State Accident Fund
Quick Reference
Telephone Directory
Toll Free Number: 1-800-521-6576
Switchboard: (803) 896-5800

Your Claim Adjuster: ________________  Tel:_________
Email:______@saf.state.sc.us
Fax:_________

Director: ....................................................... (803) 896-5875
pparker@saf.state.sc.us

Unit Managers

Accounting & Budget: ........................................... (803) 896-5872
jharmon@saf.state.sc.us

Claims Services: .................................................. (803) 896-5906
jhoward@saf.state.sc.us

Information Services: .......................................... (803) 896-5848
dfoshee@saf.state.sc.us

Legal Services: .................................................... (803) 896-5891
mcgregor@saf.state.sc.us

Policyholder Services ......................................... (803) 896-5856
(Premium, Audits, & Classifications) sholman@saf.state.sc.us

Safety & Loss Control: ....................................... (803) 896-5855
rcoleman@saf.state.sc.us

Training & Development: .................................. (803)896-5815
gmurphy@saf.state.sc.us

Mailing Address:
State Accident Fund
Post Office Box 102100
Columbia, South Carolina 29221-5000
www.state.sc.us/saf
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About This Book

The purpose of this manual is to provide each SAF policyholder with a handy desktop reference to assist in performing the recurring tasks associated with workers' compensation issues.

This manual was designed to assist our customers in training new representatives and as a job aid for experienced representatives to review, as needed. If you have any comments or suggestions regarding the information contained in this manual or the manner in which it is presented, please forward it to:

State Accident Fund
Director of Staff Training and Development
PO Box 102100
Columbia, SC 29221-5000
(803) 896-5815 or toll free (800) 521-6576
gmurphy@saf.sc.state.us

Any information on the usefulness or limitations of this manual and/or recommendations for improvements will be greatly appreciated.

SAF operational policies reflect changes instituted as a result of the ongoing conversion to a new integrated information management system. Claims filing procedures now feature an optional Internet reporting protocol, available at www.state.sc.us/saf.

Any references made to SC workers' compensation law, regulations, and forms apply to all claims with a date of accident of June 18, 1996 or later. Older claims shall be managed subject to applicable law (which may vary from the information contained in this publication) based on the date of a specific accident. Contact your claims adjuster for further details.
Background Information

**what is workers' compensation insurance?**

Workers' compensation in South Carolina is an insurance system created and regulated by law. The SC Workers' Compensation Act (SC Title 42) requires most employers to obtain insurance or be self-insured for purposes of providing money to employees injured at work to help replace income. It also requires the payment of medical bills and related expenses. Occupational diseases, as well as, injuries are covered.

**who is covered by the law?**

Employees of private industry, as well as, state and local government are covered by SC workers' compensation law. In general, any employer with four (4) or more employees, whether full-time or part-time, must cover their employees with workers' compensation insurance.

**a brief history of workers' compensation**

As the United States moved into the twentieth century, it faced the growing problem of workers who suffered occupational injuries. Not only did they suffer physical harm, but many injured workers also came to rely on charity to help them through their recoveries. Severely disabled workers became totally dependent on others for the rest of their lives.

To deal with similar problems, Germany introduced the first compensation system in 1884. In 1897, England passed the British Compensation Act. These laws required employers to pay medical benefits and lost wages to injured workers. Similar laws were enacted in the United States, but all were declared unconstitutional by the US. Supreme Court since imposing liability deprived employers of their property without "Due Process."

In 1911, Wisconsin passed the first constitutional workers' compensation law in the United States. Over time, all the other states passed some form of workers' compensation law.

The basic objectives of the workers' compensation laws were to:

- Provide swift and certain income, as well as, medical benefits to the victims of work accidents or income benefits to their dependents, regardless of fault.

**the basic objectives of state workers' compensation laws**

The basic objectives of the workers' compensation laws were to:

- Provide swift and certain income, as well as, medical benefits to the victims of work accidents or income benefits to their dependents, regardless of fault.
To provide a single remedy, as well as, reduce court delays, costs, and workloads arising out of personal injury litigation.

To relieve public and private charities of financial drains incidental to uncompensated industrial accidents.

Eliminate payment fees to lawyers and witnesses, as well as, time consuming trials and appeals.

To encourage maximum employer interest in safety and rehabilitation through an appropriate experience rating mechanism.

To promote frank study of causes of accidents rather than concealment of fault, hopefully reducing preventable accidents.

Individual state workers' compensation systems changed little over the next 60 years. In 1970, the US Congress created the National Commission on State Workers' Compensation Laws. The commission made several recommendations.

- Compulsory coverage in all acts.
- Elimination of all numerical and occupational exemption to coverage, including domestic and farm labor.
- Full coverage of work-related diseases.
- Full medical and physical rehabilitation services without arbitrary limits.
- Broad extra-territorial provision.
- Elimination of arbitrary limits on duration or sum of benefits.

The SC Workers' Compensation Commission (originally known as the Industrial Commission) was established as part of legislation creating the state's workers' compensation system in 1935. Major functions of the SC WCC include:

- Ensuring that all covered employers are properly insured.
- Monitoring benefit payments made to injured workers.
- Providing administrative resolution of disputes between injured workers, employers, and insurance carriers.
In 1943, the SC General Assembly created and continued in effect from year-to-year the State Workers' Compensation Fund as a division of the SC Industrial Commission. In 1947, the State Workers' Compensation Fund became a permanent entity per sections 42-7-10 through 42-7-100 of the 1976 Code of Laws of South Carolina.

In 1974, the State Workers' Compensation Fund was established as a separate agency. On July 1, 1993, the name of the State Workers' Compensation Fund was changed to the State Accident Fund as part of the SC state government restructuring process. The State Accident Fund is a single program agency with the following mission and goal.

Mission

*Provide a cost-effective guaranteed workers' compensation market for state agencies, other government entities, and, if required by the legislature, small businesses in the private sector.*

Goal

*Provide our policyholders, injured workers, and the taxpayers of this state with high quality services at a reasonable cost.*

The State Accident Fund ensures all SC state agencies, as well as, over 500 county, municipal, and special-purpose government entities throughout South Carolina.

