



**Northern Illinois
University**
Human Resource Services

Workers' Compensation Application Forms and Filing Overview

Call 911, as applicable, and/or seek medical attention as necessary.

Report the incident to the supervisor/department. The supervisor/department may provide application packet upon report of injury or upon request.

Call Tristar to report injury at **855-495-1554**.

Contact the Workers' Compensation Coordinator (WCC) at 815-753-6000 or workerscomp@niu.edu for additional information.

As forms are completed, please fax to 815-753-6074 or scan to workerscomp@niu.edu. If scan or fax is unavailable, please send via campus mail to Human Resource Services.

The HR website regarding [Workers' Compensation](#) contains two drop-downs: Application Forms Packet and Information Only Packet. The Application Forms Packet contains required forms to be completed by the employee, supervisor, witness(es), and physician, as applicable. The Information Only Packet is recommended viewing for all employees as it provides detailed workers' compensation information, including rights and responsibilities involving the claim process.

It is recommended that employees remain within the parameters of their own insurance in the event the claim is deemed noncompensable.

Pursuant to Public Act 97-895, the administration of the State Employee Workers' Compensation Program conducted a competitive procurement, resulting in a new third party administrator. As of 3/16/13, Tristar Risk Enterprise Management, Inc., is the current administrator.

WORKERS' COMPENSATION EMPLOYEE'S NOTICE OF INJURY (COMPLETE ALL ITEMS)

EMPLOYEE'S NAME: (last)		(first)	
EMPLOYEE'S ADDRESS: (no.)		(street)	
(city)		(state) (zip)	
TELEPHONE: Home: _____		Work: _____	
SOCIAL SECURITY NO.	DATE OF BIRTH (mo) (day) (year)	SEX: <input type="checkbox"/> Female <input type="checkbox"/> Male	
MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widow(er) <input type="checkbox"/> Divorced		NUMBER OF DEPENDENT CHILDREN UNDER 18 AT DATE OF INJURY _____	
DATE OF INJURY OR ILLNESS (mo) (day) (year)	TIME: <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST DAY WORKED: _____	
NAME OF AGENCY	ADDRESS OF AGENCY	WORK COUNTY	
REPORTED TO SUPERVISOR <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME OF SUPERVISOR	DATE & TIME REPORTED _____ (am) (pm) (mo) (day) (year)	
IF NOT REPORTED ON DATE OF INCIDENT, EXPLAIN:			
HAVE YOU SOUGHT MEDICAL ATTENTION? <input type="checkbox"/> Yes <input type="checkbox"/> No		NAME, ADDRESS AND PHONE NO. OF DOCTOR:	
ANY SICK, VACATION OR PERSONAL DAYS USED FOR THIS INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No		NUMBER AND TYPE	
HAS ANY INSURANCE COMPANY PAID FOR TREATMENT AS A RESULT OF THIS INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No		NAME AND POLICY NO.	
WHAT DUTY WERE YOU PERFORMING AT TIME OF INJURY? (BE SPECIFIC)			
PLACE WHERE INJURY OCCURRED (BE SPECIFIC)			
DETAIL HOW INJURY OCCURRED (USE REVERSE SIDE IF NECESSARY)			
DID A THIRD PARTY CAUSE OR CONTRIBUTE TO ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No			
IF YES, EXPLAIN AND PROVIDE ADDRESS AND PHONE # OF NEGLIGENT PARTY (USE REVERSE SIDE IF NECESSARY):			
DESCRIBE INJURY (INDICATE PART(S) OF BODY AFFECTED)			
ANY WITNESS(ES) TO INJURY <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, NAME(S):	
HAVE YOU SUBMITTED ANY PREVIOUS CLAIMS FOR INJURY/ILLNESS? <input type="checkbox"/> Yes <input type="checkbox"/> No (IF YES, IDENTIFY EACH ON REVERSE SIDE.)			
DATE THIS FORM COMPLETED _____ (mo) (day) (year)		SIGNATURE OF INJURED EMPLOYEE	
IF INJURED EMPLOYEE UNABLE TO SIGN ABOVE, SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM			

Reverse side must be completed if applicable before submission to Tristar

Employee Name: _____

Claim Number: _____

ADDITIONAL DETAILS HOW INJURY OCCURRED:

PREVIOUS INJURIES OR ILLNESSES

DATE(S) OF INJURY/ILLNESS	DESCRIBE INJURY/ILLNESS	WAS THIS WORKERS' COMPENSATION (YES OR NO)	NAME AND ADDRESS OF DOCTOR	IF YES, AMOUNT OF SETTLEMENT

ADDITIONAL DETAILS CONCERNING THIRD PARTY NEGLIGENCE

SUPERVISOR'S REPORT OF INJURY OR ILLNESS

Claim Number _____

This form must be completed thoroughly by employee's supervisor within 24 hours after an accident

PART I – GENERAL INFORMATION					
Employee Name		Title		Social Security No.	
Address		City/State	Zip	Home Phone	
Agency		Location		Work Phone	
Job Description and/or Assigned Duties of Employee (be specific):					
Number of Years in current job title: _____ Previous job title: _____ Number of years previous title: _____ Activity at time of accident/incident: _____					
Date of Accident/Incident		Hour: <input type="checkbox"/> AM <input type="checkbox"/> PM	Exact Location		
Did you witness? <input type="checkbox"/> Yes <input type="checkbox"/> No	How was notice received? <input type="checkbox"/> Written <input type="checkbox"/> Oral	Date Received	Time Received	From Whom Notice Received	
PART II – DETAILS OF ACCIDENT					
Description of Accident/Incident:					
Did a third party cause or contribute to the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, explain and provide name, address and phone number of negligent party (use reverse side if necessary):					
Description of Injury – Part(s) of Body Injured:					
Name(s) of Witness(es) (if none, so state):					
PART III – CAUSE OF ACCIDENT					
Describe any unsafe acts or conditions which contribute to the accident/incident:					
PART IV – CORRECTIVE ACTION TAKEN					
Was the condition above corrected (how)?			Reported to higher authority (Name & Title)?		
Name and Title of Supervisor			Did the incident result in any disciplinary action? <input type="checkbox"/> Yes <input type="checkbox"/> No		

The social security number is required for the furtherance of operations and business of the University which includes but is not limited to the provision of proper identification.

Signature of Supervisor/Phone Number

Report Date

WORKERS' COMPENSATION WITNESS REPORT

Injured Employee Name		Work Location		
Your Name		Do you work for the State of Illinois? <input type="checkbox"/> Yes <input type="checkbox"/> No		Work Phone
Home Address (Street)		(City/State/Zip)		Home Phone
Did you see the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date you witnessed?	Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Did you know employee before the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>What did you see or hear? – Be specific (use back side if necessary)</p>				
Exact location of what you saw or heard				
Name(s) and Address(es) of any other witness(es)				
I CERTIFY THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE				
_____		_____		
Date Completed		Signature of Witness		
Name and Title of Individual Making Report (print)				

Print Name				



Mail To: PO Box 2803
Clinton, IA 52733-2803
Fax: 312-445-8690
ATTN: State of Illinois

Dear Medical Provider:

The Illinois Worker's Compensation and Occupational Diseases Act provides that the employer is obligated to pay all medical, hospital and surgical charges incurred in connection with an accidental injury and/or disease which arises out of and in the course of employment. This obligation is "limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury or disease."

The Act further provides that "Every hospital, physician, surgeon or other person rendering treatment or services in accordance with the provisions of this Section shall upon written request furnish full and complete reports thereof to, and permit their records to be copied by, the employer***."

The Act also provides that "in the event the (Illinois Workers' Compensation) Commission shall find that a doctor selected by the employee is rendering improper or inadequate care, the Commission may order the employee to select another doctor certified or qualified in the medical field for which treatment is required. If the employee refuses to make such change the Commission may relieve the employer of his obligation to pay the doctor's charges from the date of refusal to the date of compliance."

In accordance with the above provisions, you are requested to complete the attached medical report. Your timely furnishing of this report will work to the benefit of the injured employee in that it will enable TRISTAR to make prompt decisions regarding the compensability of the injury and issuance of appropriate disability payments to the employee. Your detailed completion of this report is also necessary for us to process your itemized bill for payment.

Should any clarification of this report or copies of other medical records be required, we will specifically request same. Thank you in advance for your cooperation.



Mail To: PO Box 2803
Clinton, IA 52733-2803
Fax: 312-445-8690
ATTN: State of Illinois

INITIAL WORKERS' COMPENSATION MEDICAL REPORT

Claim No. _____

The Illinois Workers' Compensation and Occupational Diseases Act provides that the employer is obligated to pay all first aid, medical and surgical services reasonably necessary to cure or relieve from the effects of occupationally-related injury or disease. Every hospital and doctor shall, upon written request, furnish complete records and permit their records to be copied by the employer and/or the employee.

Your detailed completion of this report is also necessary to enable our office to process your itemized bill for payment.

A. Employee's Name _____ Date of Report _____

Agency/Facility _____

Date of Accident _____ Date Examined _____ Height _____ Weight _____

Family Doctor Specialist Chiropractor Other Number of years of Relationship _____

B. History (Description of Accident) _____

History of previous injuries and illnesses _____

Name(s) of other physician(s) who served on case _____

C. Diagnosis (ICD-9-CM Code(s)) _____

Describe nature and extent of injuries _____

D. Treatment (Proposed or completed, surgical, dressing(s), etc.) _____

Medications _____ (Given/Prescribed) _____

X-Ray Results (Attach copy of report) _____

E. Prognosis _____

Estimated date or return to work with restrictions _____ Identify Restrictions _____

Estimated date of return to work without restrictions _____

F. Final Report (Complete the following if treatment is no longer being rendered to this employee by the undersigned physician)

Date patient discharged from treatment _____ Case transferred to _____

Name of Doctor _____
(please print or type)

Address _____

Phone _____

DOCTOR'S SIGNATURE _____

Date _____



AUTHORIZATION TO USE OR DISCLOSE INFORMATION

Employer: State of Illinois **Agency/Facility:** _____

Patient Name: _____ **Claim Number:** _____

Patient Address/Telephone: _____

Patient Social Security No. _____ **Patient Date of Birth:** _____

I, _____, understand that this authorization is voluntary, and that I may refuse to sign this authorization, and that I may revoke this authorization at any time by sending my written revocation to the entity providing the information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall remain in effect until the workers' compensation claim is fully resolved unless a different date is specified here _____ (Date).

Medical Information Mental Health / Psychiatric Information

I hereby authorize any physician, psychologist, psychiatrist, dentist, hospital or other medical provider to furnish all records, reports, histories, diagnostic tests and evaluation, physician and nurses' notes and therapy notes to TRISTAR/Employing State Agency and its legal representative, for purposes of processing and administration of the workers' compensation claim identified herein.

I understand that the recipient may not lawfully further use or disclose the information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If an authorization is requested by a person / organization listed above for the use or disclosure of protected health information, the person / organization listed above must provide me with a copy of the signed authorization. I understand I have a right to receive a copy of this authorization.

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 an individual or family member of the individual, except as specifically allowed by this law. 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.

A carbon, photo static, or thermo fax copy of this true release shall be as valid as the original.

Signature of Patient, Parent or Legal Guardian

Date

If signed by other than patient, indicate relationship

Witness to Signature

The social security number is required for the furtherance of operations and business of the University which includes but is not limited to the provision of proper identification.

Medical Authorization Form -IL (Rev. 3-13)

WORKERS' COMPENSATION



is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

1. **GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation, the PPP counts as one of your two choices of providers.

2. **NOTIFY YOUR EMPLOYER.** You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.

3. **LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.

4. **KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033 Chicago: 312/814-6611 Peoria: 309/671-3019 Springfield: 217/785-7087
Web site: www.iwcc.il.gov Collinsville: 618/346-3450 Rockford: 815/987-7292 TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.			
Party handling workers' compensation claims	Tristar Risk Enterprise Management, Inc.		
Business address	216 W. Jackson Blvd. #650 Chicago IL 60606		
Business phone	855-495-1554		
Effective date	March 16, 2013	Termination date	2/8/18
Policy number	Self-insured	Employer's FEIN	376002057

ICIN 0011 Printed by the out/writy of he State of Illinois.