Injury and Claim for Compensation (Form 5) with the Vermont Department of Labor within six months of the date of injury.**
- **Information concerning injured worker rights and benefits is available on the department's Workers' Compensation website at http://www.labor.vermont.gov or by calling (802) 828-2286.**

Equal Opportunity is the Law

The State of Vermont is an Equal Opportunity/Affirmative Action Employer. Applications from women, individuals with disabilities, and people from diverse cultural backgrounds are encouraged. Auxiliary aids and services are available upon request to individuals with disabilities. 711 (TTY/Relay Service) or 802-828-4203 TDD (Vermont Department of Labor).

ESTADO DE VERMONT

Responsabilidades de la Empresa Contratante & Indemnización por Accidentes Laborales (*Workers' Compensation*)

NOTIFICACIÓN A LOS EMPLEADOS

ESTA EMPRESA CONTRATANTE, _____,
HA CUMPLIDO CON LAS DISPOSICIONES DEL TÍTULO 21 DE LOS ESTATUTOS DEL ESTADO DE VERMONT, ANOTADAS EN LA § 687, ASEGURÁNDOSE BAJO UNA PÓLIZA DE SEGURO CONTRA ACCIDENTES LABORALES EMITIDA POR:

Pie Insurance (844) 581-0828

(COMPAÑÍA DE SEGUROS)

EL EMPLEADO DE ESTA COMPAÑÍA TIENE DERECHO A SER INDEMNIZADO POR EL TIEMPO PERDIDO, GASTOS MÉDICO GENERADOS, INCAPACIDAD SUFRIDA O LA MUERTE, SI ÉSTOS FUESEN ATRIBUIBLES A UNA LESIÓN RELACIONADA CON SU TRABAJO.

- **LA LESIÓN SUFRIDA TENDRÁ QUE SER REPORTADA INMEDIATAMENTE A LA COMPAÑÍA CONTRATANTE POR EL EMPLEADO LESIONADO.**

- **LA EMPRESA CONTRATANTE TENDRÁ QUE REMITIR UNA RECLAMACIÓN A NOMBRE DEL EMPLEADO Y PRESENTAR EL PRIMER REPORTE DE UNA LESIÓN EN EL FORMULARIO CORRESPONDIENTE (FORMULARIO 1) ANTE EL MINISTERIO DE ASUNTOS LABORALES E INDUSTRIALES (*THE DEPARTMENT OF LABOR AND INDUSTRY*), POR CONCEPTO DE CUALQUIER LESIÓN QUE REQUIERA ATENCIÓN MÉDICA O QUE RESULTARA EN LA PÉRDIDA DE TIEMPO LABORAL. LA EMPRESA TENDRÁ QUE REMITIR DICHA RECLAMACIÓN Y REPORTE DENTRO DE 72 HORAS DESPUÉS DE HABER RECIBIDO NOTIFICACIÓN DE LA LESIÓN. LA EMPRESA CONTRATANTE TAMBIÉN LE TENDRÁ QUE PROPORCIONAR UNA COPIA DEL FINALIZADO FORMULARIO 1 AL EMPLEADO LESIONADO Y A LA COMPAÑÍA DE SEGUROS.**

- **SI LA EMPRESA CONTRATANTE NO CUMPLIERA CON LA PRESENTACIÓN DEL PRECITADO PRIMER REPORTE, EL EMPLEADO PODRÁ LLENAR Y REMITIR EL FORMULARIO 5 TITULADO *NOTIFICACIÓN DE LESIÓN Y RECLAMACIÓN PARA INDEMNIZACIÓN* (*NOTICE OF INJURY AND CLAIM FOR COMPENSATION—FORM 5*) ANTE EL MINISTERIO DE ASUNTOS LABORALES E INDUSTRIALES DENTRO DE SEIS MESES, CONTADOS A PARTIR DE LA FECHA DE LA LESIÓN.**

- **SI DESEA INFORMACIÓN REFERENTE A LOS DERECHOS Y BENEFICIOS DEL EMPLEADO LESIONADO VISITE EL *WEB SITE* DE SEGURO CONTRA ACCIDENTES LABORALES http://www.state.vt.us/labind/wcindex.htm O SÍRVASE LLAMAR AL (802) 828-2286**

FORMULARIO 31 2/03

NOTICE

This is a translation of a document originally drawn up in English. Accordingly, it is understood that all legal rights, responsibilities and/or obligations are governed by the original English version of this document.

