AMERICAN LIBERTY
INSURANCE

UTAH EMPLOYER

Dear American Liberty Insurance Policyholder:

Thank you for placing your workers' compensation coverage with American Liberty Insurance Company. We greatly appreciate your business and look forward to assisting your company in the future.

Your new policy and claims kit are enclosed. Please review and retain for future reference. As you review this information, please feel free to contact your insurance professional or us directly with any questions you may have.

American Liberty's management team is committed to providing you with cost effective coverage and personalized service to meet your workers' compensation insurance needs.

We are pleased to have the opportunity to serve you.

AMERICAN LIBERTY
INSURANCE

Within this packet you will find:

- ☒ Posting Notice(s) to be displayed in a public area visible to all employees
- ☒ Claim Reporting Envelope containing:
  - Actions to take immediately after any work-related injury occurs
  - First Report of Injury form
  - Prescription Letter for the employee
  - Medical Release form
  - Physician Data Sheet form

Welcome to American Liberty Insurance Company
in conjunction with our Claims Administrator (TPA),
S & C Claims Services, Inc.
3601 N. University Ave #100
Provo, Utah 84604"""

Toll Free: (866) 221-3110
24 Hour Reporting Hotline:
(800) 289-4502

AMERICAN LIBERTY
INSURANCE

How to use this kit:

***STEP #1**: Display Posting Notice in areas accessible to employees*

***STEP #2**: Report job-related injury as it happens:*

- ✓ *Seek medical treatment for injured worker*
- ✓ *Report work-related injury either online, fax, phone or by mail.*

***STEP #3**: Provide injured worker with the following:*

- ✓ *Prescription Information Letter*
- ✓ *Medical Provider List*
- ✓ *Medical Release form*
- ✓ *Physician Data Sheet form (if injury is serious or long-term)*

ACTIONS for immediately after an injury occurs:

☑ **MEDICAL TREATMENT** Immediately refer injured worker to closest directed care medical clinics or emergency room!

☑ **REPORT YOUR WORK-RELATED INJURY**

- Fill out "***FIRST REPORT***" (Form 122 included) and use ONE of the following methods for reporting:

- **INTERNET: Log on to our website to fill out form**
  www.americanliberty.net *Click on File a Claim*

- **FAX Report to: 1-801-623-6035**

- **PHONE: 1-866-221-3110**

(during normal business hours only)

AMERICAN LIBERTY
INSURANCE

For the Injured Worker:

☑ **PRESCRIPTION LETTER:** for the injured worker to present to Pharmacy so that filling prescriptions is easy and hassle free.

☑ **MEDICAL RELEASE AND DATA SHEET:** If this is a serious injury involving a joint, back, knee, shoulder or ongoing injury, please have employee fill out this form.

☑ **MEDICAL PROVIDERS LIST**: for the injured worker to help them get treatment in clinics that participate in our program.

AMERICAN LIBERTY
INSURANCE

Notice to Employers

WC Fraud: Tell-tale Signs

Experience shows that when there are two or more of the below signs present in a workers' compensation claim, there is a greater chance the workers' compensation claim may be fraudulent. Being present are not "absolutes" but are simply possible indicators. Many legitimate claims are filed on Mondays and some accidents have no witnesses.

If you are suspicious of a potential fraud claim and you are a policyholder of American Liberty Insurance Company, please send an e-mail: ***wc_fraud@american-liberty.net.***

T **hey Are Hard to Reach**
You/we have difficulty contacting claimant at home when they are allegedly disabled.

R **evolving Service Providers and Other Changes -** The claimant has a history of frequently changing physicians, changing addresses & numerous past employment changes.

U **sing the Service Providers**
Use of the same doctors and lawyers by group of claimants.

S **uspicious Service Providers -** The employee's medical providers and/or legal consultants have a past history of handling suspicious claims.

T **reatment is Refused -** The claimant refuses a diagnostic procedure to confirm the nature or extent of a work related injury.

A **ccident With No Witnesses -** The accident has no witnesses and the employee's own description does not logically support the cause of the alleged work related injury.

L **ate Reporting of Injury or Claim -** The employee delays reporting the claim without a reasonable explanation.

I **njury 'Monday Morning' -** The alleged work related injury occurs first thing on Monday morning – or occurs late on a Friday afternoon but is not reported until Monday.

C **onflicting Descriptions -** The employee's description of the work related injury conflicts with the medical history reflected on the First Report of Injury.

FORM 122

For your protection Utah Law requires notice that worker's compensation fraud is a crime. Please see back of this form for the full fraud statement.

WORKER'S COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS
STATE OF UTAH - THE LABOR COMMISSION - DIVISION OF INDUSTRIAL ACCIDENTS
160 E 300 S, P.O. BOX 146610
SALT LAKE CITY, UTAH 84114-6610

GENERAL

EMPLOYER (Name & Address Incl. Zip)

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

PHONE #

INDUSTRY CODE | EMPLOYER FEIN

CARRIER / CLAIMS ADMIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE#)

American Liberty Insurance Company
3601 North University Ave., Suite 100
Provo, UT 84604
801-226-8008

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF-INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO)

Claims Administered by:
S&C Claims Services
3601 N. University Ave #100
Provo, Utah 84604

CARRIER FEIN **20-1712892**

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN **88-0426084**

AGENT NAME AND CODE NUMBER

EMPLOYEE

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
M MALE
F FEMALE
U UNKNOWN

MARITAL STATUS
U UNMARRIED SINGLE/DIVORCE
M MARRIED
S SEPARATED
K UNKNOWN

OCCUPATION / JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | NCCI CLASS CODE

WAGE

RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER

OF DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY / ILLNESS | PART OF BODY AFFECTED

DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY / ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

CAUSE OF INJURY CODE

HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAMES & ADDRESS) | HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
0 NO MEDICAL TREATMENT
1 MINOR: BY EMPLOYER
2 MINOR CLINIC/HOSP
3 EMERGENCY CARE
4 HOSPITALIZED > 24 HRS
5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

SEE BACK FOR IMPORTANT INFORMATION

© IAIABC 2002

Copy 1: Labor Commission Copy 2: W.C. Insurance Carrier Copy 3: Employee Copy 4: Employer's File

FRAUD - "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false of fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison"

INSTRUCTIONS TO EMPLOYER

The Employer's First Report of Injury or Illness must be submitted to the Labor Commission, Division of Industrial Accidents, per Sections §34A-2-407 and §34A-3-10B, Utah Code Annotated (U.C.A.), 1997. Each employer shall file the report within **seven days** after the occurrence, or the employee's notification of the same, which results in medical treatment by a physician, loss of consciousness, loss of work, restriction of work, or transfer to another job. Each employer shall file a subsequent report with the commission of any previously reported injury; or occupational disease that later resulted in death. Also, for your information, Section §34A-6-301(3)(b)(ii) states that each employer shall, within 12 hours of occurrence, notify the Division of Occupational Safety and Health, at (801) 530-6901 or (800) 530-5090, of any; work related fatality; disabling, serious, or significant injury; or occupational disease incident. A serious injury includes: amputation, fractures of major bones (both simple and compound), and hospitalization for medical treatment.

* All information requested on this form is of vital importance. Please answer **all** items in detail in order to avoid additional correspondence or the return of this report for completion. **Do not enter data in the shaded areas.**

***** The box titled "OSHA Log Number" must be filled in with the employer assigned Case Number from OSHA's new 300 Injury Log. The Case Number needs to reflect the year of the injury - for example, your first injury in 2002 should reflect the first injury and the year 00/02 with the next injury being 00202 etc.

* Please provide **WAGE** information. This information is needed by the insurance company for paying the correct amount on a claim.

* The injury report on file with the Labor Commission, Division of Industrial Accidents, is private information and is only released to parties to the claim.

* Please make sure the **EMPLOYER NAME** is correct, as well as your **FEIN#** (Federal Tax ID Number). The employer's name should be the same as reported to The Department of Workforce Services and as it appears on your WORKERS' COMPENSATION insurance policy.

* **The Labor Commission** is to receive the **original** of this report, **Worker's Compensation Insurance Carrier** gets the **second** copy, the **employee** gets the **third** copy, and the **employer** gets the **fourth** and should maintain a copy of this report.

* Failure to file this report with the Labor Commission or failure to provide the employee with copy of the report, is a Class C misdemeanor and can also result in a citation and a civil penalty for each violation as per §34A-2-407(7), §34-a-3-108(7), §34A-6-302, and §34A-6-307, U.C. A.

* If you dispute the validity of this claim you need to contact your insurance carrier, but you must still file the "Employer's First Report of Injury or Illness" form with the Labor Commission.

* **Reminder**: Inform your injured employee of his/her rights and obligations (as outlined on the back of the employee's copy) of Utah's Workers' Compensation Act.

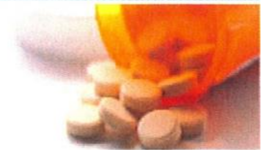
For additional information please contact:

State of Utah - Labor Commission
Division of Industrial Accidents
160 East 300 South, 3rd Floor
P.O. Box 146610
Salt Lake City, Utah 84114-6610
(801) 530-6800 (800) 530-5090

1. s &c
• • • Claims Services Inc.

S&C Claims Services, Inc.
3601 N. University Ave Suite #100
Provo, Utah 84601
Phone: 866-221-3110
Fax: 801-623-6035

New workers' compensation prescription drug card program.



Integrated Prescription Solutions (IPS) is sending you this letter on behalf of S&C CLAIMS SERVICES, INC. who has been administering claim benefits pursuant to your work related injury. These benefits include authorizing and paying for prescription medications in accordance of your approved physicians treatment plan.

After appropriate due diligence, S&C CLAIMS SERVICES, INC. has selected IPS to provide you with a prescription drug service that includes the convenience of a drug card.

IPS has a network of over 68,000 pharmacies representing almost *99%* of all pharmacies throughout the United States. The network includes all major chain pharmacies, as well as over 20,000 local independent pharmacies.

PLEASE NOTE: Card activation is required. Please contact **IPS Customer Service at (866) 846-9279** to activate before you provide to the pharmacy.

ProCare Rx

Integrated Prescription Solutions

RxBIN: 017324
Relationship Code: 01

ID:
NAME:

Pharmacy Help Desks for Pharmacists: 1-866-846-9279

Until you receive your new IPS drug card, you will need to provide this letter to your pharmacy upon your next prescription fill (new or refill). Should your pharmacy need assistance in processing prescriptions through your IPS Drug Card, please have them contact **IPS Customer Service at (866) 846-9279.**

Sincerely,

IPS Customer Service
Phone: (866) 846-9279
Email: customerservice@ipsusa.com

Confidential
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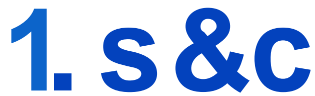
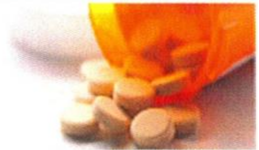


Claims Services Inc.

S&C Claims Services, Inc.
3601 N. University Ave Suite #100
Provo, Utah 84601
Phone: 866-221-3110
Fax: 801-623-6035

New workers' compensation prescription drug card program.



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IPS has a network of over *68,000* pharmacies representing almost *99%* of all pharmacies throughout the United States. The network includes all major chain pharmacies, as well as over 20,000 local independent pharmacies. We are confident that an IPS pharmacy is located near your home and, for your convenience; we have enclosed a list of the 12 IPS participating pharmacies closest to your home zip code.

Should the pharmacy of your choice not be listed as one of the twelve provided, you may utilize our 'Pharmacy Locator,' available by logging in with your claim number and IPS drug card ID number to **'Member Access.'** This can be located by visiting **www. ipsusa.com**; once logged in, you may select the 'Pharmacy Locator,' tool located on the left hand side.

PLEASE NOTE: Card activation is required. Please contact **IPS Customer Service at (866) 846-9279** to activate before you provide to the pharmacy.

You will need to provide this card to your pharmacy upon your next prescription fill (new or refill). The IPS Drug Card will allow you to receive the necessary prescriptions related to your work injury claim, without any out-of-pocket expense to you. Should your pharmacy need assistance in processing prescriptions through your IPS Drug Card, please have them contact **IPS Customer Service at (866) 846-9279.**

In the event it is lost or stolen, please contact IPS at (866) 846-9279, or your claims administrator at S&C CLAIMS SERVICES, INC.

Please be sure to utilize the IPS card for your future prescription fills.

Sincerely,

IPS Customer Service
Phone: {866} 846-9279
Email: customerservice@ ipsusa.com

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ATTENTION EMPLOYEES

IF YOU ARE INJURED ON THE JOB, REPORT TO YOUR SUPERVISOR IMMEDIATELY, THEN SEEK MEDICAL CARE AT THE CLOSEST ONE OF THE CLINICS BELOW:

Salt Lake area
Work Care Clinic
2390 South Redwood Road
Salt Lake City, Utah 84119
801-975-1600
7:30 am to 9:00 pm

Draper area
Work Care Clinic
12422 South 450 East, #A
Draper, Utah 84020
801-748-1600
8:00 am to 6:00 pm

Vernal area
Work Point Occupational Medicine
151 West 200 North
Vernal, Utah 84078
435-781-3053
8:00 am to 5:00 pm

St. George area
Work Med Clinic
385 North 3050 East
St. George, Utah 84790
435-251-2630
9:00 am to 5:00 pm (Mon-Fri)

Park City area
Family Health & Urgent Care Center
1665 Bonanza Drive
Park City, Utah 84068
435-649-7640
8:00 am to 9:00 pm (365 days a year)

Orem area
Work Care Clinic
601 North 1200 West
Orem, Utah 84057
801-224-4211
8:00 am to 6:00 pm

Layton area
Work Care Clinic
2084 North 1700 West #D
Layton, Utah 84041
801-773-3400
8:00 am to 5:00 pm

Roosevelt area
Uintah Basin Medical Center
250 West 300 North
Roosevelt, Utah 84066
435-722-4691
8:00 am to 5:00 pm

Cedar City area
Work Med Clinic
962 South Sage Dr.
Cedar City, Utah 84720
435-865-3460
8:00 am to 5:00 pm

Logan area
Work Med Clinic
412 North 200 East
Logan, UT 84321
435-713-2850
9:00 am to 5:00 pm

IN THE EVENT OF LIFE OR LIMB THREATENING INJURY REPORT TO THE NEAREST HOSPITAL EMERGENCY ROOM OR AFTER CLINIC HOURS:

After Hours:
Salt Lake Regional Medical Center
University of Utah Medical Center
Pioneer Valley Medical Center
Jordan Valley Hospital
Davis Hospital & Medical Center
Mountain View Hospital
Dixie Regional Medical Center – St. George
Intermountain Medical Center
Heber Valley Medical Center

Please send bills to S & C Claims Service Inc.
3601 N. University Ave #100
Provo, Utah 84601
Toll free 1-866-221-3110
Fax: 1-801-568-5164

Form 308 5/1/2011

STATE OF UTAH
LABOR COMMISSION
Division of Adjudication
160 East 300 South – 3rd Floor
P. O. Box 146615
Salt Lake City, Utah 84114-6615
Phone: (801) 530-6800 Fax: (801) 530-6333

AUTHORIZATION TO DISCLOSE, RELEASE AND USE PROTECTED HEALTH INFORMATION (HIPAA COMPLIANT)

Requesting Party: S & C Claims Service Inc."Toll Hree"Rj qpg:1-866-221-3110
Address: 3601 N. University Ave #100 Provo, Ut 84601 Fax:"1-801-623-6035

TO: ____ (Medical Providers as listed on Form 307)
____

This authorization permits you to release a copy of records in your possession regarding any medical treatment and/or hospitalization of:

Name of Patient ____________________________________ **Date of Birth** ________________________
Social Security Number ______________________________
Date(s) of Injury/Occupational Disease ________________

I AUTHORIZE you to disclose any information and records regarding the above named individual in your possession. This includes but is not limited to, your medical findings, diagnosis, treatment, treatment summaries, psychological or psychiatric evaluations, prognosis, clinic notes, diagnostic reports or radiology films, physical therapy records, pharmacy records, or any other health information in your records for the past 10 years (15 years if claim is being adjudicated). I understand that based on the information released it may include information related to any substance abuse.

I UNDERSTAND that the information furnished may be used to evaluate and verify my claim for benefits for a work related injury or occupational disease. The information obtained is relevant to a workers' compensation claim(s) and may be used by persons or organizations performing a service related to, or adjudicating the claim(s).

THIS AUTHORIZATION will expire 90 days following a resolution of the workers' compensation claim(s) but may be revoked by signator in writing to the requesting party. Revocation of this authorization will not be valid if the requesting party has taken action in reliance upon such authorization. Please note that the information disclosed or used pursuant to this authorization may be subject to re-disclosure and would, therefore, no longer be protected under the terms of the HIPAA privacy rule.

A PHOTOSTATIC COPY of this authorization shall be deemed to have the same authority as the original.

I hereby certify that I have read the provisions in this authorization. I understand and agree to its terms, and authorize disclosure of the information described above.

____ ______________________________
Patient Date

Form 307 5/1/2011

STATE OF UTAH – LABOR COMMISSION
Division of Adjudication
160 East 300 South – 3rd Floor
P. O. Box 146615
Salt Lake City, Utah 84114-6615
Phone: (801) 530-6800 Fax: (801) 530-6333

MEDICAL TREATMENT PROVIDER LIST

Claimant Name ______________________________ Social Security Number ____________________
Address _____________________________________ Date of Injury ______________________________
_____________________________________ Employer __________________________________
Telephone Number ___________________________

"Notification to the Workers' Compensation Claimant"

Per Labor Commission Rule R612-2-22, an injured worker who files a claim for workers' compensation benefits is required, if requested, to provide the name and address of medical providers who have provided any medical treatment for up to the past 10 years. This is your notice that any and all of the medical records within the custody of the medical provider that you have listed may be requested by the party named on this form, as authorized by Rule R612-2-22.* The medical provider is required to release the medical records per the rule, in order for the insurance carrier, self-insured employer, or the Labor Commission to make a determination in your case. *You are required to sign the "Authorization to Release Medical Records" Form 308.

Please list all the medical providers for industrial injury first.

Please list any other medical providers who have treated you for medical problems within the past _____ years (up to 10 years).

____ ____
____ ____
_________________________Zip_____________ _____________________________Zip_________
Telephone Number _________________________ Telephone Number _________________________

____ ____
____ ____
_________________________Zip_____________ _____________________________Zip_________
Telephone Number _________________________ Telephone Number _________________________

____ ____
____ ____
_________________________Zip_____________ _____________________________Zip_________
Telephone Number _________________________ Telephone Number _________________________

____ ____
____ ____
_________________________Zip_____________ _____________________________Zip_________
Telephone Number _________________________ Telephone Number _________________________

Please attach additional pages, if necessary.

Name of Party Requesting the Medical Records: S & C Claims Service Inc.
Address: 3601 N. University Ave #100 Provo, Ut 84601
Telephone Number: Toll Free 1-866-221-3110 Fax: 1-801-623-6035
Relationship to the Claim: American Liberty Insurance - Workers Compensation Third Party Administration

***Medical Providers who have treated you related to your reproductive organs or for psychological problems do not have to be listed unless you have made a claim for benefits related to these medical problems.**
Failure to return this form to the requester may result in a delay or denial of your claim.