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 NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law (RSA 281-A: 19) to report promptly to your employer an occupational injury or disease, even if you deem it to be minor. Form No. 8WCA, Notice of Accidental Injury or Occupational Disease, may be used for that purpose (RSA 281-A: 20, 21). After you have completed the form and made it available to him or her, your employer must acknowledge receipt by signing and giving you a copy.
2. You are entitled to the services of a physician. This physician shall be within a managed care network, if applicable under RSA 281-A: 23-a.
3. You may not sue your employer as a result of a work connected injury or disease by reason of your eligibility for benefits under the Workers' Compensation Law.

TO EMPLOYERS

1. You are required to display this poster so that it will be of the greatest possible benefit to your employees (RSA 281-A: 4).
2. You are required to file an Employer's First Report of Injury or Occupational Disease, Form No. 8 WCA, with the Labor Commissioner as soon as possible, but no later than five days after learning of the occurrence of any injury (RSA 281-A:53, I). A copy of this form must also be provided to the nearest claims office of your insurance carrier unless the injury requires one-time treatment costing under $2,000 and you pay the medical bill within 30 days. (RSA 281-A: 53, I and Lab 504.02). If the injury requires any additional treatment or results in lost time, you must notify your insurance carrier of the injury (Lab 504.02).
3. You are required to report to the Labor Commissioner any occupational disability, whether total or partial, of four or more days (RSA 281-A:22), on an Employer's supplemental Report of Injury, form No 13 WCA, as soon as possible but no later than ten days after the date of knowledge thereof (RSA 281-A:53, I and II).
4. You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation to an injured or disabled employee in accordance with RSA 281-A:23, 25, 26, 28, 29, 31, and 32.
5. All employers with 5 or more full time employees shall develop temporary alternative work opportunities for injured employees in accordance with RSA 281-A:23-b. Employer may be obligated to reinstate employees sustaining a compensable injury in accordance with RSA 281-A: 25-a.
6. You are required to obtain from the carrier identified below a supply of all required workers' compensation forms. NOTICE- Violation of the various provisions of the Workers Compensation Law carries civil penalties, court fines or both.

Danielle N. Albert
Deputy Labor Commissioner

Ken Merrifield
Commissioner of Labor

The undersigned employer hereby gives notice of compliance with all provisions of the workers' Compensation Law and Administrative Regulations of the Labor Commissioner of the State of New Hampshire pursuant to Revised Statutes Annotated, Chapter 281-A:, as amended

Name of Insurance Company
Or self-insurer:

Name of Employer:

By

Employer Identification No.
(If number unknown, Employer to request from IRS)

This notice must be posted conspicuously in and about the employer's place or places of business.

Prescribed by Labor Commissioner
State of New Hampshire
WCP-1 (01-24)

STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR

WORKER'S RIGHT TO KNOW ACT

Revised Statutes Annotated Chapter 277-A, as amended

EMPLOYEES

YOU HAVE A RIGHT TO KNOW ABOUT TOXIC SUBSTANCES USED IN THIS WORKPLACE

The New Hampshire "Right to Know" law (RSA 277-A) guarantees that:

- You be notified by a posting of the long and short-term health hazards of all toxic substances that you may come into contact with.
- You be trained by your employer in the safe use and handling of these toxic materials.
- You have the right to request complete information, in the form of a Material Safety Data Sheet, from your employer on any toxic substance you may have contact with. Your employer must respond to this request within five working days.

To learn more about the toxic materials used in this workplace, and to obtain Material Safety Data Sheets, contact the employer representative listed below.

_____

(EMPLOYER REPRESENTATIVE'S NAME)

INSPECTION DIVISION
95 PLEASANT ST.
CONCORD NH 03301
(603) 271-1492 & 271-3176

Danielle N. Albert
Deputy Commissioner

Ken Merrifield
Commissioner

Rev. 02-01-18

State of New Hampshire
Department of Labor

Criteria to Establish an Employee or Independent Contractor

"Employee" means and includes every person who may be permitted, required, or directed by any employer, in consideration of direct or indirect gain or profit, to engage in any employment, but shall not include any person exempted from the definition of employee as stated in RSA 281-A:2, VI(b)(2), (3), or (4), or RSA 281-A:2, VII(b), or a person providing services as part of a residential placement for individuals with developmental, acquired, or emotional disabilities, or any person who meets all of the following criteria:

(a) The person possesses or has applied for a federal employer identification number or social security number, or in the alternative, has agreed in writing to carry out the responsibilities imposed on employers under this chapter.

(b) The person has control and discretion over the means and manner of performance of the work, in that the result of the work, rather than the means or manner by which the work is performed, is the primary element bargained for by the employer.

(c) The person has control over the time when the work is performed, and the time of performance is not dictated by the employer. However, this shall not prohibit the employer from reaching an agreement with the person as to completion schedule, range of work hours, and maximum number of work hours to be provided by the person, and in the case of entertainment, the time such entertainment is to be presented.

(d) The person hires and pays the person's assistants, if any, and to the extent such assistants are employees, supervises the details of the assistants' work.

(e) The person holds himself or herself out to be in business for himself or herself or is registered with the state as a business and the person has continuing or recurring business liabilities or obligations.

(f) The person is responsible for satisfactory completion of work and may be held contractually responsible for failure to complete the work.

(g) The person is not required to work exclusively for the employer.

INSPECTION DIVISION
95 PLEASANT ST.
CONCORD NH 03301
(603) 271-1492 & 271-3176

Danielle N. Albert
Deputy Commissioner

Ken Merrifield
Commissioner

THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE

Rev. 02-01-18

LAB 500

New Hampshire

Employer's First Report of Injury

Submission Date:

WEB-8WC –

NHDOL# -

EMPLOYEE INFORMATION					
Employee Name (First & Last)		**Gender**	**Hired Date**		**Hired in NH**
ID Type - Employee ID	**Date of Birth**	**Age**	**Occupation when Injured**		
Employee Address	**Telephone**	**Wages per Hour**	**Hrs per Day**	**Days per Week**	**Average Weekly Earnings**

INJURY INFORMATION				
Injury Date / Time	**Date Employer Notified of Injury**	**Location/Jobsite & Business Name where accident occurred**		
Disability Began Date				
Claim Type	**Full Wages Paid on Injury Date**			
Accident Description				
Body part Injured		**Cause of Injury**		
Nature of Injury		**Witness Name**	**Witness Phone**	
Returned to work?	**If so, what date?**	**If so, at what occupation?**	**If so, at what duty status?**	
Initial Treatment			**Initial Treatment Date**	
Name of Treating Physician		**Name of Treating Hospital**	**Has injured died? If so, what date**	

EMPLOYER INFORMATION			
Employer Name		**Employer FEIN**	**Industry Code**
Employer Contact Name	**Contact Phone Number**	**Employer Business Address**	
Managed Care Organization			
Leased Employee? Client Company		**OCIP/Wrap-Up Policy? Name of policy holder**	

INSURER INFORMATION			
Insurance Carrier	**Insurer Type**	**Policy Number**	**Telephone Number**

SUBMITTER INFORMATION			
Submitter Name	**Title of Submitter**	**Represents**	**Telephone Number**

To file this report, email to firstreport@dol.nh.gov Fax Number: (603)271-0126 or
Mail to: NH Department of Labor Workers' Compensation Division 95 Pleasant St. Concord NH 03301