ADVERTENCIA

Ésta es la traducción de un documento originalmente redactado en inglés. Consiguientemente, hágase saber que todos los derechos legales, responsabilidades y/u obligaciones expresadas en el mismo se regirán por la versión original del documento redactada en inglés.

NOTICE

Workers' Compensation Reinstatement Rights

VERMONT LAW REQUIRES POSTING OF THIS NOTICE

21 VSA §643b Reinstatement; seniority and benefits protected

This law provides that an employer who regularly employs **ten or more** people (at least 10 of whom work more than 15 hours a week), has an obligation to rehire a worker who has suffered a work related injury **provided** that the following conditions are met:

1. The worker recovers from the injury within two (2) years of the onset of disability; and
2. The worker keeps the employer informed of his or her interest in reinstatement and his or her current mailing address; and
3. The worker had an expectation of continuing work had the injury not occurred; and
4. The worker is physically capable of performing either his or her prior job, if available, or an alternative suitable position.

Reinstatement must be with all benefits earned up to the date of injury, including both seniority and accrued leave time. Obviously, such benefits need not accrue **during** the period of actual disability.

Please note that the right to reinstatement applies only to the first **available** suitable job. Thus, the employer is not obligated either to create an "extra" position for a returning worker or to lay-off a current employee in order to comply with this law.

Should you have questions regarding the above, please contact the Vermont Department of Labor, Workers' Compensation and Safety Division at 802-828-2286 or our website: www.labor.vermont.gov.

www.labor.vermont.gov

FOR FURTHER INFORMATION CONTACT:

Vermont Department of Labor
P. O. Box 488
Montpelier, Vermont 05601-0488
Email: **LABOR.WCComp@vermont.gov**
Telephone: (802) 828-2286
TDD: (800) 650-4152
Fax: (802) 828-2195

VERMONT
DEPARTMENT OF LABOR

VERMONT

DEPARTMENT OF LABOR – ATTN: WORKERS' COMPENSATION
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

Form 1 (Rev. 9/11)
(Approved for use as OSHA 101 and 301)

State File No. _____

EMPLOYER FIRST REPORT OF INJURY

Answer every question fully and report promptly to avoid a penalty. Employer's Federal ID Number and Employee Social Security Number MUST be provided.

EMPLOYER

1. Legal Name:	2. Business Name:
3. Mail Address: No. and Street / City / State / Zip	
4. Location (if different from Mail Address):	5. Telephone Number, Extension and Contact Person.:
6. Nature of Business (list principal products or service of concern):	7. Do you regularly employ 10 or more employees? ☐ Yes ☐ No / 8. Federal ID No.:

EMPLOYEE

9. Name: First Name	Middle Initial	Last Name	10. Social Security No.:	11. Date of Birth:
12. Home Address: No. and Street		13. Home Phone No.:	14. Work Phone No:	15. Age:
City	State	Zip	16. Job Title:	17. Sex: ☐ M ☐ F
18. Wages $ Per	Hours Per Day Days Per Week	19. If board, lodging, etc. were furnished in addition to wages, state estimated value: $	20. Was employee hired in VT? ☐ Yes ☐ No	21. Date of Hire

ACCIDENT

22. Date of Accident:	Accident Time: AM PM	Began Shift: AM PM	23. Location of Accident: Town or City State
24. Machine, tool, object, motor vehicle or substance directly causing injury:			
25. On employer's premises? ☐ Yes ☐ No	If yes, name of department:		
26. Describe what employee was doing:	Was this the employee's regular occupation? ☐ Yes ☐ No		
27. How did accident occur? Describe events leading up to the accident:			

INJURY

28. Describe the injury and the part of the body injured.				**29. Was this a first-aid only injury:** ☐ Yes ☐ No
30. Any Lost Time? ☐ Yes ☐ No	If yes, date disability began	Last date paid in full:	31. Employee returned to work? ☐ Yes ☐ No	If yes, date / Medical Only Incident: Yes ☐ No ☐
32. Did injury result in death? ☐ Yes ☐ No	If yes, date of death.			
33. Name and address of Physician:				
34. Name and address of Hospital:			Remained Overnight ☐ Yes ☐	No

INS

35. Insurance Company Named on Workers' Compensation Policy	35A. Claim Administrator
Name in full: _____	Company Name _____
Policy No.	Phone Number
Signed by: _____	
Employer or Representative / Title / Date	

Equal Opportunity is the Law