**In emergency situations warranting immediate medical attention, call 911!**

- ☐ Immediately assess the employee for serious injury, including significant loss of blood, head injury, or broken bone – in case of emergency - CALL 911.
- ☐ Notify your supervisor or building leader.
- ☐ When stable, complete the Employee Injury Report found on the Staff tab of the District's website.

**In non-emergency situations:**

- ☐ Notify your supervisor or building leader.
- ☐ Complete the Employee Injury Report found on the Staff tab of the District's website and return to your supervisor or building leader.
- ☐ If immediate medical attention is not required, notify your supervisor or building leader if your injury worsens or does not improve.
- ☐ If medical attention is required, Joplin Schools' Human Resources contact* will direct your care. If you seek treatment that is not authorized, you will be financially responsible for the treatment.
    - *All employees treated for workplace injuries will be tested for nonprescribed controlled substances or alcohol. Refusal to submit to the test will result in the loss of benefits.*

**Injuries occurring after business hours:**

- ☐ Contact your immediate supervisor, who will contact the HR Director.
- ☐ If your supervisor is not available, contact the HR Director at 417-529-3680.

**Injury Investigation:**

- ☐ Be prepared to work with your supervisor to determine the cause of your injury. The purpose is to investigate, identify obvious hazards or potential hazards, and implement immediate corrective/preventive actions to prevent further work injury, illness, or exposure.

**Return to Work/Restrictions:**

Joplin Schools provides early and safe return to work opportunities for employees who experience work-related injuries. Modified work is available, regardless of regular job duties. Human Resources Employee Benefits will provide a modified duty job description for you and your supervisor to review and sign. It is important that you maintain contact with your supervisor during this time regarding restrictions and temporary reassignments.

**Follow-up Appointments:**

You are expected to take an active role in their care and treatment and go to all follow-up appointments. Every effort should be made to make these appointments before or after work. If you schedule an appointment during work hours, you must use sick leave or personal time to be paid for your absence. Worker's Compensation does not reimburse employees for appointments.

It is important that you maintain contact with your supervisor during this time regarding restrictions and temporary reassignments.

***Human Resources Contacts and Instructions:**

- Employee Benefits, 417-625-5200, ext. 2001, or
- Human Resources Manager, 417-625-5200, ext. 2023, or
- Human Resources Director, 417-625-5200, ext. 2009.

RISK ADMINISTRATION SERVICES, INC.

# First Fill Instructions for RAS

Dear Injured Claimant,

Alius Health is a business partner of RAS and has been selected to administer your injury prescription drug plan. Attached is your temporary prescription card allowing up to a 10-day supply of medication. Once your claim has been accepted by RAS, a replacement prescription card will be sent to you if you require ongoing treatment. The new card will allow monthly medications related to your injury.

Our extensive pharmacy network includes those below. Simply present this letter along with your prescription(s) to a participating pharmacy. To verify if your preferred pharmacy is in the network, you can use our pharmacy locator on www.Aliushealth.com or call 740-661-4463. Our office hours are Monday through Friday 9am – 7pm Eastern Standard Time.

Name:

Member ID: ALIUS

Member ID*: DOB (YYYYMMDD) and last 4 digits of SSN*
Example: **ALIUS194401011234**

Person Code: 01
RxGroup #: ALHFF1320216999
RxBIN/IIN: 610729
RxPCN: ALIUS

**ATTENTION PHARMACISTS:** Please process prescriptions through **Script Care**. For questions, please call Alius Health 740-661-4463

**ATTENTION INJURED CLAIMANT:** The use of this prescription card is restricted to your allowed injury' condition only. Possession of this card does not guarantee benefits.

| | | | | |
|---|---|---|---|---|
| Albertsons | Discount Drug Mart | Good Neighbor Pharmacy | Long's Drug | Sam's Club |
| BI-LO | Drug Emporium | H E B Drug stores | Medicine Shoppe | Shopko |
| Bartell Drugs | Family Pharmacy | Health mart | Meijer | Shoprite |
| Brooks Pharmacy | Fred's | Hy-Vee | Publix | Supervalu |
| Costco | Fruth Pharmacy | Kroger | Rite Aid | Valu-Rite |
| CVS | Giant Eagle Pharmacy | Lewis Drug | Safeway | Walmart |

Estimado Trabajador,

Alius Health es socio de RAS ya ha sido seleccionado para administrar su plan de medicamentos recetados para su lesiones. Aquí esta su tarjeta de prescripción temporal que permite hasta 10 días de medicamento. Una vez que su reclamación ha sido aceptada por RAS, se le enviara una tarjeta de reemplazo para requerir tratamiento continuo. La tarjeta nueva le va a permitir medicamentos mensualmente relacionados a su lesion.

