HOWARD LEASING
Professional Employee Services

Workers Compensation Injury Handbook

HOWARD LEASING
Professional Employee Services

INJURIES, REPORT PROCEDURES & RISK MANAGEMENT

Dear Valued Client:

This letter is to introduce myself and welcome you to Howard Leasing's Risk Management Department.

First, let's make sure everyone has my contact information:

Sondra Kelley – Director of Risk Management
Office Phone: (941)761-7704
Cell Phone: (941) 932-5740
Fax Number: (941) 538-7801

This packet contains everything you will need in order to report any type of injury, whether it is a report only injury, first aid injury, and moderate to severe injuries. Please take note that no matter what type of injury it may be, **even if the injured worker refuses treatment**, a minimum of a 5 panel drug screen test must be performed within 24 hours. A 10 panel drug screen is preferred.

Please review the enclosed documents in this packet to familiarize yourself with our procedures. In the event of an injury, knowing what to do is critical to everyone.

This packet should contain the following documents:

1. INJURY REPORTING PROCEDURES
2. LOCATING AN URGENT CARE/MINOR EMERGENCY FACILITY
2. WORKERS' COMPENSATION INFORMATION
3. FIRST REPORT OF INJURY OR ILLNESS
4. EMPLOYEE VERIFICATION FORM (ENGLISH AND SPANISH)
5. WITNESS STATEMENT (ENGLISH AND SPANISH
6. WORKERS' COMPENSATION QUESTIONNAIRE
7. ACKNOWLEDGEMENT OF REFUSAL OF MEDICAL TREATMENT (ENGLISH AND SPANISH)
8. AUTHORIZATION FOR RELEASE OF INFORMATION

Please advise your supervisors and employees of these procedures.

Thank you for being a part of the Risk Management Team! Together we can work to make the workplace a safe environment!

Sincerely,
Sondra Kelley
Director of Risk Management

HOWARD LEASING
Professional Employee Services

INJURY REPORTING PROCEDURES

IF THE INJURY IS AN EMERGENCY, DIAL 911 IMMEDIATELY. After calling 911, please contact Sondra Kelley as soon as possible at (941) 761-7704 between the hours of 8:00 AM and 5:00 PM. After hours you may reach Sondra Kelley at cell number (941) 932-5740. This number is available 7 days a week and 24 hours a day.

IF THE INJURY IS NOT AN EMERGENCY

1. Call Sondra Kelley immediately upon being notified of an injury at **(941) 761-7704** (Office) or **(941) 932-5740.** The State requires we report the injury to the State within a small timeframe or a fine and/or penalty could be assessed to the onsite employer.
2. Fill out the FROI (First Report of Injury Form – DFS-F2-DWC-1).
3. The Howard Leasing Risk Management/Workers Compensation department will coordinate which clinic to send the injured worker to for evaluation and mandatory drug screen.
4. A minimum of a **5 Panel Drug Screen** is mandatory for all workers' compensation claims whether the injured worker wants treatment or refuses treatment. A **10 Panel Drug Screen** is preferred.
5. The injured employee must have a **drug screen within 24 hours of the injury** or the claim can be denied. (If the injured worker reports the injury 24 hours after the injury, the injured worker is still required to submit to a drug screen immediately)
6. The employee needs to complete and sign the FROI, employee verification form, the Workers' Compensation Questionnaire, the Authorization for Release of Information, Workers' Compensation False or Fraudulent Claims and the Medical Refusal if the injured worker is refusing treatment.
7. If anyone witnessed the accident, secure the witness statement as soon as possible. The witness needs to complete the Witness Statement form.
8. If possible, take photos of the accident site.
9. Please forward all workers' compensation correspondence relating to the injury to: skelley@howardleasinginc.com or **facsimile number (941) 538-7801.**