SAF is a member of the SC Workers' Compensation Educational Association and the American Association of State Compensation Insurance Funds, as well as, a subscriber to the National Council on Compensation Insurance.
Reporting On-the-Job Injuries

employee responsibilities

All employees should be aware of their responsibilities under SC workers' compensation law. See the SAF Employee Handbook for more information. Employees must notify their employer immediately when an on-the-job injury occurs. Failure to notify the employer within ninety (90) days after an accident may deprive them of their right to benefits.

employer responsibilities

Upon notification by an employee of an on-the-job injury or illness, the employer must complete a FIRST REPORT OF INJURY OR ILLNESS (WCC Form 12-A). If no medical treatment is provided (or if medical treatment is paid via a policy deductible) and there is no lost time from work, the WCC Form 12-A should be completed and retained internally for a period of two (2) years. Otherwise, a claim must be filed immediately (via Internet, fax, or mail) with the State Accident Fund. This submission is critical because benefits can’t be paid until the employer files the claim with SAF.

The employer, as well as, the State Accident Fund can be fined for failure to report claims to the SC Workers’ Compensation Commission in a timely manner. Also, early intervention by a trained claims adjuster is essential to control claim costs and speed up the employee’s return to work. Several studies have shown that delays in reporting injuries have an adverse impact on the cost of a claim and consequently on your premiums.

To complete the FIRST REPORT OF INJURY OR ILLNESS (WCC Form 12-A), follow the instructions provided in the Internet tutorial at www.state.sc.us/saf, refer to the back of the paper form, or refer to pages 6-15 of this manual for more detailed instructions.

To save time, have the following items available when you begin filling out the form:

• The employee’s personnel records.
• The employee’s payroll records.
• Any reports, statements, or medical bills containing information on the nature of the accident and/or the extent of the injury.
Najiue (Last, First, Middle) Dickson, Janice M.

Address (Incl. ZIP): 1621 Dunwoody Place
Florence, SC 29511

Phone: (803)555-2211

Rate: $25,141 per DAY

Date of Injury/ILLNESS: 07/11/99

Type of Injury/ILLNESS: Sprains, Bruises

Department or Location Where Accident or INJURY EXPOSURE OCCURRED:

Pee Dee Regional Office, 446 Main St.
Horsefeather, SC 12345

Specific Activity the Employee Was Engaged in When Accident or ILLNESS Exposure Occurred:
Carrying files from second to first floor.

How Injury or ILLNESS/Abnormal Health Condition Occurred:
Ms. Dickson was carrying several files from the second floor file room down the stairs to her office to review, when she slipped in a small puddle of water and fell down approximately ten steps.

Date Returned to Work: 07/24/99

If Fatal, Give Date of Death: 00/00/00

Were Safeguards or Safety Equipment Provided?: Yes

If Yes, What?:

Physician/Health Care Provider (Name & Address):
John Doe, MD
Metro Orthopaedic, PA
P.O. Box 461
Florence, SC 29041/(803)555-6111

Hospital (Name & Address):
Florence Medical Center
261 Medical Drive
Florence, SC 29041

Initial Treatment:
1. Minor by Employer
2. Minor Clinic/Hospital
3. Emergency Care
4. Hospitalized > 24 hrs
5. Future Major Medical/Lost Time Anticipated

Witnesses (Name & Phone #):
Bill Payor, Admin. Specialist B., (803)631-4242

REPORT PURPOSE CODE: 0

ADDITIONAL INFORMATION:

REPRINTED WITH PERMISSION OF AABC
## Instructions for Completing First Report of Injury or Illness (WCC Form 12-A)

### SECTION A

<table>
<thead>
<tr>
<th>Item #</th>
<th>Place the following information in the blocks indicated:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Your agency name and mailing address. (If multiple locations, recommend you preprint the information for the master account.)</td>
</tr>
<tr>
<td>2</td>
<td>Address at which the employee actually works, if different from the agency.</td>
</tr>
<tr>
<td>2A</td>
<td>Only for organizations with multiple facilities or locations, who have established facility codes to track their accidents, will enter the appropriate facility code in this block, otherwise leave blank</td>
</tr>
<tr>
<td>3</td>
<td>Federal Tax Identification Number (IRS #). (Recommend you preprint this information if possible)</td>
</tr>
<tr>
<td>4</td>
<td>Telephone number of the injured employee’s local business office.</td>
</tr>
</tbody>
</table>

### CARRIER/CLAIMS ADMINISTRATOR

<table>
<thead>
<tr>
<th>CARRIER (Name, Address &amp; Phone No.)</th>
<th>POLICY PERIOD</th>
<th>CLAIMS ADMINISTRATOR (NAME, ADDRESS &amp; PHONE NO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Accident Fund</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>P.O. BOX 102100</td>
<td>FY 99 TO 00</td>
<td></td>
</tr>
<tr>
<td>Columbia, S.C. 29221-5000</td>
<td></td>
<td>SELF INSURANCE</td>
</tr>
<tr>
<td>(803)737-8100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POLICY/SELF-INSURED NUMBER</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>S99999999</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SECTION B

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Enter the State Accident Fund and our address as indicated on the example.</td>
</tr>
<tr>
<td>6</td>
<td>The policy period during which the accident took place.</td>
</tr>
<tr>
<td>7</td>
<td>Your account number.</td>
</tr>
</tbody>
</table>
# ACORD WORKERS COMPENSATION: FIRST REPORT OF INJURY OR ILLNESS

**Employer (Name & Address incl. ZIP):**
Department of Public Opinion
PO Box 549
Anywhere SC 29292
Lee County

**SIC Code**
57-5943741

**Carrier/Claims Administrator**
State Accident Fund
P.O. Box 102100
Columbia, SC 29221-5000
(803) 737-8100

**Employee/Wage**
Dickson, Janice M.

<table>
<thead>
<tr>
<th>Name (Last, First, Middle)</th>
<th>Dickson, Janice M.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>04/12/54</td>
</tr>
<tr>
<td>Social Security Number</td>
<td>999-66-6666</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Single/Divorced</td>
</tr>
<tr>
<td>Occupation/Job Title</td>
<td>Business Manager</td>
</tr>
<tr>
<td>State of Hire</td>
<td>South Carolina</td>
</tr>
</tbody>
</table>

**Address (Include ZIP):**
1621 Benwoody Place
Florence SC 29111

**Phone**
(803) 555-2211

---

**Incurrence/Treatment**

<table>
<thead>
<tr>
<th>Time Employee Began Work</th>
<th>AM</th>
<th>Time of Injury/Illness</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30</td>
<td></td>
<td>07/11/99</td>
<td></td>
</tr>
<tr>
<td>10:15</td>
<td></td>
<td>07/11/99</td>
<td></td>
</tr>
</tbody>
</table>

**Contact Name/Phone Number**
Jack Noitall, (803) 631-4243

**Type of Injury/Illness**
Sprains, Bruises

**Part of Body Affected**
Left Ankle, Lower Back, Left Shoulder and Arm

**Description**
Carrying files from second to first floor.

**How Injured or Illness/Abnormal Health Condition Occurred**
Ms. Dickson was carrying several files from the second floor file room down the stairs to her office to review, when she slipped in a small puddle of water and fell down approximately ten steps.

**Cause of Injury Code**
NA

**Physician/Healthcare Provider (Name & Address)**
John Dor, MD
Metro Orthopaedic, PA
P.O. Box 861
Florence, SC 29040(803) 555-6111

**Hospital (Name & Address)**
Florence Medical Center
261 Medical Drive
Florence, SC 29010

**Witnesses (Name & Phone #)**
Bill Payor, Admin. Specialist B., (803) 631-4242

**Date Adminstrator Notified**
07/14/99

**Date Prepared**
07/11/99

# Reporting On the Job Injuries
Instructions for Completing Workers Compensation - First Report of Injury or Illness

<table>
<thead>
<tr>
<th>EMPLOYEE/WAGE</th>
<th>DATE OF BIRTH</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>DATE HIRED</th>
<th>STATE OF HIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME (Last, First Middle)</td>
<td>04/12/54</td>
<td>999-66-6666</td>
<td>04/01/88</td>
<td>South Carolina</td>
</tr>
<tr>
<td>ADDRESS (Include County &amp; Zip)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1621 Dunwoody Place Florence, SC 29111</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHONE (803)555-2211</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SEX</th>
<th>MARITAL STATUS</th>
<th>OCCUPATION/JOB TITLE</th>
<th>EMPLOYMENT STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALE</td>
<td>UNMARRIED</td>
<td>Business Manager/SIC 3214</td>
<td>Full-Time</td>
</tr>
<tr>
<td>FEMALE</td>
<td>SINGLE/DIVORCED</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MARRIED</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SEPARATE</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>UNKNOWN</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SECTION C

**Item #** | **Place the following information in the blocks indicated:**
---|---
8 | Injured employee’s full name (last, first, and middle).
9 | Employee’s date of birth (month / day / year).
10 | Injured employee’s social security number.
11 | Date of hire of the injured employee (month / day / year).
12 | The state in which the employee was hired.
13 | Employee’s home mailing address (Include zip code and county).
14 | Employee’s home telephone number with area code.
15 | Indicate employee’s gender.
16 | Employee’s marital status.
17 | Total number of dependents. (Required only on death claims.)
18 | Employee’s occupation and Standard Industrial Classification (SIC) Code.
19 | Indicate the employee’s work status (Full-Time, Part-Time, Disabled, Volunteer, Clients, Students, Apprentice, etc.)

(Note: Enter all dates in MM/DD/YY format.)
**Section D**

### Date and Time
- Date: 07/11/99
- Time: 08:30 AM

### Date of Injury/Illness
- Date: 07/11/99

### Time of Occurrence
- Time: 08:30 AM

### Last Work Date
- Date: 07/11/99

### Date Employer Notified
- Date: 07/11/99

### Date Disability Began
- Date: 07/11/99

### Time Employee Worked
- 08:30 AM

### Department or Location Where Accident or Illness Exposure Occurred
- Pee Dee Regional Office, 446 Main St., Horsefeather, SC 12345

### Specific Activity the Employee Was Engaged in When the Accident or Illness Exposure Occurred
- Carrying files from second to first floor.

### How Injury or Illness/Abnormal Health Condition Occurred
- Ms. Dickson was carrying several files from the second floor file room down the stairs to her office to review, when she slipped in a small puddle of water and fell down approximately ten steps.

### Cause of Injury/Ilness
- CAUSE OF INJURY/ILLNESS
- PART OF BODY AFFECTED
- SPRAINS & BRUISES

### Date Returned to Work
- Date: 07/14/99

### Fatally, Give Date of Death
- Date: 07/14/99

### Were Safeguards or Safety Equipment Provided?
- YES

### Initial Treatment
- 0. NO MEDICAL TREATMENT
- 4. HOSPITALIZED > 24 HRS
- 2. MINOR CLINIC/NURSING

### Witnessess (Name & Phone #)
- Bill Payor, Admin. Specialist, (803) 631-4242

### Date Administrator Notified
- 07/14/99

### Date Prepared
- 07/11/99

### Signature
- Jack Noitall, Supervisor

### Reporting On the Job Injuries
Instructions for Completing Workers Compensation - First Report of Injury or Illness

<table>
<thead>
<tr>
<th>RATE</th>
<th>PER:</th>
<th>DAY</th>
<th>MONTH</th>
<th># OF DAYS WORKED/WEEK</th>
<th>FULL PAY FOR DAY OF INJURY</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,141</td>
<td></td>
<td></td>
<td></td>
<td>20 Annual</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>OCCURRENCE/TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME: EMPLOYEE BEGAN WORK</td>
</tr>
<tr>
<td>AM</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>CONTACT NAME/PHONE NUMBER</td>
</tr>
<tr>
<td>Jack Netall, Supervisor / (803)631-4243</td>
</tr>
<tr>
<td>TYPE OF INJURY/ILLNESS</td>
</tr>
<tr>
<td>Sprains, bruises</td>
</tr>
<tr>
<td>PART OF BODY AFFECTED</td>
</tr>
<tr>
<td>Left ankle, lower back, left shoulder and arm</td>
</tr>
</tbody>
</table>

**SECTION D**

**Item #** | **Place the following information in the blocks indicated:**

20 | Enter wage information. Indicate if the employee is paid on an hourly or salary basis. Enter the rate at which the employee is paid.

21 | Enter the number of days the employee normally works per week.

22 | Indicate if the employee received or will receive a full days pay for the day on which the injury occurred. Also indicate if the employee’s pay continued or will continue after the injury.

23 | The time the employee began work. Check appropriate box for a.m. or p.m.

24 | The date the injury actually occurred or first date conditions of disease or illness were noticed by the employee.

25 | The time of the injury or time symptoms of illness first occurred, if known. Check appropriate box for a.m. or p.m.

26 | The last day the employee worked.

27 | The date the injury was reported to the employer or his/her representative.

28 | Enter the first day the employee missed work due to the injury or illness.

29 | Enter the name and telephone number of the individual at the employer’s premises to be contacted for additional information.

30 | Enter type of illness/injury (sprain, strain, abrasion, bruise, fracture, laceration, etc.).

31 | Enter **all** of the body parts affected.
**ACORD**

**WORKERS COMPENSATION: FIRST REPORT OF INJURY OR ILLNESS**

**EMPLOYER (NAME & ADDRESS INCL. ZIP):**
Department of Public Opinion  
PO Box 549  
Anywhere SC 29292  
Lee County

**MC CODE**

**EMPLOYER FEIN**

57-5943741

**CARRIER/CLAIMS ADMINISTRATOR**

State Accident Fund  
P.O. Box 102100  
Columbia, SC 29221-3000  
(803) 737-8100

**CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO):**

**DATE OF BIRTH**

4/12/54

**SOCIAL SECURITY NUMBER**

999-66-6666

**DATE HIRED**

04/01/88

**STATE OF HIRE**

South Carolina

**SEX**

M MALE

**MARITAL STATUS**

U UNMARRIED

**OCCUPATION/JOB TITLE**

Business Manager / SIC 3114

**EMPLOYMENT STATUS**

Full-Time

**SIC CODE**

961122211

**NAME (LAST, FIRST, MIDDLE):**
Dickson, Janice M.

**ADDRESS (INCL. ZIP):**
1621 Dunwoody Place  
Florence, SC 29511

**PHONE**

(803) 555-2211

**DATE OF INJURY/ILLNESS**

07/11/99

**TIME OF OCCURRENCE**

10:15

**DATE OF WORK HISTORY**

07/11/99

**PERS. NO.**

$25,141

**AMOUNT**

Full Pay

**NUMBER OF DAYS WORKED**

5

**DATE EMPLOYER NOTIFIED**

07/11/99

**DATE DISSABILITY BEGAN**

07/12/99

**CONTACT NAME/PHONE NUMBER**

Jack Noitalli, (803) 631-4243

**DATE RETURNED TO WORK**

Still out as of 07/14/99

**ABSENT ON DATE 25/14/99**

IF FATAL, GIVE DATE OF DEATH

**SCHEDULED FOR REHABILITATION**

X Yes

**DATE PREPARED**

07/11/99

**PREPAREE’S NAME & ADDRESS**

Jack Noitalli, Supervisor  
Horsfeather, SC 29511  
(803) 631-4243

**ADDITIONAL STATE INFORMATION**

See back for important state information/signature

**ACORD CORPORATION**

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---

**Section E**

**DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS OCCURRED**

PEE DEE REGIONAL OFFICE, 446 MAIN ST.  
HORSEFEATHER, SC 12345

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

NA

**CARRYING FILES FROM SECOND TO FIRST FLOOR**

NA

**DATE RETURNED TO WORK**

Still out as of 07/14/99

**IF FATAL, GIVE DATE OF DEATH**

**WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?**

X Yes

**WERE THEY USED?**

X Yes

---

**WITNESSES (NAME & PHONE #):**
Bill Payor, Admin. Specialist B., (803) 631-4243

**DATE ADMINISTRATOR NOTIFIED**

07/11/99

**PHONE NUMBER**

(803) 631-4243

---

**CAUSE OF INJURY CODE**

2 Minor Clinical/Gift

4 Hospitalized > 24 HRS

5 Lost Time

---

**FLORENCE, SC 29501**

**SOUTH CAROLINA 1201 Reporting On the Job Injuries**
SECTION E

<table>
<thead>
<tr>
<th>Item #</th>
<th>Place the following information in the blocks indicated:</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>Indicate if the injury/illness exposure occurred on the employer's premises.</td>
</tr>
<tr>
<td>33</td>
<td>Enter the location where the accident or exposure took place. (e.g. Maintenance Shop or Client's office at 452 Main St. Columbia, SC 29203) In the case of a traffic accident, include the county in which the accident occurred.</td>
</tr>
<tr>
<td>34</td>
<td>List all equipment, materials, or chemicals the employee was using when the accident or exposure occurred. (If none, enter NA.)</td>
</tr>
<tr>
<td>35</td>
<td>Describe the specific activity the employee was engaged in when the accident, illness, or exposure occurred.</td>
</tr>
<tr>
<td>36</td>
<td>Enter the work process the employee was engaged in when the incident occurred, such as building maintenance, fire fighting, search and rescue, etc. Enter &quot;NA&quot; for not applicable if employee was not involved in a work process (e.g. walking along a hallway, going up stairs, etc.).</td>
</tr>
<tr>
<td>37</td>
<td>Describe in detail how the accident or exposure occurred.</td>
</tr>
<tr>
<td>38</td>
<td>Enter the date following the most recent disability period on which the employee returned to work. If they did NOT miss work due to the injury or illness, state &quot;No Lost Time&quot;. If they have not returned when you file the report simply state &quot;still out as of [date form completed]&quot;.</td>
</tr>
<tr>
<td>39</td>
<td>If the incident resulted in the employee’s death, enter the date of death in this block, otherwise leave it blank.</td>
</tr>
<tr>
<td>40</td>
<td>Indicate if safety equipment or safeguards were provided and if they were used.</td>
</tr>
</tbody>
</table>
Mr. Dickson was carrying files from the second to the first floor, when he slipped in a small puddle of water and fell down approximately 1111
Instructions for Completing Workers Compensation - First

<table>
<thead>
<tr>
<th>PHYSICIAN (Name &amp; Address)</th>
<th>HOSPITAL (Name &amp; Address)</th>
<th>INITIAL TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Doe, MD</td>
<td>Florence Medical Center</td>
<td></td>
</tr>
<tr>
<td>Metro Orthopedic, PA</td>
<td>261 Medical Drive</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 861</td>
<td>Florence, SC 29601</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WITNESS (Name &amp; Phone Number)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill Payor, Admin. Specialist B.</td>
<td>(803)631-4242</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE ADMINISTRATOR NOTIFIED</th>
<th>DATE PREPARED</th>
<th>PREPARERS NAME &amp; TITLE</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/14/96</td>
<td>07/14/96</td>
<td>Jack Noitall, Supervisor</td>
<td>(803)631-4243</td>
</tr>
</tbody>
</table>

SECTION F

<table>
<thead>
<tr>
<th>Item #</th>
<th>Place the following information in the blocks indicated:</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>The name, address, and telephone number (if known) of the first physician who treated the injured employee for the on-the-job injury.</td>
</tr>
<tr>
<td>42</td>
<td>The name, address, and telephone number, if known, of the hospital or medical facility which treated the injured employee.</td>
</tr>
<tr>
<td>43</td>
<td>Indicate the type of medical treatment received and if additional major medical and lost time is anticipated.</td>
</tr>
<tr>
<td>44</td>
<td>List the names and telephone numbers of all witnesses.</td>
</tr>
<tr>
<td>45</td>
<td>Enter the date the form is mailed to the “State Accident Fund”.</td>
</tr>
<tr>
<td>46</td>
<td>Enter the date the form is prepared.</td>
</tr>
<tr>
<td>47</td>
<td>The person completing the form should print or type his or her name and position in this block.</td>
</tr>
<tr>
<td>48</td>
<td>Enter the work phone number of the individual who prepared the form.</td>
</tr>
</tbody>
</table>

*Note: Please attach any additional incident reports or witness statements. If the injury was the result of negligence on the part of a third part, such as a motor vehicle accident, include accident reports and proof of insurance from the other driver, if available and a completed Third Party Option Letter (See page 19 for details). *(To minimize rework, it is recommended that a WCC Form 20 be submitted with the First Report of Injury or Illness (WCC Form 12-A) on all claims which they feel will result in disability, scaring, or payment of temporary compensation. See page 22 for additional details.)*
submitting the
"first report of
injury or illness"
(WCC Form 12-A)

You may submit the WCC Form 12-A via Internet at www.state.sc.us/saf. Otherwise, send all paperwork, including medical bills, reports, or witness statements to:

State Accident Fund
P.O. Box 102100
Columbia, SC 29221-5000

If you are affiliated with a state agency, and the injured employee has lost time from work due to the injury, explain to them and have them complete a Notice of Election Form containing the information shown in the example and attach it to the WCC Form 12-A. If you have difficulty in getting the employee to complete the election form, DO NOT delay submitting the 12-A. Send it separately at the earliest possible time.

(Note: Prepare This Form On Your Organization Letterhead)

Section 8-11-145 of the S.C. Code of laws provides that, in the event of an accidental injury arising out of and in the course of employment with the State, a disabled employee shall make an election to receive compensation under one of the following options.

A. To be placed on paid leave status, using accrued sick and/or annual leave (When such leave credits are exhausted before the employee can return to work, the employee shall be entitled to Workers’ Compensation disability benefits at the time the specific amount of leave is exhausted.

B. To use Workers’ Compensation benefits awarded in accordance with Title 42 of the 1976 Code (Under this method, the employee would receive the disability benefits equal to 66 2/3 % of the employee’s gross weekly pay, not to exceed the current rate of $507.34 per week), or

C. To receive sick and/or annual leave on a prorated basis in conjunction with Workers’ Compensation according to the attached formula approved by the Budget and Control Board.

Regardless of which method of disability compensation an employee elects, he or she would continue to be eligible for payment of medical costs provided by Workers’ Compensation.

I have read the above and understand my options regarding Workers’ Compensation. I choose Option A__, B__, or C__.

The effective date of the election is _______________.

Employee Signature Date Signature of Witness Date
SSN__________________________
The Claims Process

When the State Accident Fund receives the **First Report of Injury** (WCC Form 12-A) from the employer, the information is entered into our automated Claims Management System.

The claim is assigned a SAF claim number. This unique number is the primary means of identifying a claim and should be included in all correspondence.

Two letters are then generated, acknowledging receipt of the claim. One letter is sent to the claimant (see figure 3-1) along with a copy of a brochure outlining basic workers’ compensation benefits. The other letter goes to the employer, (see figure 3-2).
In most cases, the claim is routed to the assigned adjuster, who is responsible for reviewing the file, gathering any additional information, and determining compensability as to whether the claim is payable under SC workers' compensation law. If the adjuster determines the claim is not compensable, the denial is then reviewed by the Claims Review Team (CRT), an internal peer review group composed of claims supervisors and attorneys. CRT will either uphold the recommended denial, overrule it, or request additional information prior to making a decision. Once compensability is determined, a letter will be sent to the employer, the claimant, and the SC Workers' Compensation Commission (if required), informing them of the decision. If the claim is denied, the letter will state the reason for denial.

If a claim involves a death, heart attack, stress (or other psychological disorder), and/or questionable circumstances, it is automatically referred to an in-house investigator. After an in-depth investigation, the file is routed to the adjuster with a recommendation from the investigator as to compensability of the claim.

Figure 3-2

July 17, 1996

MR. JACK NOTIALL
Workers' Compensation Coordinator
SC DEPT OF PUBLIC OPINION
PO BOX 549
ANYWHERE, SC 29292

Dear MR. NOTIALL:

These are your claims which we either decided or received YESTERDAY.

Any number in the left column means the claim is DENIED. The letter A means ACCEPTED. The letter R means RECORDED. If blank, we only acknowledge receipt of the ACORD Form. LT in the right column means the case involves some lost time. MO means only first aid was required. MED means a course of medical treatment is involved. If you see errors or have questions please call the SAF Contact person whose last name is shown for the file in question.

ACCEPTED means only that State Fund has accepted the case as a compensable accident and injury within the meaning of the workers' compensation law. Medical expenses for approved treatment of the injury described in the ACORD form will be paid when submitted in the proper amount with proper documentation.

DENIED means State Fund has decided the claim is NOT compensable so that no compensation, medical bill or other expense should be paid. All such denials are, of course, subject to reversal. Should a DENIAL decision be changed it will be listed in a subsequent letter like this one as an ACCEPTED claim.

RECORDED means we received the ACORD form and closed the file because no medical treatment was required. If medical treatment should be required within the statutory period the case will be reopened and a compensability decision made.

<table>
<thead>
<tr>
<th>Dec - Employee</th>
<th>SAF Contact</th>
<th>SF Number</th>
<th>DATE INJURED</th>
<th>DATE REPORTED</th>
<th>CLAIM TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>J. DICKSON</td>
<td>CAPABLE</td>
<td>96-00-66666</td>
<td>7/11/96</td>
<td>7/16/96</td>
<td>MED</td>
</tr>
</tbody>
</table>
If an injury results from an auto accident, product liability, or negligence caused by a third party, the employee and/or SAF may pursue a claim against the adverse party. In these cases, an option letter (see Figure 3-3 and page B-12) must be completed by the claimant. If the option letter is not received with the Employers First Report of Injury, one will be sent to the claimant. It must be completed and returned to SAF.

If the employee elects to settle their claim with the adverse party (option 1), the workers' compensation claim is closed. If an employee elects to file a workers' compensation claim (option 2 or 3) or does not return the option letter, the adjuster manages the claim in the same manner as any other claim. However, SAF will place a lien against any third-party settlement to recover the value of benefits paid under workers' compensation insurance. Third party recovery is pursued once the workers' compensation portion of the claim is concluded. Any funds recovered are credited back to the claim, directly reducing the employer's claim costs.

Figure 3-3

STATE ACCIDENT FUND
Irvie D. Parker
Director
July 20, 1996
MR. LES FORTUNATE
ROUTE 6, BOX 666
ANYWHERE, SC 29292
RE: LES FORTUNATE vs.
DEPARTMENT OF PUBLIC OPINION
SF# 96-00-77777
D/A 14 JULY 96

IMPORTANT NOTICE TO INJURED WORKER
Since you have the right to recover for your injuries from the person who caused the accident, please review and elect which of the following three ways you wish to handle this claim.

Please CIRCLE ONE NUMBER below to indicate the statement which expresses your choice, sign, date and return this to us as soon as possible:

1) I wish to settle my claim directly with the person who caused the accident and not file a workers' compensation claim.

2) I wish to accept workers' compensation benefits and file a claim against the person who caused the accident. I understand that I must have approval from your office before I finalize settlement and that my failure to get approval will result in a denial of further workers' compensation benefits. I also understand that if I choose this option, when a settlement has been reached, your office will have a lien on any money paid out by the third party.

3) I wish to accept workers' compensation benefits and not file a claim against the person who caused the accident, allowing YOU to file a claim against the person who caused the accident.

Witness Signature
Date

Your Signature
Date

IF YOU ARE REPRESENTED BY AN ATTORNEY, PLEASE CONFER WITH HIM/HER ABOUT THIS OPTION LETTER AND PROVIDE US WITH HIS/HER NAME, ADDRESS AND TELEPHONE NUMBER.

P.O. BOX 102100 COLUMBIA, S.C. 29211-5000 (803) 737-8100 1-800-721-6576 FAX (803) 731-4428
Under SC workers’ compensation law, an injured worker is entitled to reasonable medical care (at no cost to the employee) for the duration of his/her injury, until such time that “maximum medical improvement” (MMI) has been reached, as determined by the authorized treating physician.

**South Carolina law allows the employer/insurance carrier to designate a physician.** Employers are encouraged to establish a designated physician program to develop a working relationship with a physician who specializes in occupational medicine. This physician should be the first source of evaluation, treatment, and/or referral anytime an employee is injured. An ongoing relationship such as this reduces medical costs and time lost from work.

The use of a designated physician should be included in any **written personnel policy** covering the reporting of on-the-job injuries and communicated to all employees.

To assist in reducing medical costs, the State Accident Fund is conducting a pilot program utilizing three “managed care” companies. Trained nurses review medical findings and work with medical providers to ensure injured workers receive appropriate, high quality medical care to speed healing and reduce disabilities.

Injured employees who receive medical benefits under workers’ compensation should always give the medical provider the State Accident Fund claim number (the SF number contained on the letter) to be included on all bills. This will expedite the processing and payment of these bills.

If the medical provider sends bills to the employer or the employee, the bills should be forwarded to the State Accident Fund (remember to include the SF claim number). All medical bills are entered based on the claim number and routed to the adjuster for review. If the injury is compensable, and the adjuster approves the medical bill, the fee schedule will be applied as appropriate and the Accounting Division will process the payment. If medical bills are denied, an explanation of benefits will be sent to the medical provider, with an explanation of why they were not accepted.

**The employer must notify the State Accident Fund if a claimant is unable to work due to the injury.** Based on the medical documentation submitted by the authorized
treating physician and the attendance information provided by the employer, the adjuster will determine if the claimant is eligible for temporary disability benefits. An employee must be out of work more than seven (7) calendar days to receive temporary-total disability payments. If an employee is out of work more than seven, but less than fourteen days, they receive lost time benefits beginning on the eighth day. Once they have been out of work for more than fourteen days, they receive benefits retroactive to the first day they were unable to work.

Once eligibility has been determined, the adjuster will determine the amount of lost time and the rate of payment. If the employee is totally unable to work, their compensation rate will be two thirds (.667) of their average weekly wage up to a maximum amount set by law. The adjuster will complete the first section of a WCC Form 15 (Temporary Compensation Report). (See Figure 3-4)

Figure 3-4
The benefit check is generated internally by SAF. The check and the WCC Form 15 are then sent to the claimant. The WCC Form 15 explains what the compensation rate is and the period covered by the check. If the employee is represented by an attorney, the check and the WCC Form 15 are sent to the claimant's attorney.

If the nature of the injury indicates a prolonged absence from work, the adjuster will establish a running award (automatic generation of weekly benefit checks, payable directly to the claimant.)

An employee returning to work in a light-duty or part-time capacity because of an injury may be eligible for temporary-partial benefits to help compensate for lost income.

The WCC Form 20 verifies the claimant's earnings (Average Weekly Wage) during the last twelve months prior to the accident. The rate paid for temporary and permanent compensation is based on this amount.

If a claimant receives temporary compensation, the form must be completed and submitted by the employer within 30 days. SAF must then supply a copy to the claimant. (To minimize rework and to ensure compliance with the regulation, a WCC Form 20 should be submitted with the First Report of Injury (WCC Form 12-A) on all claims which may result in disability, scaring, or payment of temporary benefits. Contact your adjuster for more information.)

When preparing the WCC Form 20, follow the instructions provided on the form (figure 3-5). Quarterly wage information needed on the WCC Form 20 is in the same format as that already reported by your organization to the SC Employment Security Commission on their form (Employer Contribution Report.)

If an employee has a second job, that income may be eligible for inclusion in the wage calculations. A second WCC Form 20 must be completed by the other employer and submitted to SAF.

Note: If a WCC Form 20 is not filed, the Workers' Compensation Commission may set the compensation rate up to the maximum amount set by law.
The Claims Process

When an employee is no longer entitled to compensation either because they have been released to return to work (or any of the other reasons stated in section two of the WCC Form 15), the adjuster must be notified immediately. Prompt notification will minimize any overpayment of compensation and possible financial hardship for the employee.

If it has been less than 150 days since the employer received notice of the injury, the adjuster will prepare another WCC Form 15. The adjuster will complete the heading and section two, “Termination of Temporary Compensation.” (See Figure 3-6)

---

**Figure 3-5**

When an employee is no longer entitled to compensation either because they have been released to return to work (or any of the other reasons stated in section two of the WCC Form 15), the adjuster must be notified immediately. Prompt notification will minimize any overpayment of compensation and possible financial hardship for the employee.

If it has been less than 150 days since the employer received notice of the injury, the adjuster will prepare another WCC Form 15. The adjuster will complete the heading and section two, “Termination of Temporary Compensation.” (See Figure 3-6)
and mail it to the claimant or their attorney with the final check.

If the claimant or their attorney disagrees with the decision to stop benefits, they may request a hearing with the SC WCC by completing Section 3 (Notice to Injured Worker or Legal Representative When Temporary Compensation Has Been Stopped) and sending a copy to the SC WCC. **Section 3 should NOT be signed and returned unless a hearing is requested.**

![Figure 3-6](image-url)

---

**Figure 3-6**

The Claims Process
If temporary compensation is terminated 150 days or more after the date the employer was notified of the accident, the adjuster must prepare the WCC Form 17 Receipt for Compensation (See Figure 3-7). They will forward this to the employee or their attorney for signature, as required by law. If the employee or their legal representative fails to sign and return this form, the State Accident Fund will file a WCC Form 21 with the SC Workers’ Compensation Commission requesting a hearing be set to stop payment of temporary total or temporary partial benefits.
Claims are closed when medical treatment is no longer necessary and all benefits have been paid. In the case of minor injuries that require minimal medical treatment, this process is quite simple. A WCC Form 19 (Status Report and Compensation Receipt) is filed with the Workers’ Compensation Commission to close the claim.

If the injury results in disability, the medical provider will send a letter to the State Accident Fund stating that “Maximum Medical Improvement” (MMI) has been reached. Included in this letter will be an impairment rating. This rating is based on objective medical findings as to whether the claimant has suffered some degree of permanent loss of use to one or more body parts. This rating usually equates to the claimant’s ability to perform basic physical functions, such as lifting, standing, sitting, ambulating, and self-care.

The adjuster will evaluate the case to determine the impact of the objective medical findings on the claimant’s overall lifestyle and their ability to maintain continued and gainful employment. This determination takes into account the claimant’s education, work history, and other personal circumstances unique to the claim. In accordance with established guidelines, the adjuster determines a disability rating (calculated as a %) to the body part(s).

SC workers’ compensation law assigns a value (number of weeks of compensation) to virtually every physical body part. The value of a body part is multiplied by the % disability rating and then by the claimant’s compensation rate to determine an actual dollar value.

Claims involving disability or disfigurement may be settled using a WCC Form 16 (Agreement for Permanent Disability/Disfigurement Compensation), an Order issued by the Workers’ Compensation Commission as a result of a formal hearing, or an Agreement and Final Release (Clincher).

Claims settled on a WCC Form 16 or by an Order may be reopened within one year from the date of the settlement if the employee undergoes an adverse change of condition.

An Agreement and Final Release (Clincher) relieves the employer and insurance carrier from any further responsibility for payment of compensation or medical expenses, unless the Clincher Agreement specifically provides otherwise.

If the claimant is represented by an attorney, the adjuster will prepare the appropriate document and forward it to the legal counsel for the appropriate signatures. It is then sent to the Workers’ Compensation Commission for a final approval. Upon receipt of the approved documents, the settlement is paid and the claim is closed.
If the claimant does not have legal representation, SAF requests an **Informal Conference** with the Workers’ Compensation Commission. The commissioner or claims mediator will review the claim and may recommend an award or set the case for an administrative hearing. If an award recommendation is made, the claimant and the insurance carrier may accept or decline the recommendation.

If both parties accept the recommendation, a WCC Form 16 is prepared and signed by the claimant and a SAF representative. The form is sent to the Workers’ Compensation Commission for approval. The adjuster prepares a check and a **WCC Form 19 (Status Report and Compensation Receipt.)** If the injured worker is still with the same employer, the check, along with the Form 19 and detailed instructions may be sent to the employer representative.

If either party declines the offer, the case is set for an administrative hearing.

If a Clincher settlement is reached with a claimant who is not represented by an attorney, a **Clincher Conference** is conducted by a commissioner. The commissioner reviews the settlement to insure it is fair and reasonable.

**Hearings** may be scheduled at the request of the claimant, their legal counsel, and/or the insurance carrier.

When a claim is scheduled for a hearing, an attorney is assigned to the case to prepare it for litigation and to represent the State Accident Fund and employer at the hearing. To insure adequate representation contract attorneys are used to supplement in-house legal counsel.

The outcome of a hearing is an **Order**. The Order is prepared as directed by the commissioner and approved by the commissioner. If the decision is not appealed, the adjuster prepares a check and a **WCC Form 19 (Status Report and Compensation Receipt.)**. If the injured worker is still with the same employer, the check, along with the Form 19 and detailed instructions may be sent to the employer representative.

*Note: When a request for a hearing is filed, the Workers’ Compensation Commission contacts the State Accident Fund and requests a WCC Form 20 (Statement of Earnings of Injured Employee). If the Form 20 has been submitted to SAF, a copy will be sent to the WCC. If the form has not been submitted, which is often true on cases where no temporary compensation has been paid, SAF will ask the employer to submit the required wage information.*
The Premium Calculation Process

**required payroll information**

The first step in calculating a workers' compensation premium is to document payroll and employee classification information, based on a fiscal (7/1-6/30) year accounting for state agencies or a calendar (1/1-12/31) year for all other policyholders. Prior to the start of a new policy period, an estimated payroll amount and employee classifications will be automatically calculated (for existing policyholders), using the previous year's estimated payroll, plus 5%. If you are a new policyholder or anticipate a substantial change in your workforce and/or total payroll, contact SAF Premium Department to complete an “Estimated Payroll Report.”

The National Council on Compensation Insurance (NCCI) has established a classification system to project anticipated losses (claim payouts) in different employee groupings, based on the type of industry. From this system, an estimated manual premium is calculated for each employee classification code.

<table>
<thead>
<tr>
<th># OF EMPLOYEES</th>
<th>NCCI CLASS CODE</th>
<th>EMPLOYMENT DESCRIPTION</th>
<th>ESTIMATED ADJUSTED PAYROLL</th>
<th>RATE</th>
<th>ESTIMATED MANUAL PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>7380</td>
<td>DRIVERS, COMM.</td>
<td>108,732.22</td>
<td>3.98</td>
<td>4,327.54</td>
</tr>
<tr>
<td>9</td>
<td>8742</td>
<td>TRAVELING CLERK.</td>
<td>201,514.21</td>
<td>.71</td>
<td>1,430.75</td>
</tr>
<tr>
<td>11</td>
<td>8868</td>
<td>SCHOOL PROF. EMP.</td>
<td>2,824,240.01</td>
<td>.54</td>
<td>15,250.90</td>
</tr>
<tr>
<td>5</td>
<td>9015</td>
<td>BLDG. OPS, MAINT.</td>
<td>92,570.03</td>
<td>3.84</td>
<td>3,554.69</td>
</tr>
<tr>
<td>29</td>
<td></td>
<td>TOTALS</td>
<td>3,227,056.47</td>
<td></td>
<td>24,563.88</td>
</tr>
</tbody>
</table>

The estimated payroll (minus 1/3 of any overtime pay) for each classification is divided by 100 and then multiplied by the assigned rate. The sum of all job classifications equals the total manual premium. (Figure 4-2, page 30)

For most policyholders, the next step in the process is to adjust the manual premium based on historical claims data. The number used in this adjustment is commonly referred to as your Experience Modifier or E-Mod. The E-Mod is determined by analyzing the frequency and severity of claims paid for a three-year period preceding the previous policy period. Basically, a policyholder's actual claims history is compared to that of other organizations with employees having the same NCCI classification codes. The E-Mod
is a reflection of previous claims history and an indicator of future claims activity.

<table>
<thead>
<tr>
<th>Current Policy Period</th>
<th>E-Mod Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999-2000</td>
<td>97-98, 96-97, 95-96</td>
</tr>
</tbody>
</table>

The manual premium is then multiplied by the E-Mod to determine your estimated premium.

<table>
<thead>
<tr>
<th>Manual Premium</th>
<th>E-Mod</th>
<th>Estimated Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$24,563.88</td>
<td>.95</td>
<td>$23,335.69</td>
</tr>
</tbody>
</table>

Approximately 30 days after the conclusion of a policy period, SAF will request verified payroll and employee classification information for that policy period, via the “Actual” Payroll Report (Figure 4-2, page 30).

Policyholders must verify and document:
- total number of employees in each individual class code,
- actual gross payroll (including salary, overtime pay, bonuses, vacation/sick/holiday pay, as well as, 401K and/or cafeteria benefits) for all employees in each individual class code,
- total amount of overtime paid within each class code, and
- provide a copy of the IRS Form W-3/941/1099, or Comptroller General’s payroll report, as appropriate.

Volunteer firefighters, First Responders, EMTs, and auxiliary police, as well as, elected or appointed officials should be listed separately (with Social Security Numbers) from regular employees.

School districts, technical schools, as well as, state-supported colleges and universities which have students engaged in an off-campus work study, marketing education, apprenticeship, and/or SC School-To-Work Transition program must complete a Student Payroll Report (SAF Form 320) (Appendix B-11).

After this information is submitted, your policy account will be audited. During the audit, all estimated payroll and employee...
classification information will be replaced with actual historical data. Your premium will then be recalculated. Any difference between your estimated and your actual premium will result in the posting of a credit or debit to your policy account.

A policy is subject to additional surcharges and/or cancellation by SAF if the required payroll information is not submitted in a timely fashion.

After the audit is completed, a Premium Statement (Figure 4-3) will be issued, reflecting verified payroll and employee classifications, as well as, other premium adjustments.

In 1996, the SC Department of Insurance approved the use of deductibles for workers’ compensation insurance policies.

Policyholders may choose a per-claim deductible for medical and indemnity (lost-time) benefits in amounts of $100, $200, $300, $400, $500, $1000, $1500, and $2000. Policyholders must pay all medical bills (at face value) under the deductible amount and maintain a claims file. If the payout on a claim exceeds the deductible, the claim must then be filed with SAF.

A special 5% premium credit is available for policyholders who establish a qualifying substance abuse prevention program, to include random testing of all employees.
Billing and payment transactions on your policy account will appear on a monthly invoice (Figure 4-4) and reflect your history of making quarterly or annual premium payments. Payments and credits are applied to the oldest outstanding billed amount. You will not receive an invoice unless there is premium or billing activity on your policy.
Recurring Reports

As a service to policyholders, historical claims and premium information is available for review on the SAF web site at www.state.sc.us/saf. SAF also provides paper copies of two (2) standard recurring reports. The first is the monthly Employee Accident Report. It is sent to all policyