ATA COMP FUND

PROTECTION | PERFORMANCE | DRIVEN

Welcome to the ATA Comp Fund!

Since 1993, the ATA Comp Fund has been providing stable, low-cost workers' compensation coverage for the transportation, distribution, supply-chain management and allied industries.

Our industry-leading, behavior-based Risk Management and Safety Services help you develop and manage a safer work environment. In addition, expert Claims Management focuses on driving down the severity, duration and total cost of claims. *The results are a proven safety culture and a more profitable business.*

In the enclosed folder, you will find information and forms for your coverage provided through the Fund. These include:

— Quarterly Payroll Monitoring Guidelines
— Annual Audit Expectations
— How to File a Claim*
— Post Job Offer Medical Questionnaire
— Notice to Alabama Employees
— Company Driver Notification
— Owner-Operator Notification
— First Report of Injury

*All Alabama claims are handled by Sedgwick. If there is a Cross Border (multi-state) policy in place, those claims are handled by CCMSI Specialty.

Risk Management Services

Contact your Risk Manager to take advantage of the many customized services provided to you as a member of the ATA Comp Fund include:

— Loss Control inspections & safety meetings
— Mock FMCSA compliance audits
— Simulated OSHA compliance surveys
— OSHA Alliance Membership
— Free Safety posters, stickers, etc.
— Customized training videos

Michael Smith, CDS, TRS, SSH
[p] 334.301.0518
[e] MSmith@ATACompFund.org

Candy Woodruff, CDS, TRS
[p] 334.312.5098
[e] CWoodruff@ATACompFund.org

Victor Whatley, CSP, CDS, TRS
[p] 251.622.1898
[e] VWhatley@ATACompFund.org

Will Moses, TRS, CSS
[p] 334.429.2293
[e] WMoses@ATACompFund.org

Sedgwick (Alabama Claims) Contact Information
[p] 877.858.9509
[e] 7184ATA@Sedgwick.com

CCMSI (Cross Border Claims) Contact Information
[p] 844.858.8237
[e] ATA@CCMSI.com

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Quarterly Payroll Monitoring

Each quarter, a reminder will be sent for copies of the previous quarter's 941 Federal Tax Return and State Unemployment Compensation tax return for all states in which your company files.

The ATA Comp Fund uses this information, as well as records of other wages, in the ongoing underwriting review of your account as the year progresses.

There are many reasons for this underwriting review:

—Payrolls are monitored and adjustments will be made to estimates in cases of growth or decline.

—Contractor wages are monitored for exposure-related concerns.

—Owner Operator/Lease Purchase/Subcontract Driver information and wages are monitored if applicable for exposure.

—All information is used to keep the account(s) as accurately estimated as possible to avoid large discrepancies with audit results.

While it is the Fund Member's responsibility to notify the Fund with any expected significant change in payrolls or operations, this process helps monitor for any change that may require further review.

This information can be submitted to our office via email (katiecoaker@atacompfund.org) or via fax (334.834.7931). We look forward to the opportunity to show you why the ATA Comp Fund is a step above in not only resources and training, but in our service as well!

Annual Audit Information

Once a policy period has ended (typically January 1st), payroll audits will be performed for the expiring policy term. The Fund partners with skilled premium auditors from Sedgwick to perform these audits nationwide. Once your account has been assigned an auditor, you will be contacted to schedule the physical audit. Audits must be completed on-site at your location and signed by an officer of the company(ies).

Some of the items the auditor will be prepared to evaluate to complete the audit are as follows:

—All quarters of previous year's 941 Federal Tax Return and State Unemployment Compensation Tax Return (all applicable states)

—Previous year 1099 forms and Year-End 1096 form

—Year-End Payroll Summary (including overtime and per diem records)

—Owner Operator/Lease Purchase/Subcontract Driver information, including weeks worked and payments made

—Casual Labor/Contract Labor/Subcontractor Labor records, including certificates of insurance for their workers' compensation coverage, if applicable

A detailed list of required information will be provided at the time of audit scheduling.

Owner Operator/Contract Driver Worksheet

**If your company has more owner operators than there is room to list on one sheet, please make additional copies.
If your company does not use owner operators, please write "NONE" on this form and sign.

EACH INDIVIDUAL DRIVER MUST BE LISTED OF SMALL FLEET OWNERS.

Fund Member ____

Owner Operator's Name	# of drivers	Age of Driver	Amount Paid during coverage period	# of weeks worked during coverage period

**Signature ____________________________________ Title ______________________

(must be signed by an officer of the company)

Lease Purchase Operator/Contract Driver Worksheet

**If your company has more lease purchase operators than there is room to list on one sheet, please make additional copies.
If your company does not use lease purchase operators, please write "NONE" on this form and sign.

Fund Member ____

Lease Purchase Operator's Name	Age of Driver	Amount Paid during coverage period	# of weeks worked during coverage period

**Signature ___________________________________ Title _____________________
(must be signed by an officer of the company)

1099 or Cash Laborer Worksheet
(Other than Owner Operators / Lease Purchase Operators)

**If your company has more laborers than there is room to list on one sheet, please make additional copies. If your company does not use 1099 or cash paid laborers, please write "NONE" on this form and sign.

Fund Member _____

Laborer's Name	Laborer's Job Description	Wages Paid during coverage period	Laborer's WC Coverage? (Y/N) Provide COI

**Signature _____ Title _____

(must be signed by an officer of the company)

Notice to Alabama Employees

If you are injured while working, you should immediately report the injury to your supervisor, even if it is a minor injury and does not require medical attention.

Workers' Compensation:

1. Is an insurance benefit provided by your employer as required by law.

2. If you are injured while working, workers' compensation pays for authorized medical treatment and other related expenses as defined by the Alabama workers' compensation statute.

Your employer has elected to provide workers' compensation coverage through:

ATA COMP FUND

Claims will be handled by:

Sedgwick

PO Box 14432

Lexington, KY 40512

(877) 858 -9509

For information on your rights under the Alabama Workers' Compensation Law, including dispute mediation (Ombudsman) service, contact: Worker's Compensation Division Department of Labor | State of Alabama | Montgomery, Alabama 36131 | (800) 528-5165

(Alabama Act 92-537)

How to Report an Alabama Claim

Complete the Alabama First Report of Injury and submit:

By e-mail: 7184ATA@Sedgwick.com

This is our preferred method of receiving your first report of injury

By phone: (877) 858-9509

After reporting the claim, a Sedgwick adjuster will contact you within 24 hours.

Additional Instructions:

If you have any supporting documents (employee files, investigation notes/pictures, medical notes, medical bills, etc.) associated with a newly reported claim, please wait for the adjuster's contact information.

ATA COMP FUND

How to Report a Cross Border Claim

Complete the State First Report of Injury and submit:

By e-mail: ATA@CCMSI.com

This is our preferred method of receiving your first report of injury

By phone: (844) 858-8237

Press '1' to report a claim
(Available anytime- days, nights & weekends)

Press '2' to inquire about a claim
(Available 8:00am to 5:00pm EST)

After reporting the claim, a CCMSI adjuster will contact you within 24 hours.

Additional Instructions:

If you have any supporting documents (reports, bills, etc.) associated with a newly reported claim, please wait for the adjuster's contact information. Do not send these documents to the call center.

ATA COMP FUND

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2
Rev. 10/2012

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

CLAIM REFERENCE

1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name
5. Physical Address 1
6. Physical Address 2
7. City 8. State 9. Zip

ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS
10. Mailing Address 1
11. Mailing Address 2
12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number	17. NAICS

INSURER / FILING OFFICE

18. Insurer Name
19. Insurer Federal ID Number
20. Type Insurer Ins Co ☐ Self-Insurer ☐ Group Fund ☐

21. Filing Office Name
22. Mailing Address 1
23. Mailing Address 2 or Telephone Number
24. City 25. State 26. Zip
27. Filing Office Federal ID Number

EMPLOYEE / WAGES

28. First Name
29. Middle Name
30. Last Name
31 Last Name Suffix (ie. Jr., Sr., III)

32. Employee ID Number
33. Type Employee ID Number
SSN ☐ Passport Number ☐ Green Card ☐
Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1
35. Mailing Address 2
36. City 37. State 38. Zip 39. Phone

40. Gender
Male ☐
Female ☐

41. Date of Birth

42.Nbr of Dependents

43. Marital Status
Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐

44. Date Hired

45. Occupation Description

46. Number of Days Worked Per Week

47. Wages $
48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐

49. Received Full Pay For Day of Injury? Yes ☐ No ☐
50. Did Salary Continue? Yes ☐ No ☐

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE
56. Site Address
57. City 58. State 59. Zip
60. County

61. Injury Occurred on Employer's Premises?
Yes ☐ No ☐

62. Date Employer Notified

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

67. Initial Treatment
First Aid By Employer ☐
Emergency Room ☐
Hospitalized > 24 Hours ☐
No Medical Treatment ☐
Minor Clinic / Hospital ☐
Hospitalized Overnight ☐
Outpatient Treatment ☐

68. Name of Treatment Facility
69. Address
70. City 71. State 72. Zip

73. Name of Physician or Other Health Care Professional

74. Has Injured Returned to Work
Yes ☐ No ☐

If so, 75. Date
76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name	79. Last Name	80. Title	81. Preparer's Telephone Number