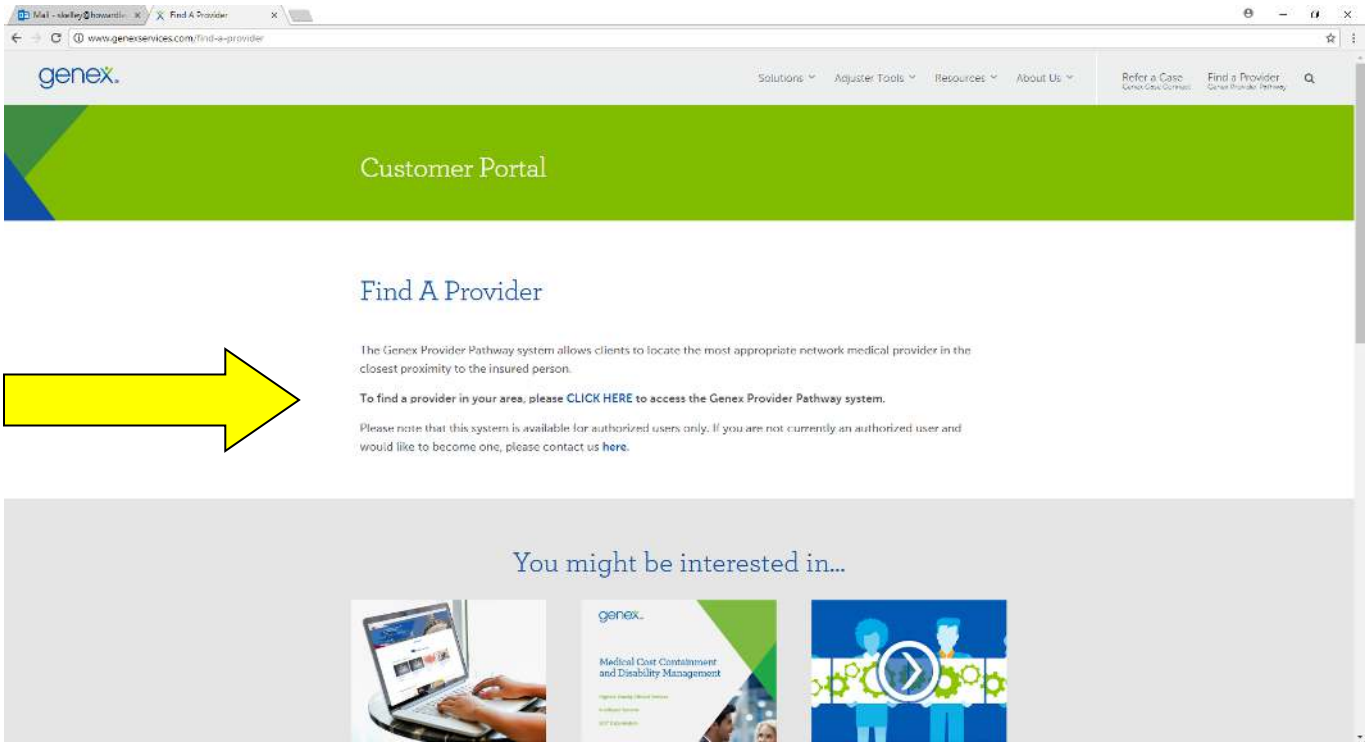
Please remember, it is imperative that you communicate any injuries to Howard Leasing as soon as you are notified by one of your employees that an injury has occurred. No matter how big or how small, call Howard Leasing immediately. With timely reporting, we will be able to assist your injured employee as efficiently as possible.

- **LATE REPORTING OF AN INJURY COULD RESULT IN PENALITIES AND FINES FROM THE STATE.**
- **FAILURE TO SECURE A DRUG SCREEN IMMEDIATELY AFTER ANY INJURY MAY RESULT IN A DENIED CLAIM.**
- **PLEASE RETAIN ANY DEFECTIVE EQUIPMENT OR FAULTY MACHINES FOR INSPECTION**.

HOWARD LEASING
Professional Employee Services

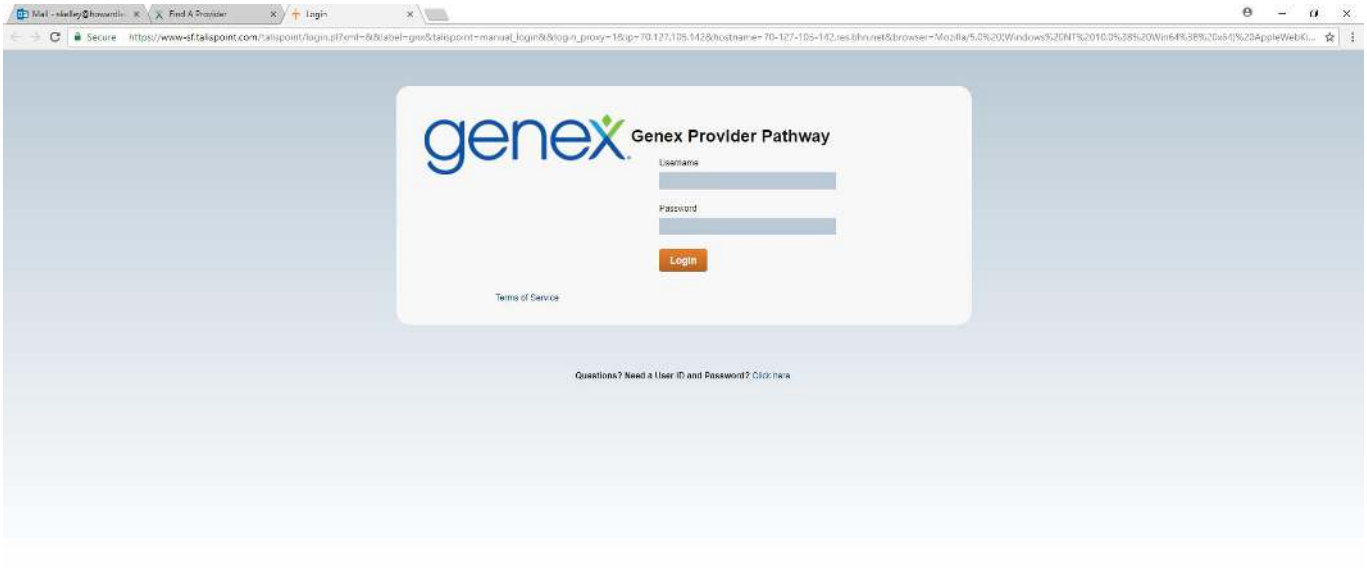
If this is a life threatening emergency, he/she will need to go to the nearest hospital for treatment. If not, please follow the instructions below to locate an in-network First Treatment Site to send your employee to for medical treatment.

Please access **http://www.genexservices.com/find-a-provider**. You will come to a screen that looks like the below screen:

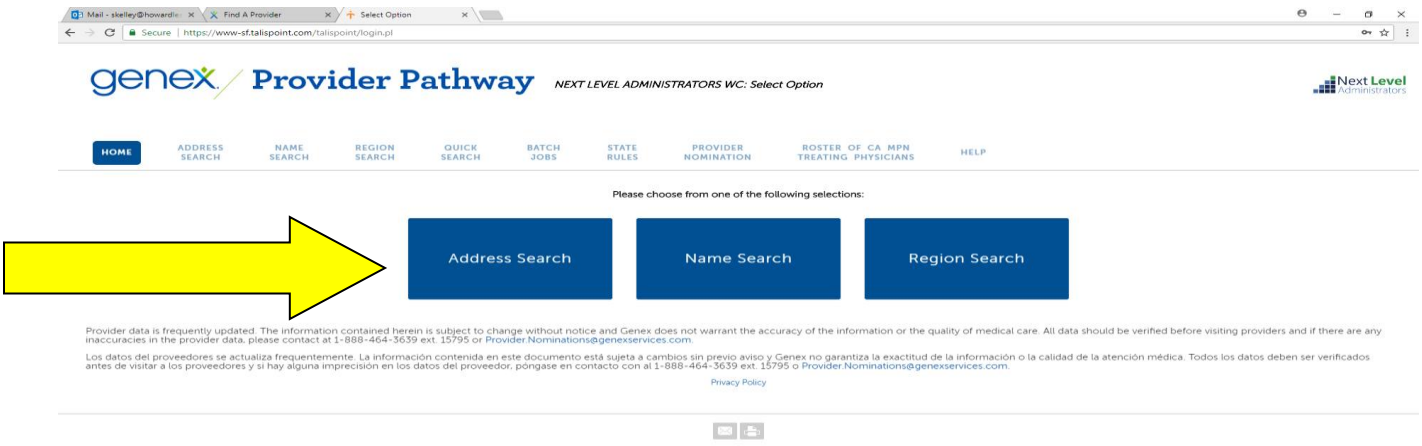


Select "CLICK HERE" as illustrated above.

HOWARD LEASING
Professional Employee Services

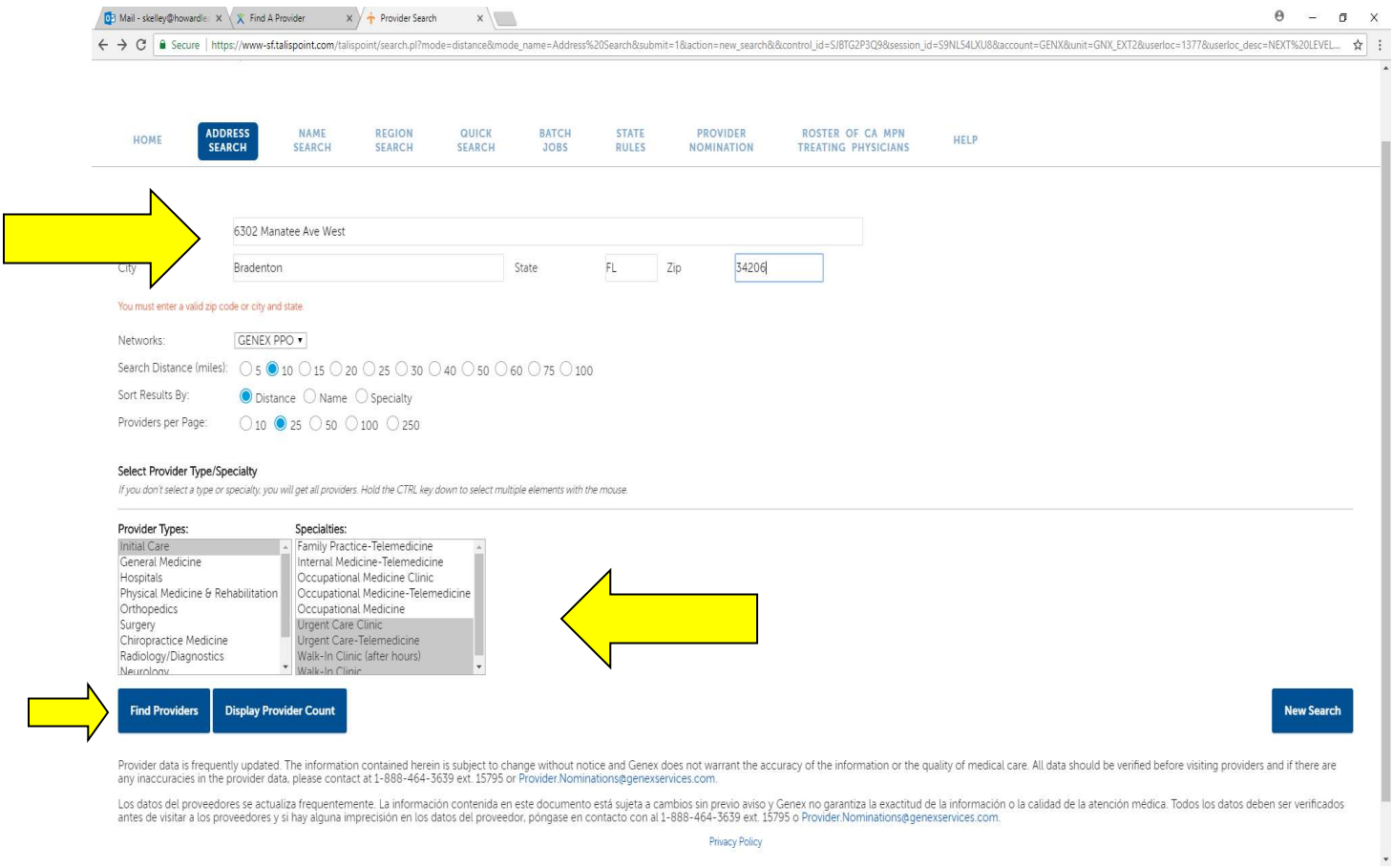


Enter the **USER NAME: Next** and **PASSWORD: Administrators** and click Login



1. Select Address Search box.

HOWARD LEASING
Professional Employee Services



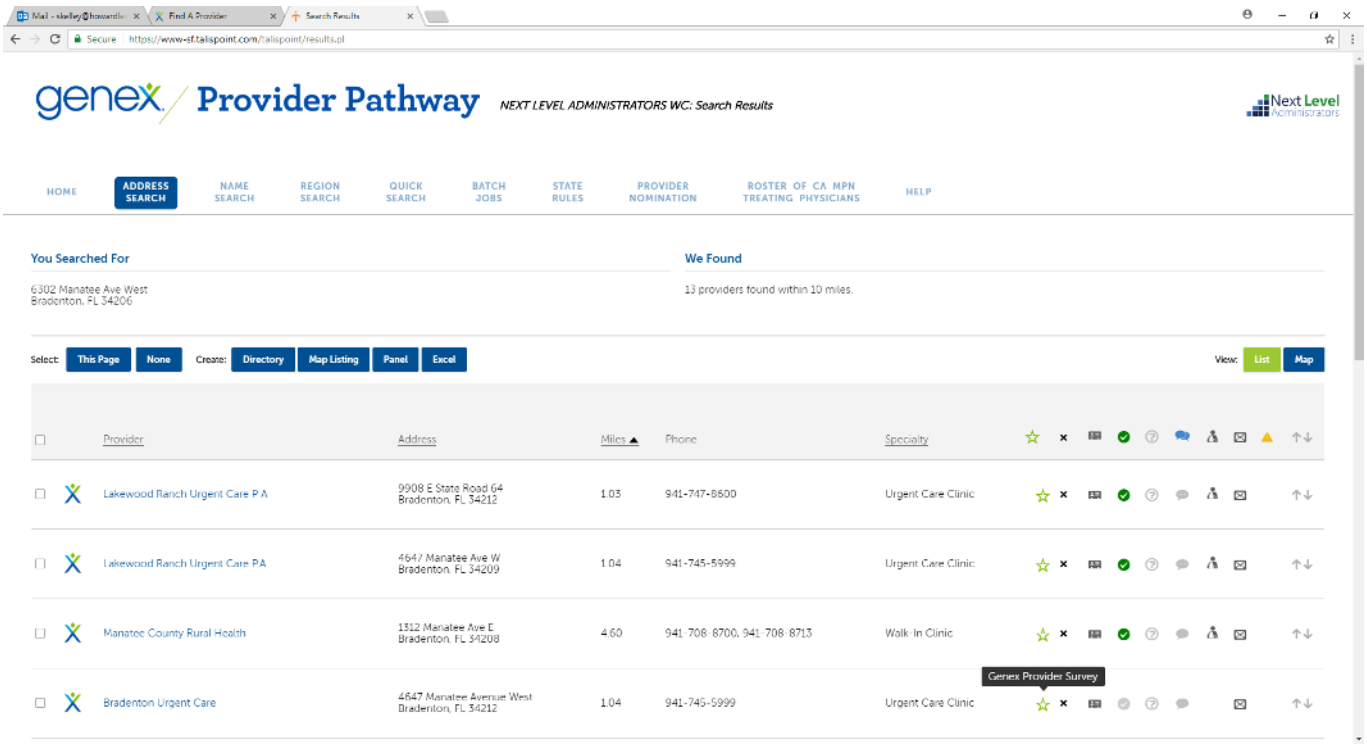
2. Enter an Address or City and State or a Zip Code in the box provided.
3. Select SEARCH RADIUS and enter the mile radius you wish to search.
4. Select Initial Care in the PROVIDER TYPES area.
5. Select Urgent Care Clinic or select multiple clinics by holding down the shift key and click on two or more clinics in the SPECIALITIES area.

