City of Austin

Rolling Owner Controlled Insurance Program VIII

(Insert Project Description)

Location Code: (Insert Project #)

Austin, Texas

ROCIP VIII CLAIMS KIT TEMPLATE

Presented By:

Marsh

(Insert Month, Year)

Accident Reporting and Claims Procedures

A. General Procedures:

This section describes basic procedures for reporting various types of Claims:

- **Workers' Compensation** (Worker/Employee Injury)
- **General Liability** (Third Party Bodily Injury or Property Damage)
- **Automobile** (notice only) and **Pollution** (notice only).

The immediate reporting of all accidents or circumstances which might lead to or involve a Claim is required. Report all injuries, occupational-related illnesses, third party bodily injury or property damage to the ***General Contractor Claim Contact*** immediately. All Parties will instruct employees and other personnel to report, in writing, within 24 hours all Accidents and Occurrences of any type to the ***General Contractor Claim Contact***.

Overview of Claims Reporting Process

Action Required:		Responsible Party:	Form:
1.	Accident/Injury occurs		
2.	On-Site Supervisor is notified	Parties involved	
3.	Claim form is completed	On-Site Supervisor	GL or WC Claim Report
4.	If injury, worker is sent for medical treatment with authorization form	On-Site Supervisor Injured Worker	Authorization for Medical Treatment
5.	Claim form is provided to GC Claim Contact within 24 hours	On-Site Supervisor	GL or WC Claim Report
6.	GC Claim Contact reports claim to insurance carrier immediately by phone to: **Liberty Mutual** **1-800-362-0000** **Account Number for ROCIP VIII: 6067424**	GC Claim Contact	GL or WC Claim Report
7.	Completed form **email** to: **Lynn Miller, ROCIP Safety** @ Lynn.Miller@Austintexas.gov **Kevin McClelland, ROCIP Claims Advocate** @ Kevin.McClelland@Marsh.com	GC Claim Contact	GL or WC Claim Report

Please refer to section B. Workers' Compensation and C. General Liability for step-by-step procedures on the following pages.

The ***General Contractor Claim Contact*** will immediately contact the **ROCIP VIII Safety Representative, Lynn Miller and Kevin McClelland, ROCIP Claim Advocate** in the event of any of the following "serious accidents", incidents and injuries:

Any injury for which an ambulance is called

- Injury to head or neck
- Possible injury to back or spinal cord
- Unconscious employee
- Possible blindness
- Amputation of limbs
- Fatality
- Heart attack or stroke
- Hospitalization
- Property damage estimated over $1,000

Investigation Assistance:

All Parties will assist in the investigation of any accident or occurrence involving injury to persons or property. All Enrolled Parties will cooperate with the companies involved in adjusting any claim by securing and giving evidence and obtaining the participation and attendance of witnesses required for the investigation and defense of any claim or suit.

When in doubt, refer all questions regarding the reporting of a claim to the ***General Contractor Claims Contact and/or ROCIP VIII Claim Advocate***

(INSERT GENERAL CONTRACTOR (GC) CLAIM CONTACT) (INSERT GC NAME)	Kevin McClelland Marsh USA, Inc.
(INSERT GC ADDRESS)	1717 Main St., Ste 4400
	Dallas, TX 75201-7357
(INSERT GC CITY, STATE, ZIP)	Phone: 214-303-8330
Phone: (INSERT CONTACT PHONE #)	Cell: 214-926-5983
(INSERT GC CONTACT EMAIL)	kevin.mcclelland@marsh.com

B. Workers' Compensation Claims Reporting Procedures:

These procedures apply to ALL employees covered by ROCIP VIII for this project.

