BerkleyNet | a Berkley Company

NOTICE:
MINNESOTA WORKERS COMPENSATION

This business operates under Minnesota Workers Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, OR AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR OR FOREMAN OF THE EMPLOYER.

Workers Compensation insurance benefits are provided through:

BerkleyNet

To report a claim, contact us at:

Website: berkleynet.com
Email: claims@berkleynet.com
Address: 9301 Innovation Drive, Suite 200, Manassas, VA 20110
Phone: 877.497.2637
Fax: 866.275.6320

Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5030

First Report of Injury

See Instructions on Reverse Side
PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA Case #		
3. DATE OF CLAIMED INJURY	4. Time of injury ☐ am ☐ pm	5. Time employee began work on date of injury ☐ am ☐ pm	
6. EMPLOYEE Name (last, first, middle)	7. Gender ☐ M ☐ F	8. Marital Status ☐ Married ☐ Unmarried	
9. Home Address	10. Home phone #	11. Date of birth	
City State Zip Code	12. Occupation	13. Regular department	14. Date hired

15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week	19. Employment Status ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer
20. Weekly value of:	Meals	Lodging	2nd Income	21. Apprentice ☐ Yes ☐ No

22. **Tell us how the injury occurred and what the employee was doing before the incident (give details).** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No If no, indicate name and address of place of occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI
	28. Date employer notified of injury	29. Date employer notified of lost time
	30. Return to work date	31. Date of death

32. TREATING PHYSICIAN (name, address, and phone)	33. HOSPITAL/CLINIC (name and address) (if any)	34. Emergency Room Visit ☐ Yes ☐ No
		35. Overnight in-patient ☐ Yes ☐ No

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)	
38. **Mailing** address	39. Employer FEIN	40. Unemployment ID#
City State Zip Code	41. Employer's contact name and phone #	
42. **Physical** address (if different)	43. Witness (name and phone)	
City State Zip Code	44. NAICS code	45. Date form completed

46. **INSURER** name		51. **CLAIMS ADMIN COMPANY** (CA) name (check one) ☐ Insurer ☐ TPA	
47. Insured legal name		52. CA address	
48. Policy # or self-insured certificate #		City State Zip Code	
49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. Claim #

Copies to: Insurer, Employer, Employee, and Workers' Compensation Division (if no insurer)

GENERAL INSTRUCTIONS TO THE EMPLOYER

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. Self-insured employers have 14 days to file this form with the Department of Labor and Industry (Department). It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will forward a copy of this form** to the Department, if necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form within **seven** days of the occurrence.

Employers are required to complete this form. Each piece of information is needed to determine liability and entitlement to benefits. Failure to complete the form may result in delayed processing and possible penalties. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department's web site at www.doli.state.mn.us. Employees are not responsible for completing this form.

SEND REPORT TO INSURER IMMEDIATELY – DO NOT WAIT FOR DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS FOR COMPLETING THIS FORM

- Item 2: OSHA Case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 15-20: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and notify your insurer if the employee misses time due to this injury after that date.
- Item 39: Fill in your Federal Employment ID number (FEIN). For information on this number, see www.firstgov.gov and click on Employer ID Number under Business.
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR/SELF-INSURED EMPLOYER

The following data elements must be completed on this form prior to filing with the Department of Labor and Industry: employee's name and social security number; date of injury; and the names of the employer and insurer. If any of this information is missing, the First Report will be rejected and returned to you (per Minn. Stat. § 176.275). Providing the name of the third party administrator does not meet the statutory requirement to provide the name of the insurer. NOTE: If the claim does not involve lost time beyond the waiting period or potential PPD, the form does **NOT** need to be filed with the Department.