.

Click Find Providers

HOWARD LEASING
Professional Employee Services

All Urgent Care clinics that accept workers' compensation insurance will be listed. You will need to contact the facility to ensure they perform post-accident drug screens.



Please make sure you are sending your employees to someone in the network. **Your employee MUST be drug tested at this location.** We prefer a 10 panel drug screen, if that is not available a minimum of a 5 panel drug screen is required.

If you have any questions feel free to contact Howard Leasing.

HOWARD LEASING, INC
WORKERS' COMPENSATION INFORMATION

SUNZ INSURANCE COMPANY
TPA: Next Level Administrators, LLC
PO Box 1061
Bradenton, FL 34206

POLICY NUMBER – WC013-00001-018

Howard Leasing, Inc
6302 Manatee Avenue West, Suite K
Bradenton, FL 34209

Phone: (941) 761-7704
Fax: 941-538-7801
Attention: Sondra Kelley
SKelley@howardleasinginc.com
Cell: (941) 932-5740

If you have any questions please contact Sondra Kelley, Director of Risk Management, Howard Leasing, Inc.

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)

Social Security Number

Date of Accident (Month-Day-Year)

Time of Accident ☐ AM ☐ PM

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

DATE OF BIRTH

_____ / _____ / _____

SEX ☐ M ☐ F

EMPLOYER INFORMATION

COMPANY NAME: _HOWARD LEASING, INC_____

D. B. A.: _____

Street: _6302 MANATEE AVENUE WEST, SUITE K_____

City: BRADENTON_____ State: FL_____ Zip: _34209____

TELEPHONE Area Code Number

941-761-7704

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

WC013-00001-018

DATE EMPLOYED

_____ / _____ / _____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED

_____ / _____ / _____

RETURNED TO WORK ☐ YES ☐ NO
IF YES, GIVE DATE

_____ / _____ / _____

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP

_____ / _____ / _____

PLACE OF ACCIDENT (Street, City, State, Zip)

Street: _____

City: _____ State: _____ Zip: _____

COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable)

_____ / _____ / _____

AGREE WITH DESCRIPTION OF ACCIDENT?

☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK

$ _____ PER ☐ DAY ☐ MO

Number of hours per day _____

Number of hours per week _____

Number of days per week _____

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.
I have reviewed, understand and acknowledge the above statement.

_____ _____
EMPLOYEE SIGNATURE (If available to sign) DATE

_____ _____
EMPLOYER SIGNATURE DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case - DWC-12, Notice of Denial Attached

☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)
Employee's 8TH Day of Disability _____ / _____ / _____
Entity's Knowledge of 8TH Day of Disability _____ / _____ / _____

☐ 3. Lost Time Case - 1st day of disability _____ / _____ / _____ Full Salary in lieu of comp? ☐ YES Full Salary End Date _____/ _____ / _____

Date First Payment Mailed _____ / _____ / _____ AWW _____ Comp Rate _____

☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH ☐ SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:

INSURER CODE #

EMPLOYEE'S CLASS CODE

EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #

CLAIMS-HANDLING ENTITY FILE #

INSURER NAME
SUNZ INSURANCE

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

Next Level Administrators, LLC
PO BOX 1061
Bradenton, FL 34206
Ph: (877) 306-6398

Form DFS-F2-DWC-1 (08/2004)

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

HOWARD LEASING
Professional Employee Services

EMPLOYEE VERIFICATION FORM

(TO BE FILLED OUT BY THE INJURED WORKER)

We are attempting to process your worker's compensation claim and need to verify the following information in order for us to determine entitlement to workers' compensation benefits.

Please verify that the following information is true and correct:

NAME: _____

EMPLOYER NAME: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

ADDRESS: _____

PHONE NUMBER: _____

DATE OF INJURY: _____

In order to receive benefits for my worker's compensation claim, I, _____, attest that the above information is true and correct.

EMPLOYEE SIGNED NAME: _____

EMPLOYEE PRINTED NAME: _____

DATE: _____

Preparer and/or Translator Certification: (To be completed and signed if this form is prepared by a person other than the injured worker.)
I attest, under penalty of perjury, that I have assisted in the completion of this form and that the form was read and/or translated to the injured worker and the answers provided on this form was provided by the injured worker.

Name: _____ ***Date:*** _____

Address: _____ ***Ph:*** _____

Signature. _____

HOWARD LEASING
Professional Employee Services

FORMULARIO DE VERIFICACIÓN DEL EMPLEADO

(PARA SER COMPLETADO POR EL TRABAJADOR LESIONADO)

Estamos tratando de procesar su reclamo de compensación al trabajador y necesitamos verificar la siguiente información para que podamos determinar el derecho a beneficios de compensación de trabajadores.

Por favor verifique que la siguiente información sea verdadera y correcta:

NOMBRE: _____

NOMBRE DEL EMPLEADOR: _____

NÚMERO DE SEGURO SOCIAL: _____

FECHA DE NACIMIENTO: _____

DIRECCIÓN: _____

NÚMERO DE TELÉFONO: _____

FECHA DE LA LESIÓN: _____

Con el fin de recibir beneficios por mi reclamo de compensación al trabajador, yo, _____ doy fe de que la información anterior es verdadera y correcta.

FIRMA DEL EMPLEADO: _____

NOMBRE EN IMPRENTA DEL EMPLEADO: _____

FECHA: _____

Certificación del Preparador y / o Traductor: (Para ser completada y firmada si este formulario es preparado por una persona distinta al trabajador lesionado.)
Doy fe, bajo pena de perjurio, que he ayudado en la preparación de este formulario y que el formulario fue leído y / o traducido al trabajador lesionado y las respuestas dadas en este formulario fueron proporcionadas por el trabajador lesionado.

Nombre: _____ ***Fecha:*** _____

Dirección: _____***Número de Teléfono:*** _____

Firma Del Preparador y / o Traductor: _____

HOWARD LEASING
Professional Employee Services

WORKERS' COMPENSATION QUESTIONNAIRE
(To Be Completed by Employee)

Name: _____ Social Security Number: _____

Street Address: _____ Phone Number: _____

City, State, Zip Code: _____ Cell Number: _____

This questionnaire is treated as a confidential document and access is limited to a "need to know" basis. Howard Leasing and its affiliates will retain this form on a confidential file and reserve the right to refer to the information in the event of an accident, sickness, injury or claim for worker's compensation.

In the past ten (10) years have you been treated for any of the following conditions or disorders?
Please answer yes or no.

Broken bones, fractures or dislocations? _____ Any joint pain or injury? _____

Muscle, tendon or ligament problems? _____ Feet, ankle, or knee problems? _____

Pains, aches, numbness or weakness in the neck, shoulder, arms, hands or fingers? _____

Strains or sprains? _____ Back complaint/back injury? _____

Head injury? _____ Any other injury not mentioned? _____

For any yes answers provided in the above section, list the details in the section below.

Accident/Injury	Details/Treatment	Begin Date	End Date

Have you ever filed for Workers Compensation? _____

Are you currently receiving Workers Compensation or Disability income? _____

Declaration
My answers relating to my medical and employment history are true and complete to the best of my knowledge.

Full Name (Please Print) _____

Signature _____ Date _____

Preparer and/or Translator Certification: (To be completed and signed if this form is prepared by a person other than the injured worker.)
I attest, under penalty of perjury, that I have assisted in the completion of this form and that the form was read and/or translated to the injured worker and the answers provided on this form was provided by the injured worker.

Name: _____ ***Date:*** _____

Address: _____ ***Ph:*** _____

Signature. _____

HOWARD LEASING
Professional Employee Services

CUESTIONARIO DE COMPENSACIÓN DE TRABAJADORES
(Para Ser Completado Por El Empleado)

Nombre: _____ Número de Seguro Social: _____

Dirección: _____ Número de Teléfono: _____

Ciudad, Estado, Código Postal: _____ Teléfono Celular: _____

Este formulario es tratado como un documento confidencial y su acceso es limitado en base a "necesidad de saber." Howard Leasing y sus afiliados mantendrán este formulario en archivo confidencial y reservan el derecho a hacer referencia a la información en el evento de un accidente, enfermedad, lesión o un reclamo de compensación al trabajador.

En los pasados (10) años, ha sido usted tratado por alguna de las siguientes condiciones o trastornos de la salud? Por favor responda sí o no.

Huesos rotos, fracturas o dislocaciones? _____ Algún dolor de coyuntura o lesión?_____

Problema de musculo, tendón o ligamento? _____ Problema de pies, tobillo o rodilla? _____

Dolores, molestias, entumecimiento o debilidad en el cuello, hombro, brazos, manos o dedos? _____

Torceduras o esguinces_____ Quejas de Espalda/Lesión de Espalda? _____

Para cualquier respuesta proporcionada en la sección anterior, liste los detalles abajo:

Accidente/Lesión	Detalles/Tratamiento	Fecha de Inicio	Fecha de Fin

Alguna vez ha solicitado Compensación de Trabajadores? _____

Este usted recibiendo Compensación de Trabajadores o Prestaciones por Discapacidad? _____

Declaración
Mis respuestas con relación a mi historial médico y de empleo son verdaderas y completas de acuerdo a mis mejores conocimientos.

Nombre Completo (Por Favor Imprente) _____

Firma: _____ Fecha: _____

Certificación del Preparador y / o Traductor: (Para ser completada y firmada si este formulario es preparado por una persona distinta al trabajador lesionado.)
Doy fe, bajo pena de perjurio, que he ayudado en la preparación de este formulario y que el formulario fue leído y / o traducido al trabajador lesionado y las respuestas dadas en este formulario fueron proporcionadas por el trabajador lesionado.

Nombre: _____ ***Fecha:*** _____

Dirección: _____ ***Número de Teléfono:*** _____

Firma Del Preparador y / o Traductor: _____

HOWARD LEASING
Professional Employee Services

WITNESS STATEMENT

INJURED WORKER: _____ REPORT DATE: _____

CLIENT COMPANY: _____ WEATHER CONDITIONS: _____

WITNESS NAME: _____ DATE & ACCIDENT TIME: _____

_____

NATURE OF ACCIDENT: _____

WITNESS STATEMENT: _____

_____

_____

_____

_____

_____

_____

POSSIBLE CAUSE OF ACCIDENT: _____

_____

To the best of my knowledge, the above statement is truth, sworn by me on this _____ day of _____ (month), _____ (year).

WITNESS SIGNATURE: _____ DATE: _____

HOME PHONE: _____

HOWARD LEASING
Professional Employee Services

DECLARACIÓN DEL TESTIGO

TRABAJADOR LESIONADO: _____ FECHA DEL INFORME: _____

EMPRESA DEL CLIENTE: _____ CONDICIONES DEL CLIMA: _____

NOMBRE DEL TESTIGO: _____ PECHA Y HORA DEL ACCIDENTE _____

NATURALEZA DEL ACCIDENTE: _____

DECLARACIÓN DEL TESTIGO: _____

_____

_____

_____

_____

_____

_____

CAUSA POSIBLE DEL ACCIDENTE: _____

_____

Bajo mis mejores conocimientos, la declaración anterior es verdadera, jurada por mi este

día de _____ (mes), _____ (año).

FIRMA DEL TESTIGO: _____ FECHA: _____

TELÉFONO DEL HOGAR: _____

HOWARD LEASING
Professional Employee Services

Acknowledgment of Refusal of Medical Treatment

I, _____, hereby acknowledge that I have refused to be medically evaluated for a work-related injury I sustained on _____. I understand that by signing this document any future claims regarding this injury will require me to notify my supervisor immediately. I also understand that even though I require no medical treatment for this injury, I still must adhere to a mandatory post-accident drug screen.

_____ _____
EMPLOYEE DATE

_____ _____
DIRECT SUPERVISOR DATE

_____ _____
WITNESS DATE

Preparer and/or Translator Certification: (To be completed and signed if this form is prepared by a person other than the injured worker.)
I attest, under penalty of perjury, that I have assisted in the completion of this form and that the form was read and/or translated to the injured worker and the answers provided on this form was provided by the injured worker.

Name: _____ ***Date:*** _____

Address: _____ ***Ph:*** _____

Signature. _____

HOWARD LEASING
Professional Employee Services

Reconocimiento de Rechazo de Tratamiento Médico

Yo, _____, el abajo firmantes, reconozco que he rechazado a ser evaluado medicamente de una lesión relacionada al trabajo la cual sufrí el _____.

Entiendo que al firmar este documento, cualquier reclamo futuro en relación a esta lesión requerirá que yo se lo notifique inmediatamente a mi supervisor. También entiendo que aunque no necesite ningún tratamiento médico para esta lesión, aun así, debo someterme a una prueba de drogas obligatoria después de un accidente.

_____	_____
EMPLEADO:	FECHA
_____	_____
SUPERVISOR	FECHA
_____	_____
TESTIGO	FECHA

Certificación del Preparador y / o Traductor: (Para ser completada y firmada si este formulario es preparado por una persona distinta al trabajador lesionado.)
Doy fe, bajo pena de perjurio, que he ayudado en la preparación de este formulario y que el formulario fue leído y / o traducido al trabajador lesionado y las respuestas dadas en este formulario fueron proporcionadas por el trabajador lesionado.

Nombre: _____ ***Fecha:*** _____

Dirección: _____ ***Número de Teléfono:*** _____

Firma Del Preparador y / o Traductor: _____

HOWARD LEASING
Professional Employee Services

AUTHORIZATION FOR RELEASE OF INFORMATION

Employee Name:	Date:
Social Security Number:	Claim Number:

I authorize any health care provider, which may include, but is not limited to, any physician, medical practitioner, hospital, clinic, other medical or medically related facility, to provide information to Howard Leasing Inc.

As used herein, "information" means information about me and may include, but is not limited to, diagnosis, prognosis, treatment or care of any physical or mental condition, and return to work information. Such information may be provided verbally or in writing.

I agree that this authorization will permit Howard Leasing Inc., and its representative to obtain; review and copy all and any information pertaining to my injury or illness and any pre-existing condition(s) that may be relevant to the injury or illness in question.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy rule under the Health Insurance Portability and Accountability Act.

I agree that this Authorization shall remain valid until my claim for benefits has been closed.

I understand that I may revoke this Authorization at any time by providing written notice to except: (i) to the extent that an individual has been taken action in reliance upon such authorization prior to notice of the revocation, or (ii) to the extent that this authorization was provided as a condition of obtaining benefits, and the law provides the right to contest a claim for coverage under the policy providing such benefits.

I agree that a copy of this Authorization is as valid as the original.

WORKERS' COMPENSATION FALSE OR FRAUDULENT CLAIM

Please read the following information carefully and sign and date this form. You must sign this form, or your workers' compensation benefits or payments may be suspended until your signature is obtained.

Workers' Compensation fraud includes, but is not limited to:

- Requesting and/or receiving temporary total, temporary partial, or permanent total disability benefits while working for gain as an employee of a business, independent contractor, yourself or a business owner and not reporting that income to the insurance company.
- Making a false statement and/or submitting false documentation concerning identity, wages and/or employment.
- Misrepresenting facts concerning an industrial accident, injury, illness, and/or the extent of your disability to your employer, your physician, or the insurance company.
- Making a false statement and/or submitting false documentation concerning transportation reimbursement requests.
- Selling your personal information to third parties for use in misrepresenting facts to any medical provider or insurance company.

I certify that I have reviewed, understand, and acknowledge the foregoing.

Print Name: _____ Signature: _____ Date: _____

Preparer and/or Translator Certification: (To be completed and signed if this form is prepared by a person other than the injured worker.)
I attest, under penalty of perjury, that I have assisted in the completion of this form and that the form was read and/or translated to the injured worker and the answers provided on this form was provided by the injured worker.

Name: _____ ***Date:*** _____

Address: _____ ***Ph:*** _____

Signature. _____

HOWARD LEASING
Professional Employee Services

AUTORIZACIÓN PARA DIVULGACIÓN DE INFORMACIÓN

Nombre del Empleado:	Fecha:
Número de Seguro Social:	Número De Reclamo:

Autorizo a cualquier proveedor del cuidado de la salud, que puede incluir, pero no se limita a, cualquier médico, profesional médico, hospital, clínica, otra instalación médica o medicamente relacionada, para proporcionar información a Howard Leasing, Inc.

Según se usa aquí, la "información" significa información sobre mí y puede incluir, pero no se limita a, el diagnóstico, el pronóstico, el tratamiento o la atención de alguna condición física o mental, e información con respecto al regreso al trabajo. Dicha información puede ser proporcionada verbalmente o por escrito.

Estoy de acuerdo que esta autorización permitirá a Howard Leasing, Inc., y su representante de obtener; revisar y copiar toda y cualquier información relacionada con mi lesión o enfermedad y cualquier condición(es) pre-existente que pueda ser relevante a la lesión o enfermedad en cuestión.

Entiendo que la información divulgada conforme a esta autorización puede estar sujeta a una nueva divulgación por el recipiente y ya no estará protegida por la regla de privacidad conforme a la Ley de Responsabilidad y Portabilidad del Seguro de Salud. (Health Insurance Portability and Accountability Act).

Estoy de acuerdo que esta autorización será válida hasta que mi reclamación de beneficios se haya cerrado.

Entiendo que puedo revocar esta autorización en cualquier momento mediante notificación por escrito a excepción de: (i) en la medida en que un individuo haya tomado una acción basándose en dicha autorización previa a la notificación de la revocación, o (ii) en la medida que esta autorización se proporcione como una condición para la obtención de beneficios, y la ley ofrezca el derecho a impugnar la cobertura de una reclamación bajo la póliza que proporciona dichos beneficios.

Estoy de acuerdo que una copia de esta autorización es tan válida como la original.

Reclamación Falsa o Fraudulenta de Compensación de Trabajadores

Por favor, lea la siguiente información cuidadosamente y firme y feche este formulario. Usted debe firmar este formulario, o sus beneficios de compensación de trabajadores o pagos pueden ser suspendidos hasta que se obtenga su firma.

Fraude de Compensación de Trabajadores incluye, pero no se limita a:

- Solicitar y / o recibir beneficios de incapacidad total temporal, total parcial, o total permanente, mientras trabaje para recibir ganancias como un empleado de una empresa, contratista independiente, por sí mismo o como propietario de un negocio y no reporte los ingresos a la compañía de seguros.
- Hacer una declaración falsa y / o la presentación de documentación falsa sobre la identidad, los salarios y / o el empleo.
- Falsificar hechos relacionados con un accidente de trabajo, lesión, enfermedad y / o el grado de su discapacidad a su empleador, su médico, o la compañía de seguros.
- Hacer una declaración falsa y/o presentar documentación falsa en relación con las solicitudes de reembolso de transporte.
- La venta de sus datos personales a terceras entidades para su uso en falsificar o tergiversar los hechos a cualquier proveedor de servicios médicos o compañía de seguros.

Certifico que he revisado, comprendo y reconozco lo anterior.

Imprimir Nombre: _____ Firma: _____ Fecha:

Certificación del Preparador y / o Traductor: (Para ser completada y firmada si este formulario es preparado por una persona distinta al trabajador lesionado.)

Doy fe, bajo pena de perjurio, que he ayudado en la preparación de este formulario y que el formulario fue leído y / o traducido al trabajador lesionado y las respuestas dadas en este formulario fueron proporcionadas por el trabajador lesionado.

Nombre: _____ ***Fecha:*** _____

Dirección: _____ ***Número de Teléfono:*** _____

Firma Del Preparador y / o Traductor: _____