Nuestra extensa red de farmacias include las siguientes. Simplemente present esta carta junto con su recetas a una farmacia participantes. Para verificar si su farmacia preferida esta en nuestra red de farmacias puede utilizar nuestro localizador de farmacia en www.Aliushealth.com o llamar 740-661-4463. Nuestra horas de operación son de Lunes a Viernes de 9:00am-7:00pm tiempo de oeste.

RISK ADMINISTRATION SERVICES, INC.

Injured Worker:

Claim No.:

Date of Birth:

# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my medical information (also known as protected health information) as described below.

**Facility Name:** _____

Enter the name of doctor's office, hospital, or other healthcare facility you are authorizing to send us your medical information.
**Use separate form for each if more than one.**

I, _____, authorize all persons or entities that provided medical treatment to me to disclose the following medical information in your possession to RAS, its employees, agents, subcontractors and authorized representatives.

Please provide RAS with any and all information in your possession concerning my physical condition, past, present and future, including but not limited to, healthcare history, diagnosis, condition, treatment or evaluation and other medical information so that they may use it or disclose it to evaluate, administer and resolve my claim related to injuries I received on _____. I understand that the medical information that is disclosed may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. *

I, _____, authorize the State to release to Insurer/RAS and/or its representatives a complete copy of all records pertaining to past or present Workers' Compensation claims.

I hereby authorize Insurer/RAS to reproduce, distribute or use any or all protected health information from any past or present Workers' Compensation claims that I may have had with Insurer/RAS. I further authorize Insurer/RAS to retain any or all protected health information it may receive related to the injury I received on _____.

This authorization shall be in force and effective until my claim related to the injury, I received on _____ is resolved, at which time this authorization to use or disclose this protected health information expires. I understand that I may revoke this authorization by notifying [**RAS Inc, PO Box 89310, Sioux Falls, SD 57109**] in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by RAS or the Releasing Party in Reliance on it before I revoked it.

As the person signing this Authorization for Release of Protected Health Information, I understand that I am giving permission to RAS to obtain and use protected health information. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

A copy of this authorization may be accepted with the same authority as the original.

I understand this authorization is voluntary. As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the **health care entity** may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. While I do not need to sign this authorization to ensure **healthcare treatment**, I understand that failure to do so may have impact on my entitlement to payment of Workers' Compensation benefits.

| | |
|---|---|
| Print Name of Patient or Personal Representative | Description of Personal Representative's Authority |
| X<br>**Signature of Patient or Personal Representative** | Date |

*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.



OFFICES IN SOUTH DAKOTA AND MINNESOTA
**Mailing Address:** PO Box 89310, Sioux Falls, SD 57109-9310
**Phone.** 800.732.1486 | **Fax.** 877.884.6573| **Email:** www.RASCompanies.com

RISK ADMINISTRATION SERVICES, INC.

# EMPLOYEE INJURY REPORT

Claim No.:

## INJURED WORKER INFORMATION

| Last Name: | First Name: | MI: | Date of Birth: | SSN: |
|---|---|---|---|---|
| | | | | |

| Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Marital Status: ☐ Married ☐ Unmarried | Gender: ☐ Male ☐ Female | Dependents: | Phone: | Email: |
|---|---|---|---|---|
| | | | | |

## EMPLOYMENT INFORMATION

| Employer: | Employer Address: | Yrs employed: |
|---|---|---|
| | | |

At the time of injury were you employed anywhere else? (**If yes please fill out the following**):

Employer Name: Address: Duties:

| Name and address of your former employers: | Have you ever filed a Workers' Compensation claim? ☐ Yes ☐ No<br>When: Employer: |
|---|---|
| | |

## INJURY INFORMATION

| Date of Injury: | Time of Injury: ☐ AM ☐ PM | Date you reported injury: | Name/title of person you reported to: |
|---|---|---|---|
| | | | |

| Describe how and what happened to cause this injury: | Where were you when injury occurred? |
|---|---|
| | |

Name all injuries from this accident:

Have you ever suffered any injuries either work or non-work related before? ☐ Yes ☐ No (**If yes please explain):**

| Are you working? ☐ Yes ☐ No | Did you miss work? ☐ Yes ☐ No | Were you paid for any part of time lost? ☐ Yes ☐ No | Date(s) of lost time: |
|---|---|---|---|
| | | | |

| Witnesses: | **TRUCKING ONLY:** Where did your Employer administer your Qualification Tests? **City/State** |
|---|---|
| | |

Was your injury the result of someone else's negligence? ☐ Yes ☐ No **(If yes, please fill out the following):**

Name:_____ Address:_____ Phone: _____

Insurance Co.:_____ Policy or Claim No.: _____

## TREATMENT INFORMATION

| Date of first medical treatment: | Are you still under a Dr's care? ☐ Yes ☐ No | Date of most recent treatment? | Are you covered by your spouse's ☐ Yes ☐ No health insurance? |
|---|---|---|---|
| | | | |

Name and Addresses of all doctors and hospitals treating you:

| Have you had previous problems or treatments to this body area(s) ☐ Yes ☐ No **(If yes, please describe and include dates experienced):** | Please list name/address of Group Health Ins: |
|---|---|
| | |

| **Employee Signature:** | **Date:** |
|---|---|
| | |



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RISK ADMINISTRATION SERVICES, INC.

# RETURN TO WORK REPORT

TO BE COMPLETED BY **ATTENDING PHYSICIAN** AND RETURNED TO EMPLOYER IMMEDIATELY FOLLOWING EACH APPOINTMENT.

## Patient Information:

| **Last Name:** | **First Name:** | **MI:** |
|---|---|---|
| | | |

| **Date of Injury:** | **Date of Treatment:** | **Brief Explanation of Diagnosis/Condition:** |
|---|---|---|
| | | |

## Limitations:

**Based on the above description of the patient's current medical problem, I am recommending the following:**

☐ Patient may return to work with no limitations on: _____

☐ Patient may not return to work with limitations listed below.

| | | |
|---|---|---|
| ☐ | **SEDENTARY WORK**<br>Lifting up to 10 pounds occasionally and frequently lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. | In an ____ hour work day, patient may:<br>**Stand:**<br>☐ None ☐ 1-4 Hours<br>☐ 4-6 hours ☐ 6-8 hours |
| ☐ | **LIGHT WORK**<br>Lifting up to **20 lbs** occasionally with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pull of arm and/or leg controls. | **Sit:**<br>☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours<br>**Drive:**<br>☐ 1-3 hours ☐ 3-5 hours<br>☐ 5-8 hours ☐ 8+ hours |
| ☐ | **MEDIUM WORK**<br>Lifting **50 lbs** maximum and frequent lifting or carrying of objects weighing up to 25 lbs. | **Patient may use hand(s) for repetitive:**<br>☐ Single Grasping ☐ Fine Manipulation<br>☐ Pushing/Pulling ☐ Firm Grasping<br>☐ Patient is not to use injured hand |
| ☐ | **LIGHT-HEAVY WORK**<br>Lifting **75 lbs** maximum and frequent lifting or carrying of objects weighting up to 40 lbs. | **Patient is able to:**<br>☐ Bend ☐ Squat ☐ Kneel ☐ Climb stairs<br>☐ Reach above shoulders |
| ☐ | **HEAVY WORK**<br>Lifting **100 lbs** maximum and frequent lifting or carrying of objects weighing up to 50 lbs. | **Patient may use foot/feet for repetitive movement as in operating foot controls.**<br>☐ Yes ☐ No |
| **Condition:**<br>☐ Worse ☐ Discharged ☐ Improved ☐ Resolved ☐ Reach above shoulders | | **No Change in:**<br>☐ Diagnosis ☐ Treatment<br>☐ Work Restriction |

**Other instructions and/or limitations, including prescribed medications:**

| ☐ **These restrictions are in effect until:** | ☐ **Or until patient is re-evaluated on:** |
|---|---|

☐ **Patient is totally incapacitated at this time and a re-evaluation is scheduled on:**

| **Physician's Signature:** | **Date:** |
|---|---|
| | |



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**Phone.** 800.732.1486 | **Fax.** 877.884.6573| **Email:** www.RASCompanies.com

# DIVISION OF WORKERS' COMPENSATION

**Missouri Division of Workers' Compensation**
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

**Insurance Company, Third Party Administrator, Service Company, or Designated Individual If Self-Insured**

Name RAS - Risk Administration Services, Inc

Address PO Box 89310
Sioux Falls, SD 57109-9310

Phone

## EMPLOYEE INFORMATION

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

## Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the injury/or 30 days when reasonably aware of the work-relatedness of occupational illness or disease) by contacting Ariana Valade (*employer representative*), 417-625-5200 ext. 2001 (*phone number*).