- Item 46: Fill in the name of the insurance company. If the employer is self-insured, indicate the name of the licensed or public self-insured company or group.
- Items 47-48: Fill in the legal name of the employer who purchased the policy from the insurer (named in Item 46) and the policy number. If the employer is licensed to self-insure, fill in the certificate number.
- Item 49: Fill in the insurer's Federal Employment ID number (FEIN) number.
- Item 51: Fill in the name and address of the company administering the claim (either the insurer or third party administrator). Be sure to mark either the "Insurer" or "TPA" box.
- Item 53-54: Fill in the claims administrator's FEIN and claim number.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Rehabilitation Rights and Responsibilities of the Injured Worker

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	

The purpose of vocational rehabilitation is to assist you (the injured worker) so that you may return to your former job, to a job related to your former employment, or to a job in another work field. The job should be physically appropriate and produce an economic status as close as possible to that which you would have enjoyed without disability.

The first step in this return to work process is a Rehabilitation Consultation with a Qualified Rehabilitation Consultant (QRC) to determine if you qualify for rehabilitation services. If the QRC determines that you are qualified, the next step is the development of a rehabilitation plan. Your QRC will help you develop and implement this plan. Consideration will be given to your former employment, the current labor market and your qualifications, including transferable skills, previous work history, age, education and interests.

YOUR RIGHTS

Under the provisions of the Minnesota Workers' Compensation Law, you (the injured worker) ***have certain rehabilitation rights. These rights include:***

- Selection of your own Qualified Rehabilitation Consultant (QRC). The employer/insurer will generally refer you to a QRC. You may choose your own QRC up to 60 days after a written rehabilitation plan is filed with the State. Any further change of QRC must be mutually agreed upon or determined to be in the best interest of the parties by the Commissioner or a compensation judge.
- When a QRC first meets or writes to contact you, he or she is required to disclose to you in writing, any affiliation or ownership interest between the QRC (or the QRC firm) and your employer/insurer or adjusting company. The QRC is also required to disclose to you and all parties to a case, any affiliation or business referral arrangement between the QRC (or the QRC firm) and any other parties to the case, including attorneys and doctors.
- If the QRC determines that you are eligible for vocational rehabilitation, a rehabilitation plan, which may include training if needed, will be developed. The rehabilitation services required to carry out the plan will be provided at no cost to you.
- The right to request a change in your rehabilitation plan.
- The right to receive a copy of your rehabilitation plan. The right to obtain a copy of any required progress records upon request.
- The right to request assistance from the Workers' Compensation Division of the Minnesota Department of Labor and Industry. If you have questions about your rehabilitation plan, call 651-284-5032 or 800-342-5354. If there is a dispute about your eligibility for statutory rehabilitation services or the rehabilitation plan, you may file a Rehabilitation Request and the Department may schedule an administrative conference in order to resolve the dispute.

WID or SSN	DATE OF INJURY	EMPLOYEE NAME

YOUR RESPONSIBILITIES

In addition to the above rights, you (the injured worker) have certain rehabilitation responsibilities under the workers' compensation law. ***These responsibilities include the following:***

- You must cooperate with reasonable medical and rehabilitation examinations and evaluations as ordered by the Commissioner.
- You must make a good faith effort to participate in your rehabilitation plan. Failure to do so may result in suspension or termination of your rehabilitation or monetary benefits.
- You must advise your QRC and insurance company of your wage, hours, employer and job title when you return to work with any employer and when your hours or wages change. This is necessary to accurately calculate your wage loss benefits and to ensure rehabilitation services are appropriate. Failure to accurately report wages earned while receiving workers' compensation benefits may result in civil or criminal consequences.

The statements below are requested to verify whether you received the documents listed and that the information on this form has been explained to you. You are not required to provide the information requested below or sign this form. Your workers' compensation benefits will not be affected if you choose not to provide the information or sign the form. This form will be filed with the Minnesota Department of Labor and Industry, and may also be provided to the Office of Administrative Hearings and law enforcement agencies.

Employee, check any that apply:

☐ The above information has been explained to me and I have been provided with a copy of this form.

☐ I have received written notification from the QRC disclosing any affiliation or business referral arrangement the QRC or QRC firm may have with any parties to my case and a written explanation of any affiliation or ownership interest the QRC or QRC firm may have with my employer/insurer, and any other insurer or adjusting company.