NATURE OF INJURY	PART OF BODY	CAUSE OF INJURY
01. No Physical Injury	10. Multiple Head Injury	01. Chemicals
02. Amputation	11. Skull	02. Hot Objects or Substances
03. Angina Pectoris	12. Brain	03. Temperature Extremes
04. Burn	13. Ear(s)	04. Fire or Flame
07. Concussion	14. Eye(s)	05. Steam or Hot Fluids
10. Contusion	15. Nose	06. Dust, Gases, Fumes or Vapors
13. Crushing	16. Teeth	07. Welding Operation
16. Dislocation	17. Mouth	08. Radiation
19. Electric Shock	18. Soft Tissue	09. Contact With, NOC.
22. Enucleation	19. Facial Bones	10. Machine or Machinery
25. Foreign Body	20. Multiple Neck Injury	11. Cold Objects or Substances
28. Fracture	21. Vertebrae	12. Object Handled
30. Freezing	22. Disc	13. Caught In, Under or Between, NOC.
31. Hearing Loss or Impairment	23. Spinal Cord	14. Abnormal Air Pressure
32. Heat Prostration	24. Larynx	15. Broken Glass
34. Hernia	25. Soft Tissue	16. Hand Tool, Utensil; Not Powered
36. Infection	26. Trachea	17. Object Being Lifted or Handled
37. Inflammation	30. Multiple Upper Extremities	18. Powered Hand Tool, Appliance
40. Laceration	31. Upper Arm	19. Caught, Puncture, Scrape, NOC.
41. Myocardial Infarction	32. Elbow	20. Collapsing Materials (Slides of Earth) Either Man Made or Natural
42. Poisoning - General	33. Lower Arm	25. From Different Level (Elevation) Off Wall, Catwalk, Bridge, Etc.
43. Puncture	34. Wrist	26. From Ladder or Scaffolding
46. Rupture	35. Hand	27. From Liquid or Grease Spills
47. Severance	36. Finger(s)	28. Into Openings Shafts, Excavations, Floor Openings, Etc.
49. Sprain or Tear	38. Shoulder(s)	29. On Same Level
52. Strain or Tear	39. Wrist (s) & Hand(s)	30. Slipped, Do Not Fall
53. Syncope	40. Multiple Trunk	31. Fall, Slip or Trip, NOC.
54. Asphyxiation	41. Upper Back Area	32. On Ice or Snow
55. Vascular	42. Lower Back Area	33. On Stairs
58. Vision Loss	43. Disc	40. Crash of Water Vehicle
59. All Other Specific Injuries, NOC	44. Chest	41. Crash of Rail Vehicle
60. Dust Disease, NOC	45. Sacrum and Coccyx	45. Collision or Sideswipe With Another Vehicle
61. Asbestosis	46. Pelvis	46. Collision with a Fixed Object Standing Vehicle or Stationary Object
62. Black Lung	47. Spinal Cord	47. Crash of Airplane
63. Byssinosis	48. Internal Organs	48. Vehicle Upset Overturned or Jackknifed
64. Silicosis	49. Heart	50. Motor Vehicle, NOC.
65. Respiratory Disorders	50. Multiple Lower Extremities	52. Continual Noise
66. Poisoning - Chemical, (Other Than Metals)	51. Hip	53. Twisting
67. Poisoning - Metal	52. Upper Leg	54. Jumping
68. Dermatitis	53. Knee	55. Holding or Carrying
69. Mental Disorder	54. Lower Leg	56. Lifting
70. Radiation	55. Ankle	57. Pushing or Pulling
71. All Other Occupational Disease Injury, NOC	56. Foot	58. Reaching
72. Loss of Hearing	57. Toes	59. Using Tool or Machinery
73. Contagious Disease	58. Big Toes	60. Strain or Injury By, NOC.
74. Cancer	60. Lungs	61. Wielding or Throwing
75. AIDS	61. Abdomen Including Groin	65. Moving Part of Machine
76. VDT - Related Diseases	62. Buttocks	66. Object Being Lifted or Handled
77. Mental Stress	63. Lumbar & or Sacral Vertebrae	67. Sanding, Scraping, Cleaning Operation
78. Carpal Tunnel Syndrome	64. Artificial Appliance	68. Stationary Object
79. Hepatitis C	65. Insufficient Info to Properly Identify	69. Stepping on Sharp Object
80. All Other Cumulative Injury, NOC	66. No Physical Injury	70. Striking Against or Stepping On, NOC.
90. Multiple Physical Injuries Only	90. Multiple Body Parts	74. Fellow Worker; Patient
91. Multiple Injuries Including Both Physical & Psychological	91. Body Systems and Multiple Body	75. Falling or Flying Object
	99. Whole Body	76. Hand Tool or Machine in Use
		77. Motor Vehicle
		78. Moving Parts of Machine
		79. Object Being Lifted or Handled
		80. Object Handled By Others
		81. Struck or Injured, NOC.
		82. Absorption, Ingestion or Inhalation, NOC
		84. Electrical Current
		85. Animal or Insect
		86. Explosion or Flare Back
		87. Foreign Matter (Body) in Eye(s)
		88. Natural Disasters
		89. Person in Act of a Crime
		90. Other Than Physical Cause of Injury
		91. Mold
		94. Repetitive Motion Callous, Blister, Etc.
		95. Rubbed or Abraded, NOC.
		96. Terrorism
		97. Repetitive Motion Carpel Tunnel Syndrome
		98. Cumulative, NOC
		99. Other - Miscellaneous, NOC

INSTRUCTIONS FOR FILING WC FIRST REPORT OF INJURY

Employers should send a completed legible form to the insurance carrier or, if self-insured, to the designated office handling their workers' compensation claims. The insurance carrier or designated office should forward this First Report on to the Workers' Compensation Division, Department of Industrial Relations, Montgomery, Alabama 36131 within fifteen (15) days from the date of injury or date of notification to the employer for all injuries for which compensation is claimed or paid. This includes deaths, permanent disabilities or temporary disabilities exceeding three (3) days).

Block 1. A number assigned by the insured to identify a specific claim

Block 2. An identifier for a specific claim within a claim administrator's claims processing system.

Block 3. Case number from log maintained for OSHA

Block 4 - Block 14. Self Explanatory

Block 15. Employer Federal ID number

Block 16. Employer Unemployment Compensation Account Number

Block 17. NAICS Industry Codes http://dir.alabama.gov/docs/forms/wc_naics.pdf

Block 18. Carrier's name

Block 19. Carrier's FEIN

Block 20. A code representing the kind of entity providing financial responsibility for the claim, exp: (I) Insurance Carrier (S) Self Insurer (G) Guarantee Fund/Group

Block 21 through Block 63. Self Explanatory

Block 64. Nature of Injury Codes http://dir.alabama.gov/docs/forms/wcio_nature_table.pdf

Block 65. Part of Body Codes http://dir.alabama.gov/docs/forms/wcio_part_table.pdf

Block 66. Cause of Injury Codes http://dir.alabama.gov/docs/forms/wcio_cause_table.pdf

Block 67 through Block 81. Self Explanatory

EMPLOYEE'S REPORT OF INJURY

1. Employee Name		Address		Telephone No.
2.Date of Birth	Social Security Number	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Widow ☐ Divorced	
3. Dependents (give name,relationship and age):				
4. Name of Family Physician		Address		Telephone No.
5. Employer's Name		Address		Telephone No.
6. On whose payroll were you when injured?			Is Employer related to You by blood or marriage?	State Relationship
7. Date of Injury	Time of Injury (specify am or pm)	What was your occupation when injured?		Were you doing your regular work?
8. How long have you worked for above Employer?			In what capacity are you employed?	
9. Address where injured		Were you on Employer's premises? ☐ Yes ☐ No	If "No", please explain	When did you first report your injury?
10. To whom did you report this injury?				Are you right or left handed?
11. Describe fully what you were doing and how the injury occurred				
12. Nature and location of injury (describe fully - give part of body, right or left, etc.)				
13. What are your weekly wages?	Were you allowed board lodging or other advantages, besides your wages? ☐ Yes ☐ No		If "Yes", please list.	
14. Date and hour last worked (please specify a.m. or p.m.)	Date wages stopped		Date and hour board, lodging other advantages stopped	
15. Date you returned to work or plan to return to work			What will your wages be?	
16. Have you recovered? ☐ Yes ☐ No	If "No", describe present ailment.			
17. Name of Doctor visited for this injury?	Address			Telephone No.
18. Who selected your doctor?	Date of Doctor's first visit	Date of Doctor's last visit	Number of doctors's visits to date	

19. If hospitalized, list name(s)	Dates(s) of Admission	Date(s) of Discharge

EMPLOYEE'S REPORT OF INJURY

20. If still under Doctor's care, how often do you see him and what treatment does he give you?		
21. If injury was caused by another person, give name	**Address**	**Telephone No.**
22. Name of Witnesses	**Address**	**Telephone No.**
23. Have you ever had any other condition or injury involving this part of your body? If "Yes", give details and dates. ☐ **Yes** ☐ **No**		
24. Have you ever filed for Workers' Compensation benefits or received an insurance settlement for a prior injury? If "Yes", give details (from whom, etc.) ☐ **Yes** ☐ **No**		
25. Remarks or other comments		
I certify this information is true and correct to the best of my knowledge.		
Employee Name (Print)	**Signature**	**Date**

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTIVE HEALTH INFORMATION

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____
(Street) (City/State/Zip)

Social Security #: _____ Telephone: ( ) -

Information to be Released – Covering the Periods of Heath Care

From (date): 1992 To (date): _____

From (date): _____ To (date): _____

Please check type of information to be released.

- ☐ Entire Medical Record
- ☐ History and Physical Exam
- ☐ Laboratory Test Results/Reports
- ☐ Operative Report
- ☐ Other (Specify)
- ☐ Pathology Report
- ☐ Consultation Reports
- ☐ X-Ray Reports
- ☐ Emergency Room Report
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ X-Ray Film/Images
- ☐ Itemized Bill

Purpose of Request

- ☐ Treatment or consultation
- ☐ Billing or claims payment
- ☐ At request of the patient
- ☐ Other (Specify)

Person Authorized to Receive Information

Name: **Sedgwick** Address: **P.O. Box 2408, Birmingham, AL 35201**

Drug and/or Alcohol Abuse, and/or Psychiatric and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing and/or other sensitive information, I agree to its release. Check One: ☐ Yes ☐ No Initials: _____

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agreed to its release. Check One: ☐ Yes ☐ No Initials: _____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer. Unless revoked, this authorization will expire on the following date of event 7 years from date of signature.

Re-Disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that any & all providers may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize any and all providers to use and disclose the protected heath information specified above.

A photocopy of this authorization shall have the same force and effect as the original.

Signature: _____ Date: _____

Verified by: _____

Doctor's Full Name _____

Hospital Name (if applicable) _____

Complete Address _____
(Number and Street or P.O. Box)

_____
(City, State and Zip)

ADDITIONAL INFORMATION

Doctor's Full Name _____

Hospital Name (if applicable) _____

Complete Address _____
(Number and Street or P.O. Box)

_____
(City, State and Zip)

WAGE STATEMENT

Re: _____ (CLAIMANT)

As Third Party Administrator for the ATA Comp Fund, Sedgwick has received the above-referenced claim.

In order to process any indemnity benefits that may be due under the referenced claim, the following is requested:

1. Wage and Fringe Benefit information, excluding per diem and expense data.

2. Value of Employer-Paid Fringe Benefits. Form is not to be completed unless fringe benefits ARE NOT CONTINUED by the Employer during the claimant's disability.

Without this information, any indemnity benefits that may be due cannot be paid.

Completed forms should be faxed to (205) 214-1191 or emailed to your assigned adjuster.

Wage Statement

Claim Number:_____ Date: _____

This is to certify that I _____ am the _____ of _____
(Name of Person certifying) *(Name of Officer or Position Held)* *(Name of Employer)*

at _____ employer of _____ injured on or about _____
(Number, Street, City, Town) *(Name of Injured Person)* *(Day, Month, Year)*

"A"

I have examined the payroll of said employer and the following table shows the days worked and the wages earned by _____
(Name of Injured Person)

and employed as a _____during the period stated herein.
(occupation)

"B"

I have examined the payroll of said employer and find that _____ did not work for said employer a substantial
(Name of Injured Person)

portion of the year before the accident. The following table shows the days worked and the wages earned by _____ another employee of the same class employed by the same employer who did work a substantial part of such year in the same or similar employment.

Date: _____ Signature:_____

	Week Ending			Days Worked	Gross Wages
	Mo	Day	Year		
1					$.
2					$.
3					$.
4					$.
5					$.
6					$.
7					$.
8					$.
9					$.
10					$.
11					$.
12					$.
13					$.
14					$.
15					$.
16					$.
17					$.
18					$.
19					$.
20					$.
21					$.
22					$.
23					$.
24					$.
25					$.
26					$.

	Week Ending			Days Worked	Gross Wages
	Mo	Day	Year		
27					$.
28					$.
29					$.
30					$.
31					$.
32					$.
33					$.
34					$.
35					$.
36					$.
37					$.
38					$.
39					$.
40					$.
41					$.
42					$.
43					$.
44					$.
45					$.
46					$.
47					$.
48					$.
49					$.
50					$.
51					$.
52					$.

Grand Total of Gross Wages: $_____

Employer: _____ Employee: _____

Date of Hire: _____ Date of Injury: _____

VALUE OF EMPLOYER PAID FRINGE BENEFITS

(COMPLETE ONLY IF FRINGE BENEFITS ARE NOT CONTINUED BY THE EMPLOYER DURING DISABILITY)

WEEKLY VALUE OF BENEFITS PAID BY EMPLOYER
IF BENEFITS ARE NOT APPLICABLE OR NOT OFFERED, INDICATED BY "NA"

Group Medical Expense paid by Employer	$.
Group Dental Expense paid by Employer	$.
Life Insurance Expense paid by Employer	$.
Pension Benefits paid by Employer	$.
Disability Insurance Expense paid by Employer	$.
Vision Protection Expense paid by Employer	$.
Other: _____	$.
Other: _____	$.
Total Weekly Value of Fringe Benefits paid by Employer	$.

I certify, to the best of my knowledge, the above information is true and accurate.

Name(Print): _____

Signature: _____

Title: _____

Date: _____

Employer Responsibilities

- **Prompt Reporting of Losses**

  Every department manager and every supervisor must be trained to immediately report all claims to the employer's workers' compensation coordinator. If the employer does not have a workers' compensation coordinator, the supervisor or manager for the employer must immediately complete the First Report of Injury form and submit it to Sedgwick for Alabama claims or CCMSI for Cross Border claims.

  All claims must be reported to Sedgwick or CCMSI as soon as possible, but in no event, shall the report be made later than five (5) days from the date the employer becomes aware of the injury. For members of the Certified Safety Program, claims must be reported within two (2) business days from the date the employer becomes aware of the injury.

- **Post-Accident Drug Testing**

  Post-Accident drug testing is a requirement of the Alabama Trucking Association Worker's Compensation Fund. When your employee receives initial medical treatment, be sure to request a "Non-DOT" DOT drug test be administered immediately; unless otherwise specified by DOT regulations. Insist the Chain of Custody is followed – especially at hospitals.

- **Aggressive Claim Investigation**

  When a workers' compensation claim is reported, immediately begin to investigate the scene. This includes but is not limited to taking pictures (camera or phone); reviewing video; locating potential witnesses and obtaining statements; and preserving evidence i.e. vehicles and/or equipment associated with the accident (ladders, grinders, saws, etc…). This investigation will assist Sedgwick and CCMSI with determining compensability of the claim and mitigating the duration of lost time from work and medical treatment.

- **Medical Treatment**

  If the injury is life threatening, then contact 911 immediately. If the injury is not life threatening, then take the injured employee to your designated medical facility. Be prepared and have this facility ready in the event of an injury. For any questions on medical facilities, please contact Sedgwick at (800) 277-7500 or your CCMSI adjuster for Cross Border claims.

- **Early Return to Work/Availability of Alternative Work**

  Employers should provide temporary modified duty consistent with the recognized treating physician's written restrictions. This temporary modified duty places injured workers back in the work arena promoting recovery and preventing "disability syndrome". If you are unable to provide temporary modified duty, please request information for your adjuster regarding the ReEmployability modified duty program.

- **Litigation**

  Employers must notify Sedgwick or CCMSI immediately of any legal correspondence you may receive and cooperate with any request made by the assigned defense attorney.

Our primary goal is to provide prompt and proper medical care for your injured employee with the best outcomes possible while at the same time positively impacting claim duration and costs.

POST JOB OFFER — MEDICAL QUESTIONNAIRE

DATE: _____ **POSITION**: _____

NAME: _____

	YES	NO
A. DO YOU EVER HAVE:		
Reactions to Medicines	___	___
Reactions to Oils	___	___
Reactions to Chemicals	___	___
Skin Rashes or Eczema	___	___
B. HAVE YOU EVER HAD:		
Asthma	___	___
Hay Fever	___	___
Shortness of Breath When Walking	___	___
C. HAVE YOU EVER HAD:		
High Blood Pressure	___	___
Heart Trouble	___	___
Heart Attack	___	___
Heart Surgery	___	___
Fainting Spells	___	___
Varicose Veins	___	___
Swelling of Ankles	___	___
D. DO YOU HAVE OR EVER HAD:		
Hernia	___	___
Diabetes	___	___
E. EYES:		
Do You Use Contacts or Eye Glasses	___	___

	YES	NO
F. HAVE YOU EVER HAD:		
Seizures or Convulsions	___	___
Epilepsy	___	___
Paralysis	___	___
Numbness of Hands or Feet	___	___
Double Vision	___	___
Severe Headaches	___	___
Migraine Headaches	___	___
Dizzy Spells	___	___
G. HAVE YOU EVER HAD:		
Neck Injury or Pain	___	___
Back Injury or Pain	___	___
Neck Surgery	___	___
Back Surgery	___	___
Knee Surgery	___	___
Shoulder Injury or Pain	___	___
Shoulder Surgery	___	___
Rheumatism or Arthritis	___	___
Fracture Break of Bone	___	___
Knee Injury or Pain	___	___
H. MEDICINE/ DRUGS/ ALCOHOL:		
Are You Taking Medicine Regularly	___	___
Are You Currently Using Illegal Drugs or Harmful Substance	___	___

How Much? _____

How Often? _____

I acknowledge that the Alabama Trucking Association Workers' Compensation Self-Insurance Fund mandates that if I refuse to submit to or cooperate with a blood or urine test after an accident, I shall forfeit workers' compensation benefits. INT. _____

I acknowledge that misrepresentation as to preexisting physical or mental conditions may void my Workers' Compensation benefits. INT. _____

Explanation of all yes answers, use back page if needed**:** _____

_____

The Undersigned understands that the Alabama Trucking Association Workers' Compensation Self-Insurance Fund ("ATA Comp Fund") requires the execution of a post job offer medical questionnaire. The Undersigned agrees to complete said questionnaire truthfully and agrees to allow the disclosure of it to the Company and/or ATA Comp Fund to determine whether the Undersigned is fit for duty. For DOT covered drivers, under 49 CFR 391.11, the motor carrier makes the final driver fitness-for-duty determination.

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Signature of Applicant: _____ **Company Representative:** _____

ATA COMP FUND

WORKERS' COMPENSATION NOTIFICATION

The undersigned applicant and/or employee (hereinafter "undersigned") acknowledges and agrees that the following terms and conditions shall govern any employment relationship for the purposes of workers' compensation benefits by or on behalf of _____ through
(Employer Company Name)
the Alabama Trucking Association Workers' Compensation Self-Insurance Fund ("ATA Fund").

1. The employer listed above is a participating member of the ATA Fund for the purposes of payment of workers' compensation benefits.

2. It is acknowledged and agreed by the undersigned that: (1) the applied for and/or proposed employment position will require the employee to regularly travel in the state of Alabama as well as in one or more other states; (2) pursuant to § 25-5-35, Ala. Code (1975), as last amended, the employment will be principally localized in the State of Alabama for the purposes of payment of any workers' compensation benefits; (3) the undersigned will accept Alabama workers' compensation benefits paid in accordance with the Workers' Compensation Act of Alabama, to the exclusion of any other state's jurisdiction or workers' compensation law; and (4) jurisdiction of any on-the-job injury and workers' compensation claim shall be in the state courts of the State of Alabama.

3. All claims for workers' compensation benefits are subject to a medically approved "early return to work" programs, including modified driving and/or job assignments in the corporate offices, assigned for work with approved charities or non-profit organizations through Transition2Work or other similarly structured programs, or as otherwise directed.

4. All claims for workers' compensation benefits are subject to immediate post-accident drug testing in accordance with § 25-5-51, Ala. Code (1975). The undersigned acknowledges and agrees that this document shall satisfy any written notice requirement of the Workers' Compensation Act of Alabama concerning post-accident drug testing and any action taken thereon. **"A positive drug test conducted and evaluated pursuant to standards adopted for drug testing by the U.S. Department of Transportation in 49 C.F.R. Part 40 shall be a conclusive presumption of impairment resulting from the use of illegal drugs. No compensation shall be allowed if the employee refuses to submit to or cooperate with a blood or urine test as set forth above following the accident, after having been warned in writing by the employer that such refusal would forfeit the employee's right to recover benefits under this chapter."**

5. All claims are examined under the Alabama Workers' Compensation Fraud Act (§ 13A-11-124, Ala. Code (1975)), which provides that any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining compensation, as defined in § 25-5-1(1), as amended, for himself or herself, or any other person is guilty of a Class C felony, which is punishable for up to (10) years imprisonment.