Immediately notify the ROCIP VIII Safety Representative in the event of a serious injury or accident. Contractors' on-site personnel will follow these procedures if any employee is involved in an accident or occurrence resulting in bodily injury:

1. Contact the Injured Worker's On-Site Project Supervisor immediately and transport the injured worker to the on-site first aid or medical facility, as necessary. An ***Authorization for Medical Treatment Form*** is to be sent with the Injured Worker prior to the first medical treatment, which includes the request for mandatory post accident drug testing.
2. Report all injuries or occupational-related illnesses to the General Contractor Claim Contact immediately.
3. Project Supervisor must complete a ***WC Claim Report Form*** and return to the General Contractor Claim Contact within 24 hours of employee's notice of injury/claim. The General Contractor Claim Contact will call the injury/claim into the Insurance Carrier immediately.
4. The General Contractor Claim Contact will fax a copy of the ***WC Claim Report Form*** to Lynn Miller, ROCIP VIII Safety Representative at 512-974-3411 and Kevin McClelland, ROCIP Claim Advocate at 214-303-8330.
5. An accident investigation is to be completed as soon as possible by all contractors involved in the accident. An ***Incident Investigation Report*** must be completed by the General Contractor Supervisor and provided to Lynn Miller and Kevin McClelland, ROCIP Claim Advocate at 214-303-8330.
6. All "serious accidents", incidents and injuries will be reported immediately by phone to Lynn Miller at 512-828-1761 and Kevin McClelland, ROCIP Claim Advocate at 214-303-8330.
7. If possible, Contractor and its lower-tier Subcontractor(s) may provide for Modified Alternate Duty based upon the work abilities given to the Injured Party from the treating physician.
8. Immediately send all subsequent return to work notes, inquiries or correspondence about an Injured Party to the ***General Contractor Claim Contact***.
9. No Injured Party will be allowed on a job site unless they have provided the ***General Contractor Claim Contact*** with the proper return to work note, either full duty or modified duty, as well as verification that post accident drug testing was completed.

C. General Liability & Property Damage Claim Reporting Procedures:

Contractors must immediately report all Accidents at the Project Site involving death, injury, or damage to property of non-employee personnel (the public, tenants, and visitors) to the ***General Contractor Claim Contact***. As soon as the onsite personnel become aware of the accident or occurrence, they must:

1. Take appropriate emergency measures to prevent additional injury or damage, including contacting police and fire authorities as required by law.
2. Complete and submit a ***GL Claim Report Form*** to the General Contractor Claim Contact within 24 hours of the incident. The General Contractor Claim Contact will call the claim into the Insurance Carrier immediately.
3. The General Contractor Claim Contact will email a copy of the ***GL Claim Report Form*** to Lynn Miller, ROCIP VIII Safety Representative Lynn.Miller@austintexas.gov and Kevin McClelland, ROCIP Claim Advocate at Kevin.McClelland@marsh.com.
4. An accident investigation is to be completed as soon as possible by all contractors involved in the accident. An ***Incident Investigation Report*** must be completed by the General Contractor Supervisor and provided to Lynn Miller ROCIP VIII Safety Representative at 512-828-1761 and Kevin McClelland, ROCIP Claim Advocate at 214-303-8330.
5. All Serious accidents, incidents and injuries will be reported immediately by phone to the City of Austin ROCIP VIII Safety Representative, Lynn Miller, at 512-828-1761 and Kevin McClelland, ROCIP Claim Advocate at 214-303-8330.
6. Immediately send all subsequent inquires or correspondence about an insured loss or claim, including a summons or other legal documents, to the General Contractor Claim Contact immediately.

The first five thousand dollars ($5,000) of any insurable general liability property damage loss will be the responsibility of and paid by the Contractor and deducted from the contract amount.

D. Automobile Liability Claims Procedures:

No coverage is provided for automobile accidents under the ROCIP VIII. It is the sole responsibility of each Party to report accidents/claims involving their automobiles to their own insurers.

However, all accidents occurring in or around the Project site must be reported to the ***General Contractor Claim Contact***. Accident investigations will occur and focus on liability arising out of the Project construction activities that could result in future claims (i.e. due to the conditions of the roads, etc.). Each Party shall cooperate in the investigation of all automobile accidents.