***Failure to do so may jeopardize your ability to receive benefits***

2. **Seek medical attention (your employer/insurer is responsible for providing medical treatment and paying the medical fees and charges unless you choose to treat with another doctor at your own expense without your employer/insurer's approval).**
3. Get more information about the benefits available under the Workers' Compensation Program or about the steps you may take to get the benefits you need.

**Visit www.labor.mo.gov/DWC or call 800-775-COMP.**

## Benefits for Injured Employees

**Medical Care:**
The employer or insurer is required to provide medical treatment and care to cure and relieve the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately**. The employer/insurer has the right to choose the healthcare provider or treating physician. You may select a different healthcare provider or treating physician, but if you do so, it may be at your own expense.

**Payment for Lost Wages:**
- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

**Permanent Disability Benefits:**
If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

**Survivor Benefits:**
If an employee dies on the job, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage along with funeral expenses up to $5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC.

# Workers' Compensation Law

*Roles and Responsibilities for Employers and Employees*

## EMPLOYER INFORMATION

With some exceptions, all employers with five or more employees, and construction industry employers with one or more employees, are required to insure their workers' compensation liability, either by purchasing a policy or obtaining self-insurance authority. Workers' compensation insurance provides benefits to workers injured on the job. Employers also are required to post this notice in the workplace for employees to view. This poster is required by section 287.127, RSMo, and is available to employers and insurers free of charge by contacting the Division at 800-775-Comp.

### Steps to Take When an Injury Occurs

1. Be sure first aid is administered and the employee is taken to a physician or hospital for further medical care, if necessary.
2. Report the injury to the insurance company or Third Party Administrator (TPA) within five days of the date of injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. The insurer, TPA, or admitted self-insurer is responsible for filing a First Report of Injury with the Division of Workers' Compensation **within 30 days** of knowledge of the injury.
3. Pay medical bills related to the work injury to cure and relieve the employee of the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. The employer has the right to choose the healthcare provider or treating physician. (The employee may select a different healthcare provider or treating physician, but if the employee does so, it may be at his/her own expense.)
4. For more liability and insurance information relating to the Workers' Compensation Program, visit www.labor.mo.gov/DWC or call 800-775-COMP.

### Workers' Safety

Developing and implementing a comprehensive safety and health program can reduce occupational injuries and help lower workers' compensation costs. Insurance carriers in the state of Missouri must provide safety assistance at the request of the insured employer. The Missouri Department of Labor evaluates these services and provides additional assistance through its Missouri Workers' Safety Program.
Visit www.labor.mo.gov/MWSP or call 573-751-4231 for more information about these programs or for a registry of independent consultants who are certified in the state of Missouri to provide safety assistance.

### Fraud/Noncompliance

**Employee Fraud** – knowingly making a claim for workers' compensation benefits to which an employee knows he/she is not entitled or knowingly presenting multiple claims for the same occurrence with intent to defraud is a class D felony, punishable by a fine of up to $10,000, or double the value of the fraud, whichever is greater. A subsequent violation is a class C felony.

**Employer Fraud** – knowingly misrepresenting an employee's job classification to obtain insurance at less than the proper rate is a class A misdemeanor. A subsequent violation is a class D felony. An employer who knowingly makes a false or fraudulent statement regarding an employee's entitlement to benefits to discourage the worker from making a legitimate claim or who knowingly makes a false or fraudulent material statement or material representation to deny benefits to a worker is guilty of a class A misdemeanor punishable by a fine of up to $10,000. A subsequent violation is a class C felony.

**Insurer Fraud** – knowingly and intentionally refusing to comply with workers' compensation obligations to which an insurance company or self-insurer knows an employee is entitled is a class D felony, punishable by a fine of up to $10,000 or double the value of the fraud, whichever is greater. A subsequent violation is a class C felony.

**Employer Noncompliance** – knowingly failing to insure workers' compensation liability under the law is a class A misdemeanor punishable by a fine of up to three times the annual premium the employer would have paid had it been insured or up to $50,000, whichever is greater. A subsequent violation is a class D felony. An employer who willfully fails to post the notice of workers' compensation at the workplace is guilty of a class A misdemeanor punishable by a fine of $50 to $1,000 or by imprisonment or both fine and imprisonment.

