Dayton Independent School District

100 Cherry Creek Road
Dayton, TX 77535

Dear DISD Employee,

Please take a minute to review the attached paperwork regarding your workman's compensation injury reporting and the steps that you will need to take in order for the claim to be filed and paid (if you are seeking medical treatment). This packet includes the following documents that will need to be filled out, reviewed and returned to me, or kept for your records.

- **Notice of Injured Employees Rights & Responsibilities** – this document informs you of your rights and responsibilities and is for your records.
- **Employee Acknowledgment of Workers' Compensation Network** – this document informs you that if you are seeking medical treatment, you must choose a doctor from the list of doctors/facilities within the network. The list of doctors can be found on the DISD website under Departments – Business Services – Employee Benefits – Texas Star Network. This form will need to be filled out and returned to me.
- **First Report of Injury** – this document is the report of the injury and must be filled out completely and returned to me.
- **Workers' Compensation and TRS** – this document is for your information and explains compensation from workers comp and your contribution to TRS.
- **Optum Prescription Form** - this form is to be filled out and used at participating pharmacies should you need a prescription for your injury.
- **Elect Leave Benefits** – should you have to be off due to your injury, you will have to choose either to use your leave days for the first 7 days or to be docked. Workmans' Comp will not pay until you have been out 8 days. They pick up and start paying on the 8th day following the date of the injury. Should you choose **not** to use your days that you have in your DISD leave bank, you will not receive compensation for those days from the district or workmans' comp. This form will need to be filled out and returned to me.

If you have any questions, please feel free to contact me at deanna.mckay@daytonisd.net or 936-258-2667 ext. 1103

Sincerely,

DeAnna McKay

DeAnna McKay
Employee Benefits Specialist

Dayton Independent School District
Workers' Compensation Claim Information

- **IF YOU CHOOSE TO SEEK MEDCIAL TREATMENT, YOU MUST SELECT A TREATING DOCTOR AND/OR PHARMACY FROM THE NETWORK LIST**

- **IF YOU SEEK MEDICAL TREATMENT, OTHER THAN AN EMERGENCY, WITH A NON-NETWORK PROVIDER, YOU WILL BE RESPONSIBLE FOR PAYMENTS TO THE DOCTOR**

- **BEFORE REPORTING TO YOUR CAMPUS/DEPT UPON RETURNING TO WORK, YOU MUST BRING A WORK STATUS REPORT TO THE PERSONNEL SERVICES DEPT.**

You can access the provider list from the DISD website under Departments-Business Services-Employee Benefits-Texas Star Network

Texas Mutual Insurance Company
Claims Correspondence
PO Box 12029
Austin, Texas 78711-2029
Phone: 1-800-892-5246
Fax: 1-877-404-7999

Dayton ISD
Benefits Coordinator
DeAnna McKay
936-258-2667 x1103
936-258-5616 fax

OFFICE OF INJURED EMPLOYEE COUNSEL

Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the State agency that administers and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. **You have the right to hire an attorney to help you with your workers' compensation claim.**
   For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or http://www.texasbar.com/. Attorney referral information can also be found on OIEC's website at www.oiec.texas.gov.

2. **You have the right to receive assistance from OIEC if you do not have an attorney.**
   OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. **You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.**
   Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. **You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.**
   You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. **You may have the right to receive income benefits for your work-related injury.**
   There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. **You may have the right to dispute resolution regarding income and medical benefits.**
   You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. **You have the right to choose a treating doctor.**
   If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however,

changing your treating doctor must be pre-approved by the DWC if you are not in a network. If you are employed by a political subdivision (e.g. city, county, school district,) you must follow its rules for choosing a treating doctor. It is important to follow all the rules in the workers' compensation system. **If you do not follow these rules, you may be held responsible for payment of medical bills.** OIEC staff can help you to understand these rules.

8. **You have the right for your workers' compensation claim information to be kept confidential.**
   In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.**

2. **You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).**
   If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. If there is something you do not understand, ask your employer or call OIEC. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at http://www.tdi.texas.gov/consumer/complfrm.html#wc.

3. **If you worked for a political subdivision (e.g., city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment.**
   Your employer should be able to provide you with the information you will need in order to determine which health care providers can treat you for your workplace injury.