E. Pollution Claims Procedures:

No coverage is provided for pollution incidents under the ROCIP VIII. It is the sole responsibility of each Party to report accidents/claims involving pollution coverage to their own insurers. However, all accidents occurring in or around the Project site must be reported to the ***General Contractor Claim Contact***. Accident investigations will occur and focus on liability arising out of the Project construction activities that could result in future claims involving Bodily Injury or Property Damage not deemed to have been caused by a pollution event. Each Party shall cooperate in the investigation of all pollution incidents.

F. Loss Runs:

An enrolled contractor may obtain loss runs for their own on-site experience by requesting, in writing on their company letterhead, directed to the ROCIP VIII Administrator. Please note that the loss information is also available from the ROCIP VIII Insurance Carrier.

G. Alcohol & Drug Testing:

Please refer to the ROCIP Project Safety Manual for the Controlled Substances Safety Policy & Procedures.

City of Austin ROCIP VIII - Project # and Name

1. Contractor Reports to General Contractor Claim Contact
2. General Contractor Reports to Liberty Mutual @ 1-800-362-0000

Liberty Mutual INSURANCE

WC

Liberty Account Number for ROCIP VIII: 6067424

CLAIM INFORMATION

Date/Time of Injury: / / : ☐☐ am pm | After the call, write claim number here. WC

Is this claim work related? Yes ☐ No ☐ | Will the employee miss time from work? Yes ☐ No ☐

Employer Name:

EMPLOYEE INFORMATION

Employee's Social Security Number: - - | Employee's Name:

Home Address: (Street, City, State, Zip)

Home Phone Number: | Male ☐ Female ☐

Date of Birth: | Marital Status (check one) Single ☐ Married ☐ Widowed ☐ Divorced ☐

Hire Date: | Number of Dependents: Dependents Under 18:

Occupation: | Department Name:

State Hired: | Supervisor Name & Phone:

Current Weekly Wage:	Hourly Wage:	Hours Worked Per Week:
Days Worked Per Week:	Hours Worked Per Day:	Employment Status:
Employer Report No:	Employee ID No:	Was Salary Continued:

Was Employee Paid in Full for Date of Injury: | How often is employee paid:

Education Level:	Any Prior WC Injuries:	OSHA Reference No.:

EMPLOYER INFORMATION

Contact Name, Telephone Number, and Title:

Work Location: (Street, City, State, Zip)

Mailing Addr. (Street, City, State, Zip)

Employer Location Code: | Employer SIC.:

Employer FED ID.: | Employer Code:

Nature of Business:

Policy Number:

ACCIDENT INFORMATION

Did the Accident Occur at the Work Location? Yes ☐ No ☐ If no, where did the accident occur?

Accident Address: (Street, City, State, Zip)

Nature of Accident:

Give a Full Description of the Accident: (Be As Complete As Possible)

Are Other WC Claims Involved? Yes ☐ No ☐ | Date and Time Reported to Employer: / / : ☐☐ AM PM

Person Reported To:

CONTINUED ON NEXT PAGE

ASC-3085 R3

INJURY INFORMATION	
Injury Description:	
Date of Death *(If applicable)*:	Is Employee Hospitalized? Yes ☐ No ☐
Lost Time? Yes ☐ No ☐	If yes, What was First Full Day Out:
Date Last Day Worked:	Date Disability Began:
Date Returned to Work:	**OR** Estimated Return to Work Date:
Time Workday Began: : ☐ AM ☐ PM	
Which Part of the Body Was Injured? (e.g. Head, Neck, Arm, Leg)	Nature of Injury: (e.g. Laceration, Bruise, Fracture)
Part of Body Location: (e.g. Left, Right, Upper, Lower)	Source of Injury:

MEDICAL INFORMATION	
Safeguards Provided? Yes ☐ No ☐	Safeguards Utilized? Yes ☐ No ☐
Initial Medical Treatment: Check One ER **Treated** and Released ☐ **Hospitalized** ☐ **Physician/Clinic** ☐ **Minor/Onsite** ☐ No Medical **Treatment** ☐	