DIVISION OF WORKERS' COMPENSATION

**Missouri Division of Workers' Compensation**
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

**Compañía de seguros, Administrador independiente, Compañía de servicios o Persona designada si tiene seguro propio**

Nombre RAS - Risk Administration Services, Inc

Dirección PO Box 89310
Sioux Falls, SD 57109-9310

Teléfono

## INFORMACIÓN DEL EMPLEADO

La División de Compensación a los Trabajadores de Missouri (DWC) administra programas para los trabajadores que se han lesionado en el trabajo o han estado expuestos a una enfermedad ocupacional que surge en el transcurso de su empleo. Los Jueces administrativos de la División tienen la autoridad para aprobar acuerdos o conceder indemnizaciones después de una audiencia relacionada con el derecho de un empleado lesionado a los beneficios.

## Pasos a tomar si se lesiona en el trabajo

1. Notifique inmediatamente a su empleador (debe presentarse un aviso por escrito dentro de los 30 días de ocurrir una lesión o 30 días cuando se sabe de manera razonable de la relación de la enfermedad ocupacional con el trabajo) comunicándose con Ariana Valade (*representante del empleador*), 417-625-5200 ext. 2001 (*número de teléfono*).

***No hacerlo puede poner en peligro la capacidad de recibir sus beneficios***

2. **Busque atención médica (su empleador/asegurador es responsable de proporcionarle el tratamiento médico y pagar los honorarios y gastos médicos, a menos que usted opte por visitar a otro médico, por su propia cuenta, sin la aprobación de su empleador/asegurador).**
3. Obtenga más información sobre los beneficios disponibles bajo el Programa de Compensación a los Trabajadores o sobre los pasos que debe seguir para obtener los beneficios que necesita.

**Visite www.labor.mo.gov/DWC o llame al 800-775-COMP.**

## Beneficios para los empleados lesionados

**Cuidado médico:**
El empleador o asegurador tiene que proporcionar tratamiento y cuidado médico para curar y aliviar los efectos de la lesión. Esto incluye todos los costos del tratamiento médico autorizado, medicamentos recetados y aparatos médicos. No hay deducibles y todos los costos los paga el empleador o su compañía de seguro de compensación a los trabajadores. Si usted recibe una factura, **comuníquese inmediatamente con su empleador o con la compañía de seguros**. El empleador o asegurador tiene derecho de escoger el proveedor de cuidado de salud o médico tratante. Usted puede seleccionar a otro proveedor de cuidado de salud o médico tratante, pero si lo hace, puede ser por su propia cuenta.

**Pago por salarios perdidos:**

- Si un médico dice que usted no puede trabajar debido a sus lesiones o a la recuperación de una cirugía, puede tener derecho a beneficios por **incapacidad total temporal** (TTD). Si un médico dice que usted puede realizar labores livianas o modificadas de trabajo y su empleador le ofrece dicho trabajo, puede que no sea elegible para beneficios de TTD. Los beneficios de TTD deben continuar hasta que el médico diga que usted puede volver a trabajar o cuando su tratamiento haya terminado porque su condición ha alcanzado la "máxima mejoría médica", lo que ocurra primero.
- Si usted regresa a trabajar en labores ligeras o modificadas por menos del salario completo, puede que tenga derecho a recibir beneficios por **incapacidad parcial temporal**.

**Beneficios por incapacidad permanente:**
Si la lesión o enfermedad da lugar a una incapacidad permanente, usted puede tener derecho a recibir beneficios ya sea por incapacidad parcial permanente o por incapacidad total permanente.

**Beneficios de sobreviviente:**
Si un empleado muere en el trabajo, los dependientes que le sobrevivan pueden recibir beneficios por muerte semanales pagados al 66 2/3% del salario promedio semanal del empleado fallecido, junto con gastos funerarios de hasta $5,000 por parte del empleador/asegurador. Para información adicional relacionada con los beneficios de sobreviviente, incluyendo oportunidades de becas universitarias para hijos sobrevivientes, visite www.labor.mo.gov/DWC.

# Ley de Compensación a los Trabajadores

*Papel a desempeñar y responsabilidades de empleadores y empleados*

## INFORMACIÓN DEL EMPLEADOR

Salvo algunas excepciones, todos los empleadores que tengan cinco o más empleados y los empleadores de la industria de la construcción que tengan uno o más empleados tienen que garantizar la obligación legal de la compensación a sus trabajadores, ya sea comprando una póliza u obteniendo la autoridad de tener seguro propio. El seguro de compensación a los trabajadores proporciona beneficios a los trabajadores que se lesionan en el trabajo. Los empleadores también tienen que exhibir este aviso en el lugar de trabajo de manera que los empleados lo vean. Este póster es obligatorio conforme a la sección 287.127, Estatutos Revisados de Missouri, y está disponible para empleadores y aseguradores sin costo alguno a través de la División llamando al 800-775-Comp.