4. **You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**

5. **You have the responsibility to send a completed Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.**
   You have one year to send the form after you were injured or first knew that your illness might be work-related. Send the completed DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. **You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.**

7. **You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages.** (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. **Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.**

9. **You are prohibited from making frivolous or fraudulent claims or demands.**

Employee Acknowledgment of Workers' Compensation Network

I have received information that tells me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual at (800) 859-5995 to notify them of my choice.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.
5. Knowingly making a false workers' compensation claim may lead to a criminal investigation that could result in criminal penalties such as fines and imprisonment.

_____ _____

Signature Date

_____

Printed Name

I live at: _____

Street Address

_____

_____

City State Zip Code

Name of Employer: _____

Name of Network: *Texas Star Network®*

Network service areas are subject to change. Call (800) 381-8067 if you need a network treating provider.

Please indicate whether this is the:

- ☐ Initial Employee Notification
- ☐ Injury Notification (Date of Injury: _____/ ____ / ____)

DO NOT RETURN THIS FORM TO TEXAS MUTUAL INSURANCE COMPANY UNLESS REQUESTED

Revised June 2011

FIRST REPORT OF INJURY

Dayton Independent School District

O DISD Employee

Social Security Number: _____/_____/_____

Name: _____

Home Phone: _____

Home Address: _____City:_____Zip:_____

Date of Birth: _____/_____/_____

Language Proficiency: [ ] Spanish [ ] English [ ] Other _____
Race: [ ] White [ ] Black [ ] Hispanic [ ] Asian [ ] Native American
[ ] Other _____

Job/Position: _____
Name and title of Supervisor: _____
Assigned to Campus/Department: _____
Place/Location where accident occurred: _____
Date supervisor informed of injury: ____/___/_____ Time informed: _____ [ ] am [ ] pm
Transported to hospital: [ ] yes [ ] no if yes, name of hospital: _____
Initial treatment: [ ] none [ ] campus nurse [ ] emergency room [ ] doctor
Equipment/materials used at time of injury: _____
Did injury occur on district property? [ ] yes [ ] no
[ ] classroom [ ] hallway [ ] office [ ] bathroom [ ] gymnasium [ ] kitchen
[ ] playground [ ] if no, give location: _____
Name(s) of witness (es) if any: _____
Hours worked per day: _____ Days worked per week: _____
Employment status: [ ] full time [ ] part time [ ] substitute
Received Notice of Injured Employee Rights and Responsibilities _____
Received Copies of First Report of Injury _____

Person taking report _____
(Please print)

FOR OFFICE USE ONLY:
Date of hire: _____/____/_____
Wage/Salary: _____ per hour _____daily wage _____weekly wage_____
Last paycheck was: $_____for _____hours _____days

Employee Statement

Dayton Independent School District
Employee's Report of Accident/Injury

Name of employee: _____ S/S # _____/____/_____

Location of accident/injury [ ] classroom [ ] hallway [ ] gym [ ] kitchen
[ ] playground [ ] other _____

Campus/Department: _____

Date of accident/injury _____/____/_____ Time _____ [ ] am [ ] pm

Witness name: _____

Witness name: _____

Description of accident:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Indicate body part (s) affected: _____

Could accident have been prevented? [ ] yes [ ] no

If no, why not?

_____
_____

If yes, how?

_____
_____

Employee's Signature: _____

Date signed: _____

Witness Statement

Dayton Independent School District
Witness Report of Accident/Injury

Name of Person Reporting an injury: _____

Name of witness: _____

Location of accident/injury: _____

Campus/Department: _____

Witness job title: _____
Date of accident/injury _____/_____/_____ Time: _____ [ ] am [ ] pm
Did you witness the accident? [ ] yes [ ] no

Description of accident:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Indicate body part (s) affected: _____

Could accident have been prevented? [ ] yes [ ] no

If no, why not?

_____
_____

If yes, how?

_____
_____

Witness Signature: _____

Date signed: _____

Workers' Compensation And TRS

Dayton I.S.D.

WORKERS' COMPENSATION AND TEACHER RETIREMENT SYSTEM

If you are off work due to a work related injury for more than seven (7) days, you will receive approximately 70% - 75% of your average weekly wage (in the form of TIBS – temporary income benefits) for as long as you are off work if your injury has been deemed to be compensable by the Texas Department of Insurance – Division of Workers' Compensation.

Please be aware that while you are off work, you are not receiving a district paycheck, unless you choose to use available paid leave instead of temporary income benefits.

If you are only receiving a check for TIBS (temporary income benefits) no funds and/or contributions are being sent to the Texas Teacher Retirement System (TRS) nor are your days off being counted toward your years of service with TRS.

Therefore, if you want to ensure that funds are being contributed to TRS to count toward the average of the highest three years annual income for your retirement, you must contact TRS at 800-223-8778 and make arrangements to contribute to your retirement annuity fund.

First Fill

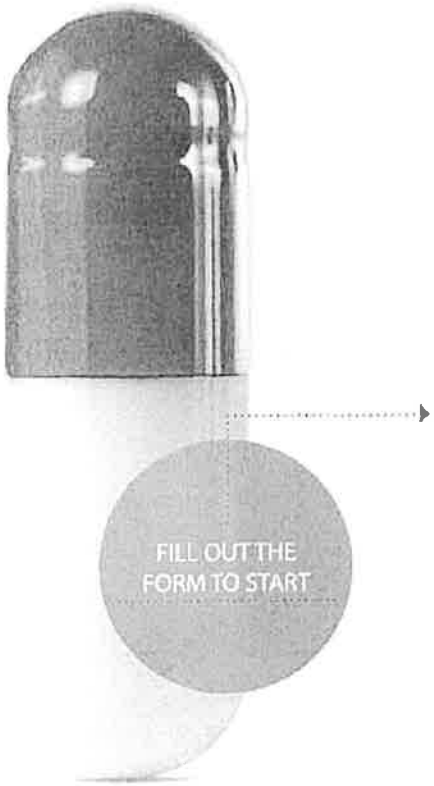
Simplifying the prescription process and helping workers take the first step toward getting well

Texas Mutual's First Fill Program enables your employees to get prescribed medication quickly after an injury occurs, even if you haven't had the opportunity to file a claim. Injured workers can get a seven-day supply for each covered prescription with a maximum of $500 per prescription with just the First Fill form.

Complete the First Fill form on the back of this sheet and advise your employee to present it at a participating Cypress Care pharmacy.

The form is valid for the first fill and cannot be used if the first prescription fill is being requested more than 10 days after the injury occurred.

If additional forms are needed, visit the employer forms section at texasmutual.com.



TexasMutual®
WORKERS' COMPENSATION INSURANCE

WORK SAFE, TEXAS®

texasmutual.com

WorkSafeTexas.com • SafeHandTexas.com • TexasOilAndGasSafety.com • TexasMutual.WordPress.com

OPTUM

Prescription First Fill Form

Texas Mutual Insurance Company

Prescription First Fill Instructions

1. Participating Optum pharmacies include Walgreens, CVS, Walmart, Kroger, Target, Costco, Sam's Club, Brookshire, HEB and Tom Thumb. To locate other participating pharmacies, visit www.texasmutual.com/hcn/hcn.shtm or www.cypresscare.com.
2. Complete the form and take to the pharmacy along with your prescription from the provider.
3. This form allows you to fill your initial prescription(s) with a maximum cost of $500 per covered prescription and a maximum 7 day supply.
4. If you have questions, please call us at 1-888-220-2805, available 24 hours a day, seven days a week.

Bin #: **Pharmacy to Call for BIN** Group Number: **TEXASMUTUALFF**

Member ID:		Last 4 digits of SSN + date of injury; No spaces (i.e. 9999050206)
Member Name:		Injured worker's first & last name
Employer Name:		
Date of Injury:		

Policyholder Information

Pharmacy Help Desk: 1-888-220-2805

PLEASE NOTE: This form is only **valid within 10 days** of the injury date. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive a pharmacy card, please call us **at 1-888-220-2805**.

Issuance of this letter or dispensing of a prescription does not constitute acceptance of your claim.

DAYTON INDEPENDENT SCHOOL DISTRICT
ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION
(NO OFFSET)

Name _____ **Employee number** _____

Position _____ **Department/Campus** _____

This employee is absent from duty because of a job-related illness or injury beginning on _____. If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

_____ _____
District authorized signature Date

Employee choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on **paid** leave and/or family and medical leave (FMLA). I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave that is not FMLA leave. I choose the following option:

- ❑ I choose to use only _____ days of available paid leave at this time.
- ❑ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or -injury wage.
- ❑ I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from _____ISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will only receive workers' compensation wage benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

_____ _____
Employee signature Date