6. The undersigned acknowledges and agrees that as a condition of employment, he or she will make no misrepresentations as to existing or prior physical condition, mental condition and/or ability to fulfill the duties of the job. **"MISREPRESENTATIONS AS TO PREEXISTING PHYSICAL OR MENTAL CONDITIONS MAY VOID YOUR WORKERS' COMPENSATION BENEFITS."** § 25-5-51, Ala. Code (1975). Any injury sustained during the course of employment, no matter how minor or trivial, **MUST IMMEDIATELY BE REPORTED TO YOUR SUPERVISOR OR OTHER MANAGEMENT PERSONNEL**.

7. The undersigned acknowledges and agrees that this document does not constitute, and shall not serve as, a contract for employment with the employer listed herein or any others. The undersigned understands and agrees that any employment relationship to be formed between the employer and the undersigned, or which currently exists, is and shall be "at will."

8. The undersigned acknowledges receipt of the fully executed copy of this form.

_____	_____
Employee/Applicant Signature	Employer/Representative Signature
_____	_____
Employee/Applicant Name (Print)	Employer/Representative Name (Print)
_____	_____
Date Signed	Position/Title

ALL EMPLOYEES ARE REQUIRED TO SIGN: If a new employee or conditional hire, a signature is required at time of the conditional offer of employment and/or the time of hire. If an existing employee, sign and return to Human Resources or your supervisor within ten (10) business day of receipt of a certified letter, this workers' compensation notification will be made a part of the employee's personnel file.

ATA COMP FUND

INDEPENDENT CONTRACTORS / OWNER OPERATORS / SUB-CONTRACT DRIVERS / LEASE PURCHASE OWNER OPERATORS AGREEMENT

_____ (The Company) is a member of the Alabama Trucking Association (ATA) Workers' Compensation Self-Insurance Fund (Fund). Because of this membership, you, as an independent contractor, owner operator, sub-contract driver or lease purchase owner operator, are eligible to purchase coverage through the "OWNER OPERATORS / SUB-CONTRACT DRIVERS UNDER LEASE TO _____" program provided by the ATA FUND. This program offers coverage if you are injured while performing the duties of your occupation. Independent Contractors, Owner Operators, Sub-contract Drivers, and Lease Purchase Owner Operators are eligible for participation. You are not eligible to participate if you are a W-2 employee or are a company driver for any company that is required by state law to provide workers' coverage to its employees or company drivers. In order to participate, you must agree to the following terms and conditions as set out below:

1. You, the undersigned Independent Contractor, Owner Operator, Sub Contract Driver, or Lease Purchase Owner Operator (hereinafter "undersigned"), acknowledge and agree that the following terms and conditions shall govern the administration of any claim for benefits arising out of an injury sustained in the course of performing your work, which said benefits are payable through your participation in the "OWNER OPERATORS / SUB-CONTRACT DRIVERS UNDER LEASE TO _____ _____" program provided by the ATA FUND. You, the undersigned, agree that:

   - **The undersigned is not an employee or company driver of a company required to provide workers' compensation coverage to its employees or company drivers.**
   - **The undersigned has chosen to obtain coverage as a result of the _____'s membership in the ATA Fund.**
   - **The amount the undersigned will be charged for the coverage (contributions) will be calculated using a wage base of $675.00 per week ($35,100.00 per year). In the event of a compensable on-the-job injury, indemnity (money) benefits will be calculated using a wage base of $675.00 per week ($35,100.00 per year).**

   Wage base as described above acknowledged: _____(undersigned initials)

2. You, the undersigned, acknowledge and agree that although the undersigned is an independent contractor, owner operator, sub-contractor or lease purchase owner operator, and not an employee of The Company, the undersigned's workers' compensation coverage, compensability determinations, and benefits payable, if any, will be determined pursuant to the Alabama Workers' Compensation Act. The undersigned acknowledges and agrees that the undersigned is not an employee of The Company.

3. You, the undersigned, acknowledge and agree that the work to be performed will require regular travel in the State of Alabama, as well as in one or more other states. The undersigned acknowledges that the lease contract and/or place of hiring (if the undersigned is a contract driver of the owner of leased equipment) is/was entered into the State of Alabama, and that the work to be performed will be principally localized within the State of Alabama for the purposes of determining the applicability of any state's workers' compensation statutes. The undersigned agrees to accept Alabama Workers' Compensation benefits paid in accordance with the Workers' Compensation Act of Alabama, to the exclusion of any other state jurisdiction or workers' compensation law. The undersigned agrees that the jurisdiction of any workers' compensation claim shall be in the state courts of the State of Alabama.

4. You, the undersigned, acknowledge and agree that all claims for workers' compensation benefits are subject to immediate post-accident drug testing in accordance with § 25-5-51, Ala. Code (1975). The

undersigned acknowledges and agrees that this document shall satisfy any written notice requirement of the Workers' Compensation Act of Alabama concerning post-accident drug testing and any action taken thereon. **"A positive drug test conducted and evaluated pursuant to standards adopted for drug testing by the U.S. Department of Transportation in 49 C.F.R. Part 40 shall be a conclusive presumption of impairment resulting from the use of illegal drugs. No compensation shall be allowed if [You refuse] to submit to or cooperate with a blood or urine test as set forth above following the accident, after having been warned in writing by [The ATA Fund] that such refusal would forfeit [Your] right to recover benefits under this chapter."**

5. You, the undersigned, acknowledge and agree that all claims are examined under the Alabama Workers' Compensation Fraud Act (§ BA-11- 124, Ala. Code (1975)), which provides that any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining compensation, as defined in § 25-5-1(1), as amended, for himself or herself, or any other person is guilty of a Class C felony, which is punishable for up to (10) years imprisonment.

