

Ten Easy Steps for Claiming and Reporting Workers' Compensation Benefits

STEP ONE

- Normally, all reasonable medical treatment at the direction of an approved physician (hospital, doctor, prescription, etc.), which occurs due to a compensable injury or occupational disease, is paid by the Fund.
- Workers' Compensation benefits begin after a three-day waiting period.
- Employees are paid 2/3 of their gross average weekly wage.
- The average weekly wage is based on the 52 weeks of wages immediately prior to the date of accident.



Wage Statement – Alabama

Claimant: «This.Claimant»

Date of Injury: _____

The following table shows the wages earned by: «This.Claimant» employed as a: _____

	Date	# of days Worked	Gross Wages		Date	# of days Worked	Gross Wages
1.				27.			
2.				28.			
3.				29.			
4.				30.			
5.				31.			
6.				32.			
7.				33.			
8.				34.			
9.				35.			
10.				36.			
11.				37.			
12.				38.			
13.				39.			
14.				40.			
15.				41.			
16.				42.			
17.				43.			
18.				44.			
19.				45.			
20.				46.			
21.				47.			
22.				48.			
23.				49.			
24.				50.			
25.				51.			
26.				52.			

Total (1-26) _____

Total (27-52) _____

**List the amount of the employer's portion of health, life or disability insurance premiums paid for this employee:

Grand Total _____

Benefits will be continued: Yes No

Signed: _____ Title: _____ Date: _____

Post Office Box 589, Montgomery, AL 36101-0589 | (334) 394-3232 Phone | (334) 394-3244 Fax
workerscompclaims@countyrisk.org



STEP TWO

- The injured employee should immediately report the accident to his/her employer.
- The employee has five days from the date of accident to report an on-the-job injury.
- If the injury is not reported within five days, the employee will not be eligible for compensation or medical benefits until the injury is reported.
- NOTE: No benefits will be paid if the injury is not reported within 90 days.

STEP THREE

- The employer is responsible for completing the *Employer's First Report of Injury* form.
- The *Employer's First Report of Injury* form should be completed by the supervisor or other appropriately designated personnel, and the form should include specific details concerning the parts of the body that were injured.
- The employee is NOT to complete the *Employer's First Report of Injury* form.

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE				
1. Insured Report Number		2. Filing Office Claim Number		3. OSHA Log Case Number
EMPLOYER				
4. Employer Business Name		ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1		10. Mailing Address 1		
6. Physical Address 2		11. Mailing Address 2		
7. City		8. State		9. Zip
12. City		13. State		14. Zip
15. Federal ID Number		16. U.C. Account Number		17. NAICS
INSURER / FILING OFFICE				
18. Insurer Name ASSOCIATION OF COUNTY COMMISSIONS OF AL SI FUND		21. Filing Office Name COUNTY RISK SERVICES, INC.		
19. Insurer Federal ID Number 63-0821025		22. Mailing Address 1 P.O. Box 589		
20. Type Insurer Ins Co <input type="checkbox"/> Self-Insurer <input type="checkbox"/> Group Fund <input type="checkbox"/>		23. Mailing Address 2 or Telephone Number (334) 394-3232		
		24. City Montgomery		
		25. State AL		
		26. Zip 36101-0589		
		27. Filing Office Federal ID Number 83-0814426		
EMPLOYEE / WAGES				
28. First Name		32. Employee ID Number		
29. Middle Name		33. Type Employee ID Number		
30. Last Name		SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)		Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1		40. Gender		41. Date of Birth
35. Mailing Address 2		Male <input type="checkbox"/>		
36. City		Female <input type="checkbox"/>		42. Nbr of Dependents
37. State		38. Zip		39. Phone
43. Marital Status		44. Date Hired		
Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>				
45. Occupation Description		46. Number of Days Worked Per Week		
47. Wages \$		49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>		50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>		
INJURY / TREATMENT				
51. Date of Injury		52. Time of Injury		53. Time Employee Began Work
		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
54. Date Disability Began		55. Date of Death		
PLACE OF ACCIDENT, INJURY, OR EXPOSURE				
56. Site Address		61. Injury Occurred on Employer's Premises?		
57. City		Yes <input type="checkbox"/> No <input type="checkbox"/>		
58. State		62. Date Employer Notified		
59. Zip				
60. County				
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)				
PROVIDE DESCRIPTION CODES to identify Nature of Injury, Part of Body that was affected, and Cause of Injury. (FOR COMPLETE LIST OF CODES, GO TO HTTP://LABOR.ALABAMA.GOV/WC)				
64. Nature of Injury Code		65. Part of Body Code		66. Cause of Injury Code
67. Initial Treatment		No Medical Treatment <input type="checkbox"/>		68. Name of Treatment Facility
First Aid By Employer <input type="checkbox"/>		Minor Clinic / Hospital <input type="checkbox"/>		69. Address
Emergency Room <input type="checkbox"/>		Hospitalized Overnight <input type="checkbox"/>		70. City
Hospitalized > 24 Hours <input type="checkbox"/>		Outpatient Treatment <input type="checkbox"/>		71. State
73. Name of Physician or Other Health Care Professional		74. Has Injured Returned to Work		If so, 75. Date
		Yes <input type="checkbox"/> No <input type="checkbox"/>		76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
OTHER				
77. Date Prepared		78. Preparer's First Name		79. Last Name
				80. Title
		81. Preparer's Telephone Number		



STEP FOUR

- The *Employer's First Report of Injury* form should be emailed, mailed or faxed as soon as possible to County Risk Services, Inc.
 - Email: workerscompclaims@countyrisk.org
 - Mail: P.O. Box 589, Montgomery, AL 36101-0589
 - Fax: 334-394-3244
- DO NOT hold the *Employer's First Report of Injury* form until medical bills are received.

STEP FIVE

- Forward all medical bills related to the injury to County Risk Services, Inc. as soon as they are received.
 - Email: workerscompclaims@countyrisk.org
 - Mail: P.O. Box 589, Montgomery, AL 36101-0589
 - Fax: 334-394-3244
- Medical bills must be paid within 25 working days from the date they are received by the County or County Risk Services.
- Late payment of medical bills could result in penalties.

STEP SIX

- The employee should be evaluated as soon as possible by the county-approved physician or facility.
- If the employee's injuries are life threatening, he/she should be immediately taken to the nearest facility for treatment.
- Otherwise, medical services provided by anyone other than the county-approved physician or facility must be pre-approved by County Risk Services, Inc.
- Call CRS at 334-394-3232 or 888-608-2009.

STEP SEVEN

- Any request for a medical referral must be directed to and approved by County Risk Services, Inc.
- Call CRS at 334-394-3232 or 888-608-2009.

STEP EIGHT

- Any accident resulting in a fatality should be immediately reported to County Risk Services at 334-394-3232 or 888-608-2009.

STEP NINE

- All on-the-job accidents, injuries and occupational diseases, no matter how big or small, must be reported to County Risk Services at 334-394-3232 or 888-608-2009.
- Failure to do so could preclude treatment under the Workers' Compensation rules.

STEP TEN

- No compensation shall be allowed for an injury or death caused by willful misconduct, refusal to use prescribed safety equipment or appliances, willful violation of the law, breach of a rule or regulation of which the employee has knowledge or intoxication by use of alcohol or drugs.

CRS WORKERS' COMPENSATION CONTACTS

- **Connie Wilson**
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Third-Party Administrator for
ACCA Workers' Compensation Self-Insurers Fund
ACCA Liability Self-Insurance Fund, Inc.
ACCA Liability Self-Insurance Fund, Inc. - Property Program