### Pasos a tomar si ocurre una lesión

1. Asegúrese de que se le den los primeros auxilios y lleven al empleado al médico o al hospital para recibir atención médica adicional, si es necesario.
2. Informe sobre la lesión a la compañía de seguros o Administrador externo (TPA) dentro de un plazo de cinco días a partir de la fecha de la lesión o de la fecha en que el empleado informó al empleador sobre la lesión, lo que ocurra más tarde. El asegurador, TPA o el asegurador por cuenta propia reconocido es responsable de presentar un Primer Informe de Lesión ante la División de Compensación a los Trabajadores **dentro de los 30 días** de haber tenido conocimiento de la lesión.
3. Pague las facturas médicas relacionadas con la lesión en el trabajo para curar y aliviar al empleado de los efectos de la lesión. Esto incluye todos los costos del tratamiento médico autorizado, medicamentos recetados y aparatos médicos. El empleador tiene derecho de escoger el proveedor de cuidado de la salud o médico tratante. (El empleado puede seleccionar a otro proveedor de cuidado de la salud o médico tratante, pero si lo hace, puede ser por su propia cuenta).
4. Para más información de seguro y responsabilidad relacionados con el Programa de Compensación a los Trabajadores, visite www.labor.mo.gov/DWC o llame al 800-775-COMP.

### Seguridad de los trabajadores

Desarrollar e implementar un programa completo de salud y seguridad puede reducir las lesiones ocupacionales y ayudar a reducir los gastos de compensación a los trabajadores. Las compañías aseguradoras en el estado de Missouri tienen que proporcionar asistencia en seguridad cuando un empleador asegurado la solicita. El Departamento del Trabajo de Missouri evalúa estos servicios y brinda ayuda adicional a través de su Programa de Seguridad de los Trabajadores de Missouri. Visite www.labor.mo.gov/MWSP o llame al 573-751-4231 para obtener más información sobre estos programas o un registro de consultores independientes que están certificados en el estado de Missouri para proporcionar asistencia en seguridad.

### Fraude/Falta de cumplimiento

**Fraude del empleado** – presentar a sabiendas una reclamación de beneficios por compensación a los trabajadores a los cuales el empleado sabe que no tiene derecho o presentar a sabiendas múltiples reclamaciones por el mismo incidente con intención de defraudar es un delito grave de clase D, que se castiga con una multa de $10,000 o del doble del valor del fraude, lo que sea mayor. Una infracción posterior es un delito grave de clase C.

**Fraude del empleador** – alterar a sabiendas la clasificación de empleo de un empleado con el objetivo de obtener seguro a una tarifa menor de la que corresponde es un delito menor de clase A. Una infracción posterior es un delito grave de clase D. Un empleador que hace una declaración falsa o fraudulenta a sabiendas relacionada con el derecho de un empleado a recibir beneficios con el objetivo de disuadir al trabajador de presentar una reclamación legítima, o que hace una declaración o descripción fundamental falsa o fraudulenta a sabiendas para negar beneficios a un trabajador es culpable de un delito menor de clase A que se castiga con una multa de hasta $10,000. Una infracción subsiguiente es un delito grave de clase C.

**Fraude del asegurador** – negarse, a sabiendas y deliberadamente, a cumplir con las obligaciones de la compensación a los trabajadores a la cual la compañía de seguros o asegurador por cuenta propia sabe que un empleado tiene derecho es un delito grave de clase D que se castiga con una multa de hasta $10,000 o el doble del valor del fraude, lo que sea mayor. Una infracción posterior es un delito grave de clase C.

**Falta de cumplimiento del empleador** – no garantizar, a sabiendas, la obligación de la compensación a los Trabajadores es un delito menor de clase A que se castiga con una multa civil de hasta tres veces la prima anual que el empleador habría tenido que pagar de estar asegurado, o hasta $50,000, lo que sea mayor. Una infracción posterior es un delito grave de clase D. Un empleador que intencionalmente no coloca el anuncio de la compensación a los trabajadores en el lugar de trabajo es culpable de un delito menor de clase A que se castiga con una multa de $50 a $1,000, o prisión o ambas.