☐ The QRC has informed me that he/she and the QRC firm have no affiliation or ownership interest or business referral arrangement with any parties to my case or any other insurer or adjusting company.

EMPLOYEE SIGNATURE		DATE
QRC SIGNATURE	QRC NUMBER	DATE

PROVIDING THE INFORMATION ON THIS FORM TO THE INJURED WORKER IS REQUIRED BY MINNESOTA STATUTES SECTION 176.102, SUBD. 4C AND MINNESOTA RULES, PART 5220.1803, SUBP. 1 AND 1A.

THIS MATERIAL CAN BE MADE AVAILABLE IN DIFFERENT FORMS, SUCH AS LARGE PRINT, BRAILLE OR ON TAPE. TO REQUEST, CALL (651) 284-5030 OR 1-800-342-5354 (DIAL-DLI)/VOICE OR TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

The QRC must sign and date this form at the first in-person contact with the employee, and must provide a copy to the employee and the insurer. The QRC must also provide a copy of this form to the Department of Labor and Industry.

Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032
1-800-342-5354 (DIAL-DLI)

Derechos de Rehabilitación y Responsabilidades del Trabajador Lesionado

(Rehabilitation Rights and Responsibilities of the Injured Worker – Spanish version)

Escriba las fechas en el formato MM/DD/AAAA.

NO USE ESTE ESPACIO

IDENTIFICACIÓN DE TRABAJADOR (WID) O NÚMERO DE SEGURO SOCIAL (SSN)	FECHA DE LA LESIÓN
NOMBRE DEL EMPLEADO	

El propósito de la Rehabilitación Vocacional es ayudarle a usted (el trabajador lesionado) de manera que pueda regresar a su trabajo anterior, a un trabajo relacionado con su empleo anterior, o a un trabajo en otro campo de trabajo. El trabajo debe ser físicamente apropiado y debe proporcionarle una condición económica tan cercana como sea posible a la que usted disfrutaba sin la incapacidad.

El primer paso en este proceso de regresar al trabajo es una Consulta de Rehabilitación con un Consejero de Rehabilitación Calificado (QRC, por sus siglas en inglés) para determinar si califica para los servicios de rehabilitación.
Si el QRC determina que usted califica, el próximo paso es desarrollar un plan de rehabilitación. Su QRC le ayudará a desarrollar e implementar este plan. Se dará consideración a tales factores como su empleo anterior, el mercado laboral actual y sus calificaciones, incluyendo destrezas transferibles, historial del trabajo previo, edad, educación e intereses.

SUS DERECHOS

Bajo las disposiciones de la Ley de Compensación de Trabajadores Accidentados en el Trabajo en Minnesota, usted (el trabajador lesionado) ***tiene ciertos derechos de rehabilitación. Estos derechos incluyen:***

- Selección de su propio Consejero de Rehabilitación Calificado (QRC). El empleador/asegurador por lo general lo referirá a un QRC. Usted puede elegir su propio QRC hasta 60 días después de que se presente un plan de rehabilitación por escrito al Estado. Cualquier cambio posterior de QRC deberá ser acordado mutuamente o el Comisionado o un juez de compensación deberá determinar el que sea para el mayor beneficio de las partes.
- Cuando un QRC se reúne o le escribe por primera vez para ponerse en contacto con usted, se le requiere a él o a ella que le revele por escrito si existe alguna afiliación o interés de propiedad entre el QRC (o la firma del QRC) y su empleador/asegurador o la compañía ajustadora. Al QRC también se le requiere que le revele a usted y a todas las partes a cargo de un caso cualquier afiliación o arreglo de referidos comerciales que pueda existir entre el QRC (o la firma del QRC) y cualesquiera otras partes en el caso, incluyendo abogados y médicos.
- Si el QRC determina que usted califica para recibir rehabilitación vocacional, se desarrollará un plan de rehabilitación, el cual puede incluir capacitación, si se necesita. Los servicios de rehabilitación requeridos para llevar a cabo el plan se le proporcionarán a usted sin costo alguno.
- El derecho de solicitar un cambio en su plan de rehabilitación.
- El derecho de obtener copias de su plan de rehabilitación y de los informes de rehabilitación requeridos, si usted los solicita.
- El derecho de solicitar ayuda de la División de Compensación de Trabajadores Accidentados en el Trabajo del Departamento del Trabajo y la Industria de Minnesota. Si tiene preguntas acerca de su plan de rehabilitación, llame al 651-284-5032 o al 800-342-5354. Si existe una disputa acerca de su elegibilidad para los servicios de rehabilitación estatutarios, puede presentar una Solicitud de Rehabilitación y el Departamento podría programar una conferencia administrativa para resolver la disputa.

