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 the Workday 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.
EMLOYEE ACCIDENT/INJURY REPORT

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

EMLOYEE 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):

List ____________________________________________________________

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

Employee signature ____________________________________________________________  Date _________________________

Florida Institute of Technology • Office of Compliance and Risk Management • 150 W. University Blvd., Melbourne, FL 32901-6975 • 321-674-8885

Florida’s STEM UNIVERSITY®
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

Federal ID number 59-6046500

Nature of business Education

Restricted duty?  ❑ Yes  ❑ No

MMI date _____________________________

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

Policy/member number 0000217012000030129462019

Did supervisor accommodate restriction?  ❑ Yes  ❑ No

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

FLORIDA'S STEM UNIVERSITY*
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: __________________________________________________________________________________________________________

Claim #: ________________________________  Employee: _____________________________________________________

Employer: _______________________________________________________________________________________________________________

Employee’s Address: ______________________________________________________________________________________________________

Phone: __________________________________________________________________________________________________________________

Worker’s Signature: ____________________________________________________  Date: _____________________________
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: ____________________________________________________________________
REQUEST FOR MILEAGE REIMBURSEMENT

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

Name: 

Employer: Florida Institute of Technology

Claim Number: 

Claimant Address: 

Work Address: 

Date Of Injury: Adjusters: Terri Krepps/Pamela Schlegel

<table>
<thead>
<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>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Total Miles: _________________ x 0.445 = $ ___________________________

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: __________________________

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
**Employer:**

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

<table>
<thead>
<tr>
<th><strong>Employee Name</strong></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Group#:</td>
<td>P2KA</td>
</tr>
<tr>
<td>PCN:</td>
<td>Workers’ Compensation</td>
</tr>
<tr>
<td>ID# (Claim Number):</td>
<td></td>
</tr>
<tr>
<td>Date of Accident:</td>
<td></td>
</tr>
<tr>
<td>Processor:</td>
<td>myMatrixx</td>
</tr>
<tr>
<td>Bin#:</td>
<td>003858</td>
</tr>
</tbody>
</table>

Day supply is limited to 14 days for a new injury.

myMatrixx Help Desk: (877) 804-4900

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**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.**

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**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**

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2022-1831
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 ___________

(To be completed by witness only)
Procedural Information—Section D

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 circumstance. 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 CCSMI 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 CCSMI (407-660-5637or 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 CCSMI if they have already completed the following forms: Florida Tech Employee Accident/Injury Report, False and Fradulent 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 be exempt if:

- The owner 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 for a period of two years or 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.

Sole proprietors 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.

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.

Customer Service

1-800-342-1741

Employment Assistance and Ombudsman Office

1-800-342-1741

Injured worker e-mail inquiries

workcompCustServ@MyFloridaCFO.com

Employer e-mail inquiries

WorkCompCustServ@MyFloridaCFO.com

Workers’ Compensation Fraud Hotline

1-800-378-0445

Employer Facts

What Your Employee Can Expect From the Insurance Carrier

• Timely provision of medical treatment
• Timely payment of wage replacement benefits
• Timely payment of medical bills
• Timely reporting of the employee’s claim information to the Division of Workers Compensation
• Timely notification of any changes in the status of the employee’s claim. This information should be provided to the injured worker by mail or telephone. A Notice of Change or Notice of Denial form (DWC-10) is not required.

Frequently Asked Questions

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

A) Employers should encourage employees to report accidents as soon as the work-related injuries or illnesses occur. By law, however, employees are required to report work-related injuries or illnesses within 30 days.

2) 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, you have seven days from the first knowledge of the work-related injury.

3) 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.

4) 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 contact the Division of Workers’ Compensation Customer Service Office at 1-800-342-1741.

If your carrier is unable to answer the question or resolve the problem, you or your employees should call the Employment Assistance and Ombudsman Office.

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.
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 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).

Even if employers 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 concealed payroll
- materially misrepresented or concealed employee duties to avoid proper classification for premium calculations
- 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 become aware of a work-related injury or illness, immediately contact your workers’ compensation insurance carrier. If you do not report the injury or illness to your insurance carrier within seven days of the date you were informed, you may be subject to an administrative fine not to exceed $2,000 per occurrence. Most insurance companies have a toll-free number to report work-related injuries. If you report the injury or illness to the insurance carrier by telephone, the carrier will complete the form and send a copy to you and the employee within three business days. You can also fill out the First Report of Injury or Illness form (WJC-1) and send it to the insurance carrier. The form contains employer, employee and accident information and can be obtained on the Division of Workers’ Compensation Web site at https://www.MyFloridaCFO.com/Division/WC/wjc02wjc1.pdf. You may also provide a copy of the First Report of Injury or Illness form to the employee. The employee is required to sign the form, but the signature may be entered in the employee’s signature box.

Workplace Fatalities

Employers must also report deaths resulting from work-related injuries or illnesses to the Division of Workers’ Compensation within 24 hours. To report a workplace fatality, call 1-800-342-1741 or fax the First Report of Injury or Illness form containing the fatality information to 353-345-5400.

To access the form, go to https://www.MyFloridaCFO.com/Division/WC/PublicationsForms/Manuals/Reports/Forms/Default.htm.

Medical Benefits

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
- Provide a one-time change of physician within five business days of receipt of your written request

Authorized treatment and care may include:

- Doctor’s visits
- Hospitalization
- Physical therapy
- Medical tests
- Prescription drugs
- Posttheses
- 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 healed to the extent that further improvement is not likely.

Wage Replacement Benefits

Workers’ compensation benefits provide the injured employee a wage that 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 that temporarily prevents the employee returning to work and the employee has not reached MMI.
- Temporary Partial Benefits: These benefits are provided when the injured employee reaches MMI that permanently prevents the employee returning 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 or above your pre-injury wage, the permanent impairment benefit is reduced by 50%.
- Permanent Total Benefits: These benefits are provided when the injury causes the employee to be permanently and totally disabled according to the conditions stated in law.
- Death Benefits: Compensation for deaths resulting from work-related injuries or illnesses include payment of funeral expenses and dependency benefits (such as subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

Wage Statement Form

You must complete and provide a wage statement form (WJC-2) to your carrier for any employee who is entitled to wage replacement benefits, within 14 days after knowledge of the accident. You must also complete this form upon the termination of the employee or upon termination of fringe benefits for any employee who is collecting wage replacement benefits within seven days of such termination. To access the form go to https://www.MyFloridaCFO.com/Division/WC/PublicationsForms/Manuals/Reports/Forms/wjc2.htm and click on WJC-2a.

Employee Assistance Office

If you have any questions or concerns about your employees’ workers’ compensation benefits, call your workers’ compensation insurance carrier. If the insurance carrier does not provide the information that you have requested, you can call the Division of Workers’ Compensation, Employee Assistance Office (EAO) at 1-800-342-1741. This office helps prevent and resolve disputes between injured workers and employers/carriers. EAO specialists are knowledgeable about the workers’ compensation system and may be able to answer your questions. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at www.MyFloridaCFO.com/Division/WC/Employee/Anti-Fraud.htm.

In addition, the Division of Workers’ Compensation has a Web site section on “Frequently Asked Questions for Employers,” which can be accessed at https://www.MyFloridaCFO.com/Division/WC/Employee/FAQ.htm.

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 Office of Judges of Compensation Claims. The form can be accessed at www.jcc.state.fl.us/JCC/forms/. Anti-Fraud Reward Program

Workers’ compensation fraud occurs when one 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, Provision of workers’ compensation is a third degree felony that can result in fines, civil liability and jail time. Rewards of up to $5,000 may be paid to individuals who provide information that leads to the arrest and conviction of persons committing insurance fraud. To report suspected workers’ compensation fraud, call 1-800-378-0445.
Información para empleadores

Preguntas hechas con frecuencia

P) ¿Cuántos días tienen las empleadas para reportar lesiones o enfermedades relacionadas con el trabajo?
R) Los empleadores sueltos deben reportar la lesión u enfermedad a su compañía de seguro tan pronto como ocurran lesiones o enfermedades relacionadas con el trabajo. Por ley, siempre se requiere que los empleadores reporten lesiones o enfermedades relacionadas con el trabajo en los 30 días.

P) ¿A quién debo reportar la lesión relacionada con el trabajo?
R) Usted debe reportar el accidente a su compañía de seguro tan pronto usted 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. Esto incluye las demandas de lesiones o enfermedades relacionadas con el trabajo.

P) ¿El empleado paga parte de la prima de seguro por accidentes de trabajo?
R) No. La ley es muy específica en este punto. Es la responsabilidad del empleador pagar la prima entera del seguro.


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

DIVISION OF WORKERS’ COMPENSATION
Florida Department of Financial Services

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 69L-3.235, F.A.C. Forms
DFS-F2-DWC-66
Revised March 2010
Su póliza de seguro por accidentes de trabajo cubre beneficios médicos para cualquier enfermedad relacionada con su trabajo.

**Formulario de reemplazo de salario**

Usted debe llenar el formulario de la declaración del salario por cada consulta para tratamiento médico. La máxima mejoría adicional no es probable.

**Beneficios de reemplazo parcial del salario**

La cantidad que recibirán los beneficiarios de reemplazo parcial del salario igualará a dos tercios (2/3) del salario semanal regular del empleado antes de sufrir la lesión o enfermedad, pero el beneficio no excederá el promedio de los salarios que el empleado ganó menos del 80% del salario que ganaba antes de sufrir la lesión.

**Determinación de la lesión**

La División de Compensación por Accidentes de Trabajo determinará si la lesión es compensable.

**Información sobre la compañía de seguros**

Usted debe proporcionar información sobre la compañía de seguros, la fecha de terminación, el médico que ha atendido a su empleado, y el empleado no ha alcanzado la máxima mejoría médica, y el empleado no ha sido rehabilitado, no se rehabilitará, y el empleado no ha sido reclamado.

**Reclamación de beneficios**

Si la compañía de seguros no da el beneficio del pago de reemplazo parcial del salario, el empleado puede probar ante la División de Compensación por Accidentes de Trabajo la aplicación de un factor de modificación de experiencia.

**Aviso de seguro por accidentes de trabajo**

La compañía de seguros se entera de la lesión o enfermedad. Los siguientes beneficios están disponibles para el empleado que no puede trabajar a menos que ha estado incapacitado.

**Programa de rehabilitación**

El programa de rehabilitación puede ser elegible para entrenamiento vocacional.

**Fraude en el seguro por accidentes de trabajo**

El fraude en el seguro por accidentes de trabajo ocurre cuando el empleado no cuenta con la información que se le debe según la ley pero la compañía de seguros no da el beneficio del pago.
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