



The following forms and information are intended to make the claims process easier for you to navigate. You are not required to use all of the forms, however it is essential that you maintain contact with your BIAW claim representative.

PLEASE BE SURE TO CONTACT YOUR BIAW CLAIM REPRESENTATIVE WITH ANY QUESTIONS OR CONCERNS. OUR PHONE NUMBER IS 1-800-228-4229.

ANY CLAIM STAFF MEMBER IS AVAILABLE TO ASSIST YOU.

Company Name Begins With	BIAW Claims Specialist
A, D.....	Laine Romero, ext 126
B, J, L.....	L J Jensen, ext 122
C, U, #'s.....	Teresa Sheldon, ext 136
E, K, N, W, Y.....	Chloe Kaufman, ext 118
F, G, H, I, Q.....	Amy Sutton, ext 127
M, P.....	Amanda Kramer, ext 143
O, S, V, X, Z.....	Chris Creekpaum, ext 121
R, T.....	Michele Whinery, ext 141
Structured Settlements.....	Dave Ducey, ext 131

INITIAL REPORT OF ACCIDENT TO BIAW

CLAIM NUMBER # _____

EMPLOYEE NAME:		SOCIAL SECURITY #:	
Home Address:			
Home Phone:		Contact/Message Phone:	
Date of Birth:		Date of Hire: Pay Rate: \$ per	
Employment Pattern: <input type="checkbox"/> Full Time/Regular <input type="checkbox"/> Part Time/On Call <input type="checkbox"/> Seasonal (Supporting Documentation will be needed)			
Job Title:		Name of Supervisor:	
Date of Incident: Time of Incident:		Date & Time Reported:	
Place of Incident (address, worksite, etc.):			

DO YOU QUESTION THE VALIDITY OF THE CLAIM?:
<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, what is your reason for questioning the validity of the claim? _____

RETURN TO WORK:
Did the worker miss any time from work?
<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, did you pay regular wages (KOS) while off work? <input type="checkbox"/> Yes <input type="checkbox"/> No
If worker missed work and you paid KOS, what dates did you pay? _____

DESCRIPTION: Be as specific as possible.
How did the accident/exposure happen?
List Witnesses Below (names, titles & how to contact them)

EMPLOYER'S SIGNATURE:	DATE OF REPORT:
COMPANY NAME:	PHONE NUMBER:

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Kept On Salary (KOS) Instructions

PLEASE BE SURE TO CONTACT YOUR BIAW CLAIM REPRESENTATIVE WITH ANY QUESTIONS OR CONCERNS. OUR PHONE NUMBER IS 1-800-228-4229.

R.O.I.I. Select participants are required to pay an injured employee, who has been certified not able to work, 100% of wages and benefits as if the employee were still working, for the first 30 days from the first day of time loss or light duty certification from the doctor. The 30-day requirement is to be applied to the first 30 working days (6 weeks) on the same injury.

■ You must pay the worker from the date of first certification from a medical provider that the worker is unable to perform their regular job. You must continue all of their other benefits such as health insurance, vacation and sick leave accrual, retirement plan, etc. In other words, the worker is treated as if there is no lost time from work due to the injury. ***If you have any questions regarding medical certification or which days to pay, please contact your BIAW claim representative for assistance.***

■ Sick leave, vacation leave or any other leave will *not* be considered KOS by L&I.

■ Establish and maintain close contact with the injured worker and the doctor to assure that there is always written medical certification to support the worker being off of work and continuing on KOS.

■ Your company should have a strong return to work program in place to avoid paying too many days where the worker is not at work. If the worker returns to light/modified work, continue to pay the regular salary until the 30 days has expired. Refer to the Return to Work Program section for instructions on documenting and communicating with the doctor, claimant, BIAW and Labor and Industries.

Provide BIAW with the *Kept on Salary* form as soon as possible so it can be forwarded to Labor & Industries to assure that a time loss payment is not paid to the worker.

Kept On Salary (KOS) Form

Complete this form **ONLY** when you are paying or have paid the worker's wages during the recovery period. The claimant will not be paid time loss benefits from L&I during the timeframe you pay KOS per RCW 51.32.090 (6).

Claimant: _____

Employer Name: _____

Claim No. #: _____

Date of Injury: _____ / _____ / _____

Complete this section when you **BEGIN** KOS.

Claimant is Kept on Salary from (date) _____ / _____ / _____ through _____ / _____ / _____.
(Estimate through date if not sure when the claimant will be released to return to work.)

Complete this section when you **STOP** KOS.

Claimant **was** Kept on Salary from (date) _____ / _____ / _____ through _____ / _____ / _____.

Claimant will no longer be KOS because (check one):

- The recovery period has extended past our KOS policy for ____ days or ____ weeks.
- The claimant has been released to work modified duty and **has** accepted a job offer to return to work on ____ / ____ / _____. (Attach: forms #1a, #1b, #1c, and #1d).
- The claimant has been released to work modified duty and has **not** accepted the job offer mailed ____ / ____ / _____. (Attach: forms #1a, #1c, #1d, and #1f).
- The worker has been terminated from employment due to reasons unrelated to the claim.
- Other: _____

Employer Signature

Date

Mail completed forms to:

BIAW
Claims Assistance Program
P.O. Box 1909
Olympia, WA 98507



Notification of Return to Work

Employer: Complete this form when injured worker returns to work and send to BIAW.

Attach a copy of the Doctor's release to return to work and/or any modified duty paperwork.

Claimant: _____

Claim No. #: _____

Employer Name: _____

Date returned to:

REGULAR duty work: _____ / _____ / _____

MODIFIED duty work: _____ / _____ / _____

Rate of pay at modified duty: _____

Hours working at modified duty: _____

- L&I will pay Loss of Earning Power (LEP) benefits (approximately 80% of the difference between Job of Injury wages and the Modified return to work wages) to workers who return to modified jobs at a reduced rate of pay or decreased hours that result in a loss of more than 5% of their regular gross earnings.
- When filling out the LEP form please be sure to note the hours that were available to work. The worker should not be paid LEP for time missed from work due to personal reasons or appointments.
- If you have questions regarding how to complete the LEP form, please contact your BIAW claims representative (or any available claims representative) at 1-800-228-4229.

Employer Signature

Date

USE THIS FORM ONLY IF WORKER HAS NOT RTW & NO APF/RESTRICTIONS RECEIVED

DOCTOR'S RELEASE FOR WORK

JOB DUTIES ASSIGNED TO THIS EMPLOYEE WILL BE SENT TO YOU FOR APPROVAL

EMPLOYEE NAME:	CLAIM NUMBER:
DIAGNOSIS:	DATE OF INJURY:

RETURN TO WORK STATUS	
<input type="checkbox"/> May return to regular work (date):	<input type="checkbox"/> May not return to work until (estimated date):
<input type="checkbox"/> May return to modified work (date):	Estimated duration of modified work:

PHYSICAL LIMITATIONS: I certify the employee can perform the duties within the capabilities defined as follows -
<input type="checkbox"/> Without any restrictions.

NOTE: In terms of an 8 hour workday, "Occasionally" equals 1-33%, "Frequently" equals 34-66%, "Continuously" equals 67-100%									
CAPABILITIES	Never	Occas.	Freq.	Contin.	LIFTING/CARRYING	Never	Occas.	Freq.	Contin.
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0-5 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6-10 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11-20 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21-25 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26-50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51-100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb stairs/steps/step-stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repeated push/pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repeated simple grasp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk on uneven ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repeated fine manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Restrictions of activities	None	Mild	Moderate	Total	Comments
Unprotected heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Be around moving machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exposure to changed in temp. & humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Driving automotive equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exposure to dust, fumes, & gasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

IN AN 8 HOUR WORKDAY, WORKER CAN: (CHECK FULL CAPACITY FOR EACH ACTIVITY)																					
TOTAL AT ONE TIME (hours)											TOTAL DURING ENTIRE 8 HOUR DAY (hours)										
HOURS:	0	½	1	2	3	4	5	6	7	8	HOURS:	0	½	1	2	3	4	5	6	7	8
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROGNOSIS	
Permanent restrictions likely? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown at this time.	Medically stationary? <input type="checkbox"/> No <input type="checkbox"/> Yes, date:
Physician name (PRINT):	Phone:
Signature:	Date: