EMPLOYER MANUAL

A Practical Guide on How to Handle Workers’ Compensation

For more information regarding prevention of risk, visit our website at floridatech.edu/compliance-and-risk-management/office-for-risk-management
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Florida Tech Florida Guidelines—Section A

Employer Responsibilities During a Nonemergency

1. Contact the Office of Compliance and Risk Management (OCRM) at 321-674-8885 about the accident/injury.


3. Instruct the employee that he or she has the right to medical care. Assist the employee seeking care with calling Holzer Health Center to ensure availability at 321-674-8078. If Holzer cannot schedule with the employee or is closed, please refer the injured employee to Premier Urgent Care (6300 N. Wickham Rd., Suite 101) (321-242-7425) or Holmes Regional Medical Center (1350 Hickory St.) (321-434-7000). The injured employee may go to the nearest urgent care or hospital that is closer in proximity if needed.

4. Drop off or email all executed forms, including Supervisor Accident/Injury Report to the Office of Compliance and Risk Management.

Steps for an Emergency

1. The employee, witness or supervisor should call 911 immediately when needed, and call the Florida Tech Department of Security (ext. 8111). The supervisor must then contact the Office of Compliance and Risk Management (OCRM) at 321-674-8885 about the accident/injury.


3. Drop off or email all executed forms, including Supervisor Accident/Injury Report to the Office of Compliance and Risk Management.
Do’s & Don’ts of Reporting a Claim

**DO**

- Write legibly on all pages of the injury report document.
- Report the injury immediately via email to the Office of Compliance and Risk Management (OCRM).
- Use (current) Florida Tech Employee Accident/Injury Report for Cannon Cochran Management Services Inc.
- Drop off or email the completed Accident/Injury Report packet to the Office of Compliance and Risk Management immediately after you are notified of a work-related injury.
- Refer the injured employee to Holzer Health Center. If the location is not within the vicinity of Holzer, please refer the injured employee to Premier Urgent Care, Holmes Regional Medical Center or the nearest urgent care or hospital.

**DON’T**

- Use pencils or light-colored pens to complete the accident/injury documents, including the Florida Tech Employee Accident/Injury Report.
- Email forms with missing information.
### Departmental Information—Section B

#### Compliance and Risk Management Contact List

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Phone</th>
<th>Email</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fanak Baarmand</td>
<td>321-674-8885</td>
<td><a href="mailto:fbaarman@fit.edu">fbaarman@fit.edu</a></td>
<td>Executive Director of Compliance and Risk Management</td>
</tr>
<tr>
<td>Christina Lind</td>
<td>321-674-7563</td>
<td><a href="mailto:clind@fit.edu">clind@fit.edu</a></td>
<td>Administrative Assistant</td>
</tr>
</tbody>
</table>

All injuries/illnesses must be reported to the Office of Compliance and Risk Management (321-674-8885) or via email to fbaarman@fit.edu.

For injuries/illnesses that occur after hours, on weekends or holidays when Holzer Health Center is closed, please refer the injured employee to Premier Urgent Care, Holmes Regional Medical Center or the closest urgent care facility or hospital. In an emergency, call 911.

**Send Medical Bills To:**

CCMSI Risk Services Group Inc.
2600 Lake Lucien Dr., Suite 225
Maitland, FL 32751
Phone: 866-291-0194
Procedural Information & Injury Report Forms—Section C

In the event a job-related accident or illness occurs, the following procedures must be followed:

If the injury or illness is life-or-limb-threatening, instruct the employee and/or supervisor to call 911 if needed first, then call the Department of Security (ext. 8111) and last call the Office of Compliance and Risk Management (ext. 8885). Typically, the employee will be transported to the closest hospital, Holmes Regional Medical Center.

Department heads, supervisors and/or Holzer Health Center must provide the Compliance and Risk Management staff with the executed accident/injury report, which includes Employee Accident/Injury Report, Supervisor Accident/Injury Report, CCMSI False and Fraudulent Claim Warning, CCMSI Authorization for Medical Records and Communication Release, CCMSI Request for Mileage Reimbursement, FICURMA Workers’ Compensation Prescription Information and Workers’ Compensation Witness Report. Failure to do so could result in monetary and other serious fines against the university. Therefore, all supervisors and/or employees must report all work-related injuries immediately for filing. Employees are to report work-related injuries to their supervisors regardless of the severity of the injury.

Department heads, supervisors, Human Resources and the Office of Compliance and Risk Management must remind employees that they are not allowed to use their private doctor to cover work-related injuries/illnesses. Treatment provided for a work-related injury or illness is not covered by regular medical insurance. In addition, all follow-up appointments (e.g., physical therapy) must be authorized in advance through the Office of Compliance and Risk Management 321-674-8885.

Employees should coordinate scheduling follow-up appointments, preferably before or after the regular work schedule. Otherwise, permission must be obtained from a direct report prior to scheduling any therapy or office visits to the doctor.

If the employee is put on medical leave, the Office of Compliance and Risk Management will notify the Office of Human Resources.

The Office of Compliance and Risk Management will verify that the information contained on the Florida Tech Employee Accident/Injury report is accurate to include ensuring that the individual is an employee via Banner system before uploading information to the CCMSI’s database.