(al dorso)

SUS RESPONSABILIDADES

Además de los derechos antes mencionados, usted (el trabajador lesionado) tiene ciertas responsabilidades de rehabilitación bajo la ley de compensación de trabajadores accidentados en el trabajo. ***Estas responsabilidades incluyen las siguientes:***

- Usted debe cooperar con los exámenes y evaluaciones médicas y de rehabilitación razonables ordenados por el Comisionado.
- Usted debe hacer un esfuerzo de buena fe por participar en su plan de rehabilitación. No hacerlo puede resultar en la suspensión o terminación de sus beneficios de rehabilitación o monetarios.
- Usted debe notificar a su Consejero de Rehabilitación Calificado (QRC) y a la compañía de seguros cuál es su sueldo, horas, empleador y cargo cuando regrese al trabajo con cualquier empleador y cuando sus horas o su sueldo cambien. Esto es necesario para calcular con precisión sus beneficios por pérdida de sueldo y asegurar que se provean los servicios de rehabilitación apropiados. No reportar correctamente el sueldo ganado mientras recibe beneficios de compensación de trabajadores accidentados en el trabajo puede resultar en consecuencias civiles o penales.

Las declaraciones a continuación se requieren para verificar que usted haya recibido los documentos indicados y que la información en este formulario se le haya explicado. No se le requiere proporcionar la información solicitada a continuación ni firmar este formulario. Sus beneficios de compensación de trabajadores accidentados en el trabajo no se verán afectados si elige no proporcionar la información ni firmar este formulario. Este formulario se presentará al Departamento del Trabajo y la Industria de Minnesota y también se podría proporcionar a la Oficina de Audiencias Administrativas y a las agencias del orden público.

Empleado, marque lo siguiente:

☐ Se me ha explicado la información anterior y se me ha proporcionado una copia de este formulario.

☐ He recibido notificación por escrito del QRC revelando cualquier afiliación o arreglo de referidos comerciales que el QRC o la firma del QRC pueda tener con cualquiera de las personas a cargo de mi caso y una explicación por escrito de cualquier afiliación o interés de propiedad que el QRC o la firma del QRC pueda tener con mi empleador/asegurador y cualquier otro asegurador o compañía ajustadora.

☐ El QRC me ha informado que él/ella y la firma del QRC no tienen ninguna afiliación, interés de propiedad o arreglo de referido de negocio con ninguna de las partes en mi caso ni ningún otro asegurador o compañía ajustadora.

FIRMA DEL EMPLEADO		FECHA
FIRMA DEL QRC	No. DEL QRC	FECHA

LA SECCIÓN 176.102, INCISO 4C DE LOS ESTATUTOS DE MINNESOTA Y LA PARTE 5220.1803, INCISOS 1 Y 1A DE LAS REGLAS DE MINNESOTA, REQUIEREN QUE SE PROVEA LA INFORMACIÓN EN ESTE FORMULARIO AL TRABAJADOR LESIONADO.

ESTE MATERIAL ESTÁ A SU DISPOSICIÓN EN DIFERENTES FORMAS, TALES COMO LETRA GRANDE, BRAILLE O EN CINTA. PARA SOLICITARLO LLAME AL (651) 284-5030 O AL 1-800-342-5354 (DIAL-DLI)/VOZ O TDD (651) 297-4198.

CUALQUIER PERSONA QUE, CON LA INTENCIÓN DE DEFRAUDAR, RECIBE BENEFICIOS DE COMPENSACIÓN DE TRABAJADORES ACCIDENTADOS EN EL TRABAJO A LOS QUE DICHA PERSONA NO TIENE DERECHO, HACIENDO A SABIENDAS DECLARACIONES FALSAS O ENGAÑOSAS O NO REVELANDO CUALQUIER HECHO ESENCIAL, ES CULPABLE DE ROBO Y SERÁ SENTENCIADA DE ACUERDO CON LA SECCIÓN 609.52, INCISO 3.

El QRC debe firmar y escribir la fecha en este formulario en la primera reunión en persona con el empleado, y debe proporcionar una copia al empleador y al asegurador. El QRC también debe proporcionar una copia de este formulario al Departamento del Trabajo y la Industria.

Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032
1-800-342-5354 (DIAL-DLI)

MINNESOTA DEPARTMENT OF
LABOR & INDUSTRY

Workers' compensation

If you are injured

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not make a timely report of the injury to your employer. The time limit may be as short as 14 days.
- Provide your employer with as much information as possible about your injury.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO), you may treat with a doctor of your choice. Your employer must notify you in writing if you are covered by a CMCO.
- Cooperate with all requests for information concerning your claim.

  The law allows the workers' compensation insurer to obtain medical information related to your work injury without your authorization, but they must send you written notification when they request the information.

  The insurer cannot obtain other medical records unless you sign a written authorization.
- Get written confirmation from your doctor about any authorization to be off work. The note should be as specific as possible.

Workers' compensation pays for

- Medical care for your work injury, as long as it is reasonable and necessary.
- Wage-loss benefits for part of your lost income.
- Compensation for permanent damage to or loss of function of a body part.
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer due to your work injury.
- Benefits to your spouse and/or dependents if you die as a result of a work injury.

What the insurer must do

- The insurer must investigate your claim promptly. If you have been disabled for more than three calendar-days, the insurer must begin payment of benefits or send you a denial of liability within 14 days after your employer knew you were off work or had lost wages because of your claimed injury.
- **If the insurer accepts your claim for wage-loss benefits and you have been disabled for more than three calendar-days:** The insurer will notify you and must start paying wage-loss benefits within the 14 days noted above. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.
- **If the insurer denies your claim for wage-loss benefits and you have been disabled for more than three calendar-days:** The insurer will send notice to you within 14 days. The notice must clearly explain the facts and reasons why they believe your injury or illness did not result from your work or why the claimed wage-loss benefits are not related to your injury.

  If you disagree with the denial, talk with the insurance claims adjuster who is handling your claim. If you are not satisfied and still disagree with the denial, **call the Minnesota Department of Labor and Industry's Workers' Compensation Hotline at 1-800-342-5354.**

Fraud

Collecting workers' compensation benefits you are not entitled to is theft. If you have reason to suspect someone is committing workers' compensation fraud, call 1-888-FRAUD MN (1-888-372-8366).

For more information about workers' compensation or if you need assistance with a claim, contact:

Department of Labor and Industry
Workers' Compensation
443 Lafayette Road N.
St. Paul, MN 55155

(651) 284-5032
1-800-DIAL-DLI (1-800-342-5354)
dli.workcomp@state.mn.us
www.dli.mn.gov

Insurer name

Phone number

Posting required by law in a conspicuous location wherever the employer is engaged in business.

This material can be provided to you in different formats (Braille, large print or audio) if you call (651) 284-5005; toll-free at 1-800-DIAL-DLI (1-800-342-5354); or via TTY at (651) 297-4198.