6. You, the undersigned, acknowledge and agree that as a condition of eligibility, you will make no misrepresentations as to existing or prior physical condition, mental condition and/or ability to fulfill the duties of the job. **"MISREPRESENTATIONS AS TO PREEXISTING PHYSICAL OR MENTAL CONDITIONS MAY VOID YOUR WORKERS' COMPENSATION BENEFITS."** § 25-5-51, Ala. Code (1975). Any injury sustained during the course of [Your work], no matter how minor or trivial, **MUST IMMEDIATELY BE REPORTED TO YOUR SUPERVISOR OR OTHER MANAGEMENT PERSONNEL.**

7. You, the undersigned, acknowledge and agree that all claims for workers' compensation benefits are subject to a medically approved "early return to work" program, including modified driving and/or job assignments in the corporate offices, assigned for work with approved charities or non-profit organizations through Transition2Work or other similarly structured programs, or as otherwise directed.

8. You, the undersigned, acknowledge and agree that this document does not constitute, and shall not serve as, a contract for employment with The Company listed herein.

9. You, the undersigned, acknowledge and agree that the clauses and paragraphs contained in this agreement are intended to be read and construed independently of each other, and of any separate lease agreement entered into between the parties. If any term, covenant, condition or provision of this agreement is determined to be invalid, void, or unenforceable, by a circuit court within the State of Alabama, the remaining provisions shall not be affected, and shall remain in full force and effect as between the parties.

10. You, the undersigned, acknowledge receipt of the fully executed copy of this Form.

Independent Contractor / Owner-Operator Sub-Contract Driver / Lease Purchase Owner Operator (Signature)	Company Representative (Signature)
Print Name	Print Name
Date Signed	Title and Date Signed

REPORTE DEL EMPLEADO DE LESION

1 Nombre del Empleado		Dirección	Numero de Teléfono
2. Fecha de Nacimiento	Numero de Seguro Social	Sexo ☐ Masculino ☐ Femenino	Estado Civil ☐ Soltero(a) ☐ Casado(a) ☐ Viudo(a) ☐ Divorciado(a)
3. Dependientes (Dar Nombre, Relación, y Edad)			
4. Nombre del Médico de Familia		Dirección	Numero de Teléfono
5. Nombre del Empleador		Dirección	Numero de Teléfono
6. En que nomina estaba cuando se lesión		El empleador es pariente de usted por sangre o matrimonio?	Relación
7.Fecha de la lesión	Hora dela lesión (especifique AM o PM.)	Cuál era su ocupación cuando se lesiono?	Estaba haciendo su trabajo regular
8. Cuanto tiempo ha trabajado con el empleador?		En qué capacidad empleo?	
9. Dirección donde se lesiono	Estaba en los locales del empleador? Si " NO" por favor explique ☐ SI ☐ NO		Cuando reporto su lesión?
10. A quien le reporto esta lesión?		Usted es de mano derecha o izquierda?	
11. Describa completamente lo que estaba haciendo y como ocurrió la lesión			
12. Índole y lugar de lesión (describa completamente- dar parte del cuerpo, derecha o izquierda, etc.)			
13. Cuáles son sus salarios semanales?	Estaba permitido alojamiento o otra ventajas aparte de su salario? ☐ SI ☐ NO		Si "SI", por favor liste
14. Fecha y hora que trabajo por última vez(especifique A.M. o P.M.)	Fecha que detuvieron su salario		Fecha y hora que detuvieron otras ventajas
15. Fecha que regreso a trabajar o planea regresar a trabajar		Cuál será su salario?	
16. Se ha Recuperado? ☐ SI ☐ NO Si "NO" describa el actual dolor			
17. Nombre del Doctor que visito		Dirección	Numero de Teléfono
18. Quien selecciono su Medico?	Fecha de la primera visita al Medico	Fecha de la Última visita al Medico	Número de visitas al Médico hasta la fecha
19. Si fue Hospitalizado, liste el Nombre		Fecha de admisión	Fecha de dar de alta

REPORTE DEL EMPLEADO DE LESION

20. Si todavía está bajo atención del Médico, con qué frecuencia lo ve y que tratamiento le da?		
21. Si la lesión fue causada por otra persona, dar el nombre	Dirección	Numero de Teléfono
22. Nombre de Testigos	Dirección	Numero de Teléfono
23. Ha tenido usted cualquier otra afección o lesión que implica esta parte su cuerpo? Si "SI" denos detalles y fecha. ☐ SI ☐ NO		
24. Usted ha alguna vez solicitado los beneficios de compensación o recibido un acuerdo de seguros por una lesión previa? Si "SI" dar detalles (de quien, etc.) ☐ SI ☐ NO		
25. Observaciones o otros Comentarios		
Yo Certifico que esta información es verdadera y correcta a lo mejor de mi conocimiento.		
Nombre del Empleado (imprimir/texto)	**Firma**	**Fecha**

REPORTE DEL EMPLEADO DE LESION