Further, after reviewing the information contained in the Employee Accident/Injury Report and supporting documents, the Office of Compliance and Risk Management will forward a hard copy of all forms to CCMSI.
List of Medical Treatment Locations

**Holzer Health Center**
3976 Country Club Rd.
Melbourne, FL 32901
Phone: 321-674-8078

*Hours:*
- **Summer:**
  Monday–Friday: 9 a.m.–3 p.m.
- **Fall and spring semester:**
  Monday–Thursday: 8 a.m.–7 p.m.
  Friday: 8 a.m.–5 p.m.

To be used only if employees are outside the Florida Tech area or if the injury occurs and Holzer Health Center (Florida Tech’s clinic) is closed/cannot accommodate the employee:

**Premier Urgent Care**
6300 N. Wickham Rd., Suite 101
Melbourne, FL 32940
Phone: 321-253-2126
Fax: 321-253-1720

*Hours:*
- Monday–Friday: 8 a.m.–7 p.m.
- Saturday–Sunday: 8 a.m.–5 p.m.

**Holmes Regional Medical Center**
1350 Hickory St.
Melbourne, FL 32901
Phone: 321-434-7000

*Hours:*
- 24/7

If the injured employee is not in close proximity to Premier Urgent Care or Holmes Regional Medical Center, please send the injured employee to the nearest urgent care or hospital. Please call 911 when needed.
EMPLOYEE ACCIDENT/INJURY REPORT

Please contact the Office of Compliance and Risk Management at 321-674-8885 IMMEDIATELY regarding an employee’s injury.

EMPLOYEE INFORMATION

Last name _______________________________ First name ___________________ Middle name _______________

Full SSN ___________________________ DOB ___________________ Gender: ❑ Male ❑ Female Marital status ________________

Home address __________________________________________ Street/Apt. # _______________________

City _______________________________ State _______________ ZIP _____________

Cell # __________________ Work # __________________ Email _______________________________

❑ Full time ❑ Part time Salary/hourly wage ___________________________ Date of hire ______________________

ACCIDENT INFORMATION

Date of accident ___________ Time of accident ___________ ❑ AM ❑ PM Date first reported _______________

Occurred on campus: ❑ Yes ❑ No If on campus, exact location _____________________________________________

Type of location (lab shop, office, warehouse, etc.) _________________________________________________

Employee description of accident (include cause of injury):

Injury/illness that occurred ___________________________ Part of body affected _______________________

Cause of injury _____________________________________________________________

Paid for date of injury: ❑ Yes ❑ No Last date employee worked ______________________________

Return to work? ❑ Yes ❑ No If yes, give date ___________________________ Date of death (if applicable) __________

MEDICAL INFORMATION

Employee refused medical care at time of injury: ❑ Yes ❑ No Treated by a physician? ❑ Yes ❑ No

Physician/hospital name ___________________________ Phone ___________________________

Address __________________________________________ City ___________________ State _____ ZIP ______

List of activity prior to accident (work-related activity only):

Has this part of your body been injured before? ❑ Yes ❑ No If yes, when ___________________________

Employee signature ___________________________________________ Date __________________

FLORIDA’S STEM UNIVERSITY

Florida Institute of Technology • Office of Compliance and Risk Management • 150 W. University Blvd., Melbourne, FL 32901-6975 • 321-674-8885
SUPERVISOR ACCIDENT/INJURY REPORT
(To be completed by supervisor)

Did activity involve operating a vehicle?  ❑ Yes  ❑ No  
Was individual licensed to operate vehicle/equipment?  ❑ Yes  ❑ No

Did individual take the appropriate safety training?  ❑ Yes  ❑ No  
If yes, what was the course(s)? ____________________________

Personal protective equipment required and available?  ❑ Yes  ❑ No

Personal protective equipment used?  ❑ Yes  ❑ No

If yes, what type of equipment? ____________________________

If no, what PPE should have been used to prevent/minimize the accident/injury? ____________________________

Were stated or written procedures followed that caused or contributed to the accident?  ❑ Yes  ❑ No

Was there a discrepancy?  ❑ Yes  ❑ No

How was it performed improperly? ____________________________

Type of property/material involved in accident ____________________________

Owner of property ____________________________

Estimated cost of damage ____________________________

Supervisor name ____________________________ Phone # ____________________________

Supervisor signature ____________________________ Date ____________________________

TO BE COMPLETED BY THE OFFICE OF COMPLIANCE AND RISK MANAGEMENT

Name of company:  
Florida Institute of Technology  
150 W. University Blvd.  
Melbourne, FL 32901

Insurer information:  
Cannon Cochran Management Services Inc.  
P.O. Box 948399, Maitland, FL 32749-8399  
866-291-0194 / 407-660-5600 / Fax: 217-477-6946  
FICURMAmail@ccmsi.com

Federal ID number 59-6046500

Policy/member number 00002170120000030129462019

Nature of business Education

MMI date ____________________________

Did supervisor accommodate restriction?  ❑ Yes  ❑ No

If yes, from (start date) ______________ to (end date) ______________

RESTRICTED DUTY?

SAT 12/23/2019

1ST EDITION

20200423  Page 2 of 2
FALSE AND FRAUDULENT CLAIM WARNING

Please read the following information carefully. This form must be signed and returned within 30 days of the date it was received, stating that you have reviewed, understand and acknowledge the statement of benefits and/or payments shall be suspended until such signature obtained.

Workers' Compensation fraud includes but is not limited to the following:

- Requesting and/or receiving temporary total, temporary partial, permanent total disability or impairment benefits while working for gain as an employee of a business, independent contractor, yourself or a business and not reporting that income to the insurance company.
- Making a false or written statement and/or submitting false documents to your employer, your physician and/or the insurance company or their representatives for the purpose of filing or supporting a claim for workers’ compensation benefits.
- Misrepresenting facts concerning an industrial accident, injury or illness to your employer, your physician and/or the insurance company or their representatives.
- Failing to report earnings when requested to do so by the insurance company.
- Selling your personal information to third parties for use of misrepresenting facts to any medical provider or insurance company.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud punishable as provided in Florida Statute 817.234.

I have reviewed, understand and acknowledge the above. This information is true and correct to the best of my knowledge.

Worker’s Name: ________________________________________________________________

Please type or print

Claim #: _____________________________ Employee: ________________________________

Employer: _______________________________________________________________________

Employee’s Address: _______________________________________________________________________

Phone: ___________________________________________________________________________

Worker’s Signature: ___________________________________________ Date: ________________________

Please type or print

Cannon Cochran Management Services, Inc.
PO Box 948399 | Maitland, FL 32794-8399
866-291-0194 | 407-660-5600 | Fax: 217-477-6946 | FICURMAmail@ccmsi.com

20200423
AUTHORIZATION FOR MEDICAL RECORDS AND COMMUNICATION RELEASE

Name: _____________________________________ Date of Birth: _____________ Social Security #: _____________________

I hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of my mental or physical health, history, condition or wellbeing, to supply such information to my employer or its insurance carrier, claims administrator or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer or its insurance company, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment, and as to any other issues including diagnosis, prognosis, causal connection of care and treatment to my work injury or duties, and ability to work. I hereby waive my physician-patient privilege. In conjunction with this, I also authorize any treating physician or medical provider to review any additional materials provided to them.

A photocopy of this authorization shall be as valid as the original. This release shall remain valid for the length of my claim.

Note: Workers’ Compensation Requests Are Exempt From HIPAA. Pursuant to 45 CFR, Sect. 164.512(1) a covered entity may without penalty under HIPAA disclose protected health information to the extent necessary to comply with the law relating to workers’ compensation.

Name (please print): _________________________________________________________________________________________

Signature: ___________________________________________________________  Date: _____________________________
Employer:
Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th></th>
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<tbody>
<tr>
<td>Group#</td>
<td>10602857</td>
</tr>
<tr>
<td>Member ID (SSN):</td>
<td></td>
</tr>
<tr>
<td>Date of Injury:</td>
<td></td>
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<tr>
<td>Processor:</td>
<td>myMatrixx</td>
</tr>
<tr>
<td>Bin#:</td>
<td>014211</td>
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</tbody>
</table>

Day supply is limited to 14 days for a new injury.
myMatrixx Help Desk: (877) 804-4900

Employee:
FICURMA has partnered with myMatrixx to make filling workers’ compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY, PLEASE CALL (877) 804-4900.

Pharmacist:
Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers’ compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900
REQUEST FOR MILEAGE REIMBURSEMENT

Please fax or email the completed form to the adjuster for handling. Thank you.

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<th>Name:</th>
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<tr>
<td>Employer: Florida Institute of Technology</td>
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<tr>
<td>Claim Number:</td>
</tr>
<tr>
<td>Claimant Address:</td>
</tr>
<tr>
<td>Work Address:</td>
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<tr>
<td>Date Of Injury:</td>
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<tr>
<td>Adjusters: Terri Krepps/Pamela Schlegel</td>
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<tr>
<th>Date of Visit</th>
<th>Name of Medical Facility (including pharmacies) with address</th>
<th>Roundtrip Miles</th>
<th>Residence or Work (Please indicate)</th>
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Total Miles: _________________  x 0.44.5 = $ ___________________________

I hereby certify or affirm that the above mileage was incurred by me as necessary traveling expenses related to those medical facility visits pursuant to my workers’ compensation case.

Signature: ___________________________________________________________  Date: _____________________________
FLORIDA TECH

WORKERS’ COMPENSATION WITNESS REPORT

(To be completed by witness only)

Name of injured employee ___________________________________________________________

Name of witness _________________________________________________________________

Telephone # of witness ___________________________________________________________

Location where incident occurred _____________________________________________

Date of incident ___________________________ Time of incident ______________________

1. What were you (the witness) doing at the time of the incident?
   ___________________________________________________________________________

2. How and when did you become aware of the incident?
   ___________________________________________________________________________

3. What did you hear at the time of the incident?
   ___________________________________________________________________________

4. Describe what you saw at the time of the incident?
   ___________________________________________________________________________

5. Who else was present?
   ___________________________________________________________________________

6. Please relate any additional information you have pertaining to the incident:
   ___________________________________________________________________________

Witness signature _____________________________________________________________ Date ______________________

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Florida Tech Workers’ Compensation Quick Facts

**Reporting Period:** An employee who suffers an injury/illness arising out of and in the course of employment must advise the Office of Compliance and Risk Management and his/her supervisor of the injury immediately, but no later than within 30 days after the date of or initial manifestation of the injury. The law requires that you report the accident or your knowledge of a job-related injury within 30 days of your knowledge of the accident or injury. Failure to report the injury/illness in the noted timeframe could result in the denial of the claim under certain circumstances. However, if the employee reports the injury after the 30-day period, the information must be reported to the Office of Compliance and Risk Management immediately.

**Waiting Period for Comp Benefits after Injury:** Seven days

**Wage Replacement Benefits:** If an authorized treating physician places an injured worker off work, the workers’ compensation benefits for lost wages will start on the eighth day that the employee is unable to work. No wage replacement benefits are paid for the first seven days of work missed, unless the employee is out of work for more than 21 days due to the work-related injury. The wage replacement benefits will equal two-thirds (66-2/3%) of the employee’s pre-injury regular weekly wage, but the benefit will not exceed Florida’s Maximum Compensation Rate for the year of the accident and is on a paid biweekly basis. An injured worker who is receiving wage replacement can use 2.6 hours or equivalent hours of his/her own accrued sick, personal or vacation hours toward full wage compensation.

**Choice of Physician:** If a non-life-threatening, on-the-job injury occurs, the employee must notify their supervisor and then call the Office of Compliance and Risk Management at 321-674-8885. The employee needs to be directed to Holzer Health Center. If Holzer is closed, please encourage the employee to go to Premier Urgent Care or Holmes Regional Medical Center. The injured employee may go to the nearest urgent care or hospital that is closer in proximity if needed. If it is after hours and the employee cannot reach his or her supervisor or the Office of Compliance and Risk Management, please refer the employee to Premier Urgent Care, Holmes Regional Medical Center or the nearest urgent care or hospital and let the Office of Compliance and Risk Management know as soon as possible what has happened. If it is an emergency, the injured employee or witness should call 911.

Per Florida Statute 440.13(2)(f), an injured worker is entitled to a one-time change per accident. The insurance company will authorize an alternative physician within five days of receiving a written request from the injured worker. If medical care is provided outside an authorized approved network, the employer chooses the physician.
Transportation During Disability Period: Medical transportation is available if the injured worker needs it. If the injured worker uses his/her vehicle for transportation to medical providers, they are reimbursed at the current rate of 44.5¢ per mile. The CCSMI agent can supply mileage forms. Call CCMSI immediately at 407-660-5637 or 866-291-0194 if you need transportation or cannot make an appointment.

Prescription Benefit: Medications can be dispensed at any pharmacy (see myMatrixx listing). The injured worker pays no copay (prior to MMI) for Rx if an authorized medical provider prescribes medical services, devices, appliances, etc., as it relates to the injury/illness. Please contact your claims adjuster at CCMSI (407-660-5637 or 866-291-0194) for authorization prior to receiving service or Risk Management for assistance.

Notification from Insurance Company: Within 3–5 business days after the accident/injury is reported, the employee should receive an information brochure explaining his or her rights and obligations and a notification letter explaining the services provided by the Employee Assistance Office of the Division of Workers’ Compensation. The employee must notify CCMSI if they have already completed the following forms: Florida Tech Employee Accident/Injury Report, False and Fraudulent Claim Warning, Authorization for Medical Records and Communication Release and Request for Mileage Reimbursement.
FAQs Regarding Workers’ Compensation

How long do I have to report a claim to my employer?

All injured workers must contact their supervisor/employer immediately to notify them of any on-the-job injury. Claims reported after 30 days could be denied.

Which forms do I need to complete?

All injured workers should complete the following forms: Florida Tech Employee Accident/Injury Report, CCMSI False and Fraudulent Claim Warning, CCMSI Authorization for Medical Records and Communication Release, CCMSI Request for Mileage Reimbursement, FICURMA Workers’ Compensation Prescription Information and Workers’ Compensation Witness Report, when filing.

It is important that all injured workers complete the workers’ compensation packet including the fraud statement. Benefits might become suspended if said injured workers refuse to provide the requested signature.

What doctor can I go to?

The insurance company (CCMSI), upon becoming aware of your injury, will direct you to a healthcare provider for such period as the nature of the injury or the process of recovery may require. Medical care must be authorized by the insurance company.

Why can’t I go to the doctor of my choice?

Per Florida Statute 440.13(2)(a), the law requires that the employer/insurance company provide the appropriate medical care.

Can I go to my own personal physician?

No. You must go to an authorized physician provided by your employer or CCMSI.

The doctor is not helping me. Can I request a different doctor for my treatment?

Yes. Per Florida Statute 440.13(2)(f), you are entitled to one-time change per accident. The request for a change in physician must be in writing and provided to the insurance company (CCMSI). Upon receipt of the request, the insurance company will select and authorize an alternative physician within five days of receipt of the written request. The injured worker or insurance company (CCMSI) may also select a one-time Independent Medical Examination (IME), per accident. Please note, if your accident occurred on or after 10/1/03, the party requesting the IME is responsible for payment.
Will I have to pay any medical bills?

No, all authorized medical bills should be submitted by the medical provider to CCMSI for payment until you reach maximum medical improvement. Once you reach Maximum Medical Improvement, you will be required to pay $10 copay per visit.

If prescribed, how do I get my prescription filled?

If a prescription is prescribed by your authorized physician, please take the prescription to your pharmacist along with the information from myMatrixx to ensure your prescriptions are billed directly to the insurance company. In rare cases, you may be asked to pay for your medications; if this happens, you will be reimbursed any money you have to advance once receipts are provided to the insurance company.

What is my responsibility when the doctor places me on restricted duty?

It is your responsibility to communicate with your supervisor and the Office of Compliance and Risk Management following your appointment. If you are given restrictions or placed out of work anytime during your treatment, please ensure they are communicated to your supervisor and Office of Compliance and Risk Management immediately.

Do I have to attend my appointments?

Yes. Time, effort and expense are put into providing your medical care. If you do not follow the doctor’s direction and attend all medical appointments, your case may be terminated for noncompliance and all benefits suspended.

If a medical bill comes to my house, what do I do?

Mail or drop off the medical bill to the Office of Compliance and Risk Management. It will be forwarded to your adjuster. CCMSI will pay all authorized invoices for your claim.

Will I get paid mileage to my medical appointments?

If you, a family member or friend drives you to an authorized appointment, physical therapy, hospital, diagnostic testing or pharmacy, you are entitled to mileage reimbursement at 44.5 cents per mile or current rate. A form is available to document the appropriate mileage.

When do I get my first check?

You should receive the first check within three (3) weeks after reporting your injury to FICURMA/CCMSI and have been off work by an authorized treating physician beyond the waiting period.

All injured workers must report any wages (from all employment) earned to the insurance carrier.
How much will I be paid?

In most cases, benefits are calculated at 66-2/3% of your average weekly wage up to the state max for the year of your accident. If you were injured on or after Oct. 1, 2003, your average weekly wage is calculated using wages earned 13 weeks prior to your injury, not counting the week in which you were injured.

Will I be paid if the doctor takes me off work?

In most cases, your first check will be from the eighth day of disability through the time your authorized treating physician releases you to return to work. Under Florida law, you are not paid for the first seven days of disability, unless you are out more than 21 days.

Will the check come to my house?

If you are entitled to benefits, your check will be mailed to your home. Please make sure we have the most up-to-date information regarding your address and phone number.

Can I receive unemployment compensation and workers’ compensation benefits at the same time?

No, not if you are receiving temporary total or permanent disability benefits. You must be medically able and available to work to qualify for unemployment benefits.

Will I get fired because of my injury?

No. It is against the law to fire you because you have filed or attempted to file a workers’ compensation claim.

Who do I contact if I have any questions concerning my benefits?

Contact CCSMI at 407-660-5660. Their mailing address is 2600 Lake Lucien Dr., Suite 225, Maitland, FL 32751.

Disclaimer: The above represents a summary of information pertaining to Florida Tech’s workers’ compensation benefit. Please note that workers’ compensation law can be complex, and these laws and policies are subject to amendment at any time. If you need help with a workers’ compensation issue, please consult your CCMSI and/or workers’ compensation risk management team.
**Workers’ Compensation Exemptions**

**Construction Industry**

An employer in the construction industry who employs one or more part-time or full-time employees, including the owner, must obtain workers’ compensation coverage.

Corporate officers or members of a limited liability company (LLC) in the construction industry may elect to be exempt:

- The officer owns at least 10 percent of the stock of the corporation, or in the case of an LLC, a statement attesting to the minimum 10 percent ownership.
- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.
- No more than three corporate officers per corporation or limited liability member are allowed to be exempt.

A $50 fee is required for each application submitted to obtain an exemption. Construction exemptions are valid until a voluntary revocation is filed or the exemption is revoked by the Division.

**Non-Construction Industry**

An employer in the non-construction industry, who employs four or more part-time or full-time employees, must obtain workers’ compensation coverage.

Self-employed partners and partners in the non-construction industry are automatically exempt from the law, but can elect to be covered.

Non-construction industry corporate officers may elect to be exempt if:

- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.
- There is no limit to the number of corporate officers who can be exempt and there is no application fee.
- Non-construction exemptions are valid until a voluntary revocation is filed or the exemption is revoked by the Division.

For copies of the exemption form, contact the Division’s Bureau of Compliance at (860) 413-1609 or go to https://www.MyFloridaCFO.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm and click on Rule 69L-6 and Form number DWC-250, Notice of Election to Be Exempt.

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**Frequently Asked Questions**

**Q)** How many days do employees have to report work-related injuries or illnesses?

A) Employers should encourage employees to report accidents as soon as they have knowledge of the injury. While law does not specify a number of days, the sooner the report is made, the sooner the employee can receive medical treatment and wage replacement benefits.

- Non-construction industry corporate officers may elect to be exempt if:
  - The officer owns at least 10 percent of the stock of the corporation, or in the case of an LLC, a statement attesting to the minimum 10 percent ownership.
  - The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
  - The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.
  - There is no limit to the number of corporate officers who can be exempt and there is no application fee.
  - Non-construction exemptions are valid until a voluntary revocation is filed or the exemption is revoked by the Division.

**Q)** To whom should I report the work-related injury?

A) You should report the accident to your insurance company as soon as you have knowledge of the injury. By law, however, employees are required to report work-related injuries or illnesses within 30 days.

**Q)** Do I have to report a claim if I do not believe it is a work-related injury or illness?

A) Yes. You should report all claims of work-related injuries or illnesses to your workers’ compensation insurance carrier. This includes claims in which there are no witnesses of the injury or illness. It is your workers’ compensation insurance carrier’s responsibility to investigate all claims and determine if employees are entitled to benefits under Florida’s Workers’ Compensation Law.

**Q)** Does the employee pay any part of my workers’ compensation insurance premium?

A) No. The law is very specific on this point. It is the employer’s responsibility to pay the entire premium for workers’ compensation.

Employers who secure workers’ compensation coverage can also apply to become a drug-free workplace and may receive a premium discount. To learn more about the Drug-Free Workplace Program, please call the Division of Workers’ Compensation Customer Service Office at 850-413-1609.

**Questions about workers’ compensation?**

Please visit our Web site at www.MyFloridaCFO.com/Division/WC where you will find extensive information such as publications, databases, rules and forms that will give you a better understanding of workers’ compensation.

**Employer Assistance and Ombudsman Office**

Injured worker e-mail inquiries
workcomp@MyFloridaCFO.com

Employee e-mail inquiries
WorkCompCustServ@MyFloridaCFO.com

Workers’ Compensation Fraud Hotline
1-800-378-0445

**Disclaimer:**

This publication is being offered as an informational tool only and complies with s. 440.185 (4) F.S., with the understanding that this is not official language of the Florida Statutes. In no event will the Division of Workers’ Compensation be liable for direct or consequential damages resulting from the use of this printed material.

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**EMPLOYER FACTS**

**IMPORTANT WORKERS’ COMPENSATION INFORMATION FOR FLORIDA’S EMPLOYERS**

**INFORMATION FOR**

**FLORIDA’S EMPLOYERS**

**Important**

**WORKERS’ COMPENSATION LAW**

**Rule 69L-3.0036, F.A.C. Employer Informational Brochure**

**Florida Department of Financial Services**

**Revised March 2010**
Your workers’ compensation insurance policy covers medical and partial wage-replacement benefits for any employee who sustains a work-related injury or illness.

This brochure will give you a better understanding of your role and responsibilities under the workers’ compensation system.

Workers’ Compensation Notice

The law requires that every employer who has secured workers’ compensation coverage post in conspicuous places(1) a notice that contains the employer’s insurance carrier information, the expiration date of the policy, and an anti-fraud statement. The Division of Workers’ Compensation has developed the notice, in poster form, for carriers to provide to their policyholders. Your carrier is required by law to provide you with the poster(s). If employees have purchased workers’ compensation policies, they shall be deemed to have failed to secure workers’ compensation coverage if they have committed any of the following actions:

- materially understated or cualesd payroll
- materially misrepresented or concealed employee duties to avoid proper classification for premium calculations, or
- materially misrepresented or concealed information pertinent to the computation and application of an experience modification factor.

Employers who fail to secure workers’ compensation coverage or fail to update information on their workers’ compensation insurance application are subject to stop work orders and civil and criminal penalties.

First Report of Injury

As soon as you notify your carrier about your employee’s work-related injury, the carrier will:

- Determine the compensability of the injury
- Provide an authorized doctor
- Pay for all authorized medically necessary care and treatment related to the injury or illness

Unauthorized treatment and care may include:

- Doctors’ visits
- Hospitalization
- Physical therapy
- Medical tests
- Prescription drugs
- Prostheses
- Travel expenses to and from authorized providers or pharmacies.

Upon reaching maximum medical improvement (MMI), the employee is required to pay a $10 copayment per visit for medical treatment. MMI occurs when the treating physician determines that the employee’s injury has stabilized to the extent that further improvement is not likely.

Wage Replacement Benefits

Workers’ compensation benefits to lost wages will start on the eighth day that the injured employee is unable to work. The injured employee will not receive wage replacement benefits for the first seven days of work missed, unless he or she is out of work for more than 21 days due to the work-related injury. In most cases, the wage-replacement benefits will equal two-thirds of the employee’s pre-injury regular weekly wage, but the benefit will not be higher than Florida’s average weekly wage. If the employee qualifies for wage replacement benefits, he or she can expect to receive the first benefit check within 21 days after the carrier becomes aware of the injury or illness and bi-weekly thereafter. The injured employee will be eligible for different types of wage replacement benefits, depending on the progress of the claim and the severity of the injury.

Temporary Total Benefits: These benefits are provided as a result of an injury temporarily prevents the employee from working and the employee has not reached MMI.

Temporary Partial Benefits: These benefits are provided when the doctor releases the employee to return to work, and the employee has not reached MMI.

Permanent Impairment Benefits: These benefits are provided when the injury causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole. If you return to work at or above your pre-injury wage, the permanent impairment benefit is reduced by 50%.

Petition for Benefits

To begin the judicial procedure for obtaining benefits that you believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Judge of Compensation Claims. The form can be accessed at www.jcc.state.fl.us/JCC/forms/Default.htm.

Anti-Fraud Reward Program

Workers’ compensation fraud occurs when a person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program, files false or misleading information.

To report suspected workers’ compensation fraud, call 1-800-378-0445.
Certificado de elección para exenciones

Industrias dedicadas a la construcción

Un empleador que no participa en la industria de construcción tiene que cumplir con el requisito de que su empleo sea de jornada completa o parcial, y que los empleados no enriquezcan el beneficio de seguros contratos de seguros de seguros de accidentes de trabajo

Propietarios y socios en industrias que no participan en la construcción están exentos de la cobertura de seguros de accidentes de trabajo

Un empleador que no participa en la industria de construcción se puede exentar de la cobertura de seguros de seguros de accidentes de trabajo

Preguntas hechas con frecuencia

P) ¿Cuántos días tienen los empleados para reportar lesiones u enfermedades relacionadas con el trabajo?

R) Los patrones deben advertir a sus empleados que reporten cualquier lesión o enfermedad relacionada con el trabajo en el plazo de 30 días.

P) ¿A quién le debo reportar la lesión relacionada con el trabajo?

R) Usted debe reportar el accidente a su compañía de seguros tan pronto como tenga conocimiento de la lesión. Por ley, usted tiene siete días desde su primer conocimiento de la lesión relacionada con el trabajo.

P) ¿Tengo que reportar un reclamo si no creo que la lesión o enfermedad es relacionada con el trabajo?

R) Sí. Usted debe reportar todas las demandas de lesiones o enfermedades relacionadas con el trabajo a su compañía de seguros.

P) ¿El empleado paga parte de la prima de seguro por accidentes de trabajo?


INFORMACIÓN IMPORTANTE

DEL SEGURO DE INDEMNIZACIÓN POR ACCIDENTES DE TRABAJO PARA LOS EMPLEADORES DE LA FLORIDA

69L-3.0036, F.A.C. Employer Informational Brochure

Revised March 2010
Su póliza de seguro por accidentes de trabajo cubre beneficios médicos y reemplazo parcial del salario para cualquier empleado que soporte lesión o enfermedad relacionada con su trabajo.

Este folleto le dará una mejor comprensión de su papel y responsabilidades bajo el sistema de seguro por accidentes de trabajo.

**Aviso de seguro por accidentes de trabajo**

La ley requiere que cada empleador que ha adquirido una póliza de seguro por accidentes de trabajo coloque en un lugar donde estén las oficinas visitando el sitio: www.MyFloridaCFO.com/Division/WC/Employee/eao_offices.htm. Los especialistas de la EAO poseen conocimiento sobre lo que la compañía de seguros debe proporcionar a sus empleadores.

Si se présente a la División de Compensación por Accidentes de Trabajo ha desarrollado este aviso en forma de cartel, para que las compañías de seguros se las proporcionen a sus empleadores. Su compañía de seguros tiene obligación legal de proveer los carteles.

Aunque el empleador adquiere una póliza de seguros por accidentes de trabajo, se considera en línea con el sistema de seguro si ha cumplido correctamente las siguientes acciones:

- **Subministrar un cómic de pago.**
- **Subministrar una nómina de pago.**
- **Falso conlleva responsabilidad del empleado para evitar la clasificación apropiada para los cálculos de prima de seguro.**
- **Falso que no informe la compañía de seguros de un accidente de trabajo, son sujetos a recibir una orden de suspensión de trabajo.**

**Primer reporte de la lesión o enfermedad**

Tan pronto usted se entere de una lesión o enfermedad relacionada con un accidente de trabajo, llame a su compañía de seguros por accidentes de trabajo. Si usted no reporta la lesión o la enfermedad a su compañía de seguros en un plazo de siete días después de que la lesión o enfermedad se entresenta durante el primer día, la compañía de seguros puede o no está disponible para firmarlo, escriba “no disponible” en la caja donde se pide la firma del empleado.

**Beneficios de reemplazo de salario**

Los beneficios de reemplazo de salario comenzarán al octavo día que el empleado no pueda trabajar. El empleado lesionado no recibirá beneficio de reemplazo de salario por los primeros siete días que no pudo trabajar a menos que haya estado incapacitado por más de 21 días debido a su lesión o enfermedad relacionada con su empleo. En la mayoría de los casos, los beneficios de reemplazo de salario igualan a dos terceros (1/3) del salario semanal regular del empleado antes de sufrir la lesión o enfermedad, pero el beneficio no excederá el promedio de los siete salarios semestrales más altos de la Florida. Si el empleado califica para los beneficios de reemplazo de salario, él o ella puede esperar recibir el primer cheque dentro de 21 días después de que la compañía de seguros se entere de la lesión o enfermedad. Los siguientes cheques se les enviarán cada dos semanas. El empleado lesionado será elegible para diversos tipos de beneficios de reemplazo de salario durante el promedio del resguardo y de la severidad de la lesión.

- **Beneficios por incapacidad total temporal (TTD por su sigla en inglés):** Estos beneficios son proveídos cuando la lesión o enfermedad es de carácter permanente que no permite al empleado volver a trabajar, y el empleado no ha alcanzado la máxima mejora médica.
- **Beneficios por incapacidad parcial temporal (TPD por su sigla en inglés):** Estos beneficios son proveídos cuando el empleado se permite volver a trabajar, pero el beneficiario no alcanza la máxima mejora médica.

Tan pronto usted le notifique a la compañía de seguro de una lesión que sufrió su empleado en el trabajo, la compañía:

- **Determinará si la lesión es compensable.**
- **Proveer un médico autorizado.**
- **Pagará por todo el cuidado autorizado que sea médicamente necesario y relacionado con la lesión o enfermedad.**
- **Proporcionará un solo cambio de médico dentro de cinco jornadas laborales del recibo de la petición de cambio de médico por el empleado.**

**Atención médica y tratamientos autorizados pueden incluir:**

- **Consultas médicas.**
- **Hospitalización.**
- **Terapia física.**
- **Exámenes médicos.**
- **Medicamentos recetados.**
- **Prótesis.**
- **Gastos de vida y vuelo por viajes a consultas médicas o farmacias autorizadas.**

En cuanto usted alcance la máxima mejora médica (MMI por su sigla en inglés): Esto es la fecha en que una lesión o enfermedad causa cualquier pérdida física, psicológica o funcional y el empleador está dispuesto después de la fecha de la máxima mejora médica (MMI). Un médico asignará una valoración de incapacidad permanente a la lesión que será expresada como un porcentaje.

- **Beneficios por daños permanentes (BD por su sigla en inglés):** Estos beneficios son proveídos cuando la lesión causa el empleado sea permanente y totalmente incapacitado (es) según las estipulaciones de la ley.
- **Indemnizaciones para fallecimiento: Compensación por accidentes de trabajo que resultan en la muerte del trabajador incluye pago de gastos para el funeral y beneficios para los dependientes del fallecido (estos son sujetos a límites semestrales de pago por el año). Un cómputo dependiente puede ser elegible para entrenamiento vocacional.

**Formulario de declaración del salario**

Usted debe llenar el formulario de declaración del salario (DFS-F2-DWC-1a) para cualquier empleado que tenga derecho a recibir beneficios de reemplazo de salario y proveerlo a su compañía de seguros dentro de 14 días después del conocimiento del accidente. Usted también debe llenar el formulario de indemnización de seguro de vida (DFS-F2-DWC-1b) para cualquier empleado que esté recibiendo beneficios de reemplazo de salario. Éste debe hacerse en un plazo de 7 días después del terminación. Para llenar de forma segura, vaya a la página web https://www.MyFloridaCFO.com/Division/WC/ Programa索赔/FormsManualsReports/Forms/Default.htm y haga clic en DWC-1a.

**Relación con los seguros de vida**

Los especialistas de la EAO pueden conocer sobre el sistema de seguro por accidentes de trabajadores pueden contener las preguntas de su compañía de seguros. Los especialistas de la EAO pueden conocer sobre el sistema de seguro por accidentes de trabajadores pueden contener las preguntas de su compañía de seguros. Además, la División de Compensación por Accidentes de Trabajo tiene una sección en el Web, “Preguntas fechadas con frecuencia por empleadores,” que puede alcanzar en https://www.MyFloridaCFO.com/Division/WC/Pages/faq.aspx.

**Peticiones de beneficio**

Si se presenta a la División de Compensación por Accidentes de Trabajo tiene una sección en el Web, “Preguntas fechadas con frecuencia por empleadores,” que puede alcanzar en https://www.MyFloridaCFO.com/Division/WC/Pages/faq.aspx.

**Programa de recompensas contra fraude**

El fraude en el seguro de vida ocurre cuando cualquier persona a sabiendas y con intención de hacer daño, defraudar o engañar a cualquier empleador o trabajador, compañía de seguros, auto compañía de seguros, presenta, informe falsifica o engaña. El fraude del seguro por accidentes de trabajo es un delito mayor de tercer grado que puede resultar en multas, responsabilidad civil, o encarcelamiento. Recompensas de hasta $25,000.00 se les puede pagar a personas quienes proveen informations que resulte en la detención y la condena de personas que han cometido fraude de seguros. Ustea al 1-800-342-1741 para reportar sospechas de fraude de seguros por accidentes de trabajadores.
Resources

Office of Compliance and Risk Management
Florida Institute of Technology
John E. Miller Building
150 W. University Blvd.
Melbourne, FL 32901-6975
321-674-8885 | fbaarman@fit.edu

Claims-Handling Entity
Cannon Cochran Management Services Inc. (CCMSI)
2600 Lake Lucien Dr., Suite 225
Maitland, FL 32794
Phone: 407-660-5637 | 866-291-0194 | Fax: 217-477-6623
After Hours: 877-253-5169