April 2012

MINNESOTA DEPARTMENT OF LABOR & INDUSTRY

Compensación laboral

Si usted se lesiona

- Informe cualquier lesión a su supervisor tan pronto le sea posible; no importa qué tan leve le pueda parecer. Usted podría perder el derecho a los beneficios de compensación laboral si no presenta a tiempo un informe de la lesión a su empleador. El tiempo límite puede ser tan corto como 14 días.
- Provea a su empleador la mayor cantidad de información posible sobre su lesión.
- Obtenga el tratamiento médico que necesite lo más pronto posible. Si no está cubierto por una organización de atención médica certificada (CMCO, por sus siglas en inglés), usted puede recibir tratamiento con el doctor que usted elija. Su empleador debe notificarle por escrito si tiene cobertura con una CMCO.
- Colabore con todas las solicitudes de información relacionadas con su reclamo.

  La ley permite que la aseguradora de compensación laboral obtenga la información médica relacionada con su lesión sin su autorización, pero le debe enviar una notificación por escrito cuando solicite la información.

  La compañía aseguradora no puede obtener otros expedientes médicos a menos que usted firme una autorización por escrito.
- Cualquier autorización para ausentarse del trabajo necesitará una confirmación escrita de su médico. La nota debe ser lo más específica posible.

Pagos por compensación laboral

- Atención médica razonable y necesaria para su lesión ocurrida en el trabajo.
- Beneficios por salario perdido para cubrir parte de los ingresos no recibidos.
- Compensación por daños permanentes o por pérdida de la función de una parte del cuerpo.
- Servicios de rehabilitación vocacional si usted no puede regresar al trabajo o a su empleador previo al accidente, debido a su lesión en el trabajo.
- Beneficios para su cónyuge o dependientes si usted fallece como consecuencia de una lesión laboral.

Lo que la aseguradora debe hacer

- La compañía aseguradora deberá investigar su reclamo con prontitud. Si usted ha estado incapacitado por más de tres días calendario, la aseguradora debe iniciar el pago de beneficios o enviarle un aviso de negación de responsabilidades dentro de los 14 días después que su empleador se enteró de su ausencia laboral o había perdido parte de su salario debido a una demanda por lesión.
- **Si la compañía aseguradora acepta su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días consecutivos:** La aseguradora le notificará y deberá iniciar el pago de los beneficios por pérdida de salario dentro de los 14 días mencionados anteriormente. La aseguradora deberá pagar los beneficios puntualmente. Los beneficios por pérdida de salario se pagan en los mismos intervalos que sus cheques de nómina.
- **Si la compañía aseguradora deniega su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días consecutivos:** La aseguradora le enviará una notificación dentro de los 14 días. La notificación debe explicar claramente los hechos y motivos por los cuales ellos consideran que su lesión o enfermedad no fue resultado de su trabajo o por qué los beneficios por pérdida de salarios que reclama no están relacionados con su lesión.

  Si usted no está de acuerdo con la denegación, hable con el ajustador de reclamos de la aseguradora a cargo de su reclamo. Si usted no está satisfecho y aún está en desacuerdo con la denegación, **comuníquese con la unidad de Compensación para Trabajadores del Departamento de Trabajo e Industria de Minnesota (Minnesota Department of Labor and Industry) al teléfono gratuito 1-800-342-5354.**

Fraude

Cobrar beneficios de compensación laboral a los cuales no tiene derecho, se considera robo. Si tiene motivos para sospechar que alguien está cometiendo fraude con el programa de compensación laboral, llame al 1-888-FRAUD MN (1-888-372-8366).

Para obtener información adicional sobre compensación laboral o si necesita ayuda con un reclamo, comuníquese con el:

Department of Labor and Industry
Workers' Compensation
443 Lafayette Road N.
St. Paul, MN 55155

(651) 284-5032
1-800-DIAL-DLI (1-800-342-5354)
dli.workcomp@state.mn.us
www.dli.mn.gov

Nombre de la compañía aseguradora

Número de teléfono

Por ley, esta información se debe colocar en un lugar visible en todas las áreas en las que la empresa hace negocios.

Este material está disponible en diferentes formatos (Braille, letra de imprenta grande o audio) si llama al (651) 284-5005; llamada gratuita al 1-800-DIAL-DLI (1-800-342-5354) o vía TTY (retransmisión) al (651)297-4198.

Abril de 2012