Hospital - Name, Address, Phone, Fax:

Clinic/Doctor - Name, Address, Phone, Fax, Specialty:

WITNESS INFORMATION
Were There Any Witnesses? Yes ☐ No ☐
If Yes, List Names and How to Contact Them:

ADDITIONAL COMMENTS & INFORMATION

REPORT PREPARED BY	
Name:	Title:
Signature:	Phone:

Click for Fillable
ROCIP WC Claim Form

City of Austin ROCIP VIII - Project # and Name

1. Contractor Reports to General Contractor Claim Contact
2. General Contractor Reports to Liberty Mutual @ 1-800-362-0000

Liberty Mutual INSURANCE

GL

Liberty Account Number for ROCIP VIII: 6067424

Date of Accident	Time

POLICYHOLDER

Insured Name	Location Code	Insured Phone

Insured Address, City, State, Zip

Mailing Address, City, State, Zip (If Different)

DESCRIPTION OF ACCIDENT

Address Where Accident Occurred (Street, City, State, Zip)

Exact Location of Accident (i.e.: AISLE1, PRODUCE DEPT.)

Accident Description (be as specific as possible)

Was there a 3rd Party Involved? Yes ☐ No ☐	Name of 3rd Party

WITNESSES

Witness Name	Address, City, State, Zip	Phone
Witness Name	Address, City, State, Zip	Phone
Witness Name	Address, City, State, Zip	Phone

PROPERTY DAMAGE

Name of Owner	Home Phone	Business Phone

Address, City, State, Zip

Type of Property and Extent of Damage

PERSONAL INJURY

INJURED PARTY 1			INJURED PARTY 2		
Name of Person Injured		Sex	Name of Person Injured		Sex
Name of Parent or Guardian if Under 18 Yrs.			Name of Parent or Guardian if Under 18 Yrs.		
Address, City, State, Zip			Address, City, State, Zip		
Home Phone		Business Phone	Home Phone		Business Phone
D.O.B.	Age	Social Security Number	D.O.B.	Age	Social Security Number
Description of Injuries			Description of Injuries		
Medical Treatment (i.e.: Hospital/Clinic Name, Address, Phone)			Medical Treatment (i.e.: Hospital/Clinic Name, Address, Phone)		

ADDITIONAL COMMENTS

ASC-3094 R1

Click for Fillable
ROCIP GL Claim Form.

City of Austin
ROCIP VIII

AUTHORIZATION FOR MEDICAL TREATMENT

**SEND WITH INJURED WORKER TO HAND TO MEDICAL PROVIDER
PRIOR TO THE FIRST MEDICAL TREATMENT**

FACSIMILE TRANSMITTAL SHEET

TO: **FAX NUMBER:**

Medical Provider

FROM: **PHONE:**

TOTAL NO. OF PAGES INCLUDING COVER: **DATE:**

RE:

Injured Worker

CITY OF AUSTIN ROCIP VIII

Project Name & Site Code: (INSERT PROJECT # AND DESCRIPTION)

Enrolled Contractor Name & Address:
_____ **Contractor WC Policy Number:**

Contractor Main Contact Person: _____ **Phone:** _____

Employee Name/Injured Worker: _____ **DOB:** _____

Date of Incident: _____ **Description of Incident:** _____

Which of the following test(s) will be administered to the injured worker?

__**Drug Screen** **Breath Alcohol** **X Drug Screen & Breath Alcohol** **Urine Collection Only**

ALL DRUG SCREEN/BREATH ALCOHOL TEST RESULTS & BILLS WILL BE SENT TO:
(INSERT GC CLAIM CONTACT INFO – FROM CLAIM CONTACT SECTION)

TO MEDICAL PROVIDER:

Send **Medical Bills only** and **Reports** to ROCIP VIII Insurance Carrier:

Liberty Mutual Group
Central Billing Unit
P.O. Box 7203
London, KY 40742

Phone: 1-800-300-0110 for inquiries or pre-authorization
ROCIP VIII Account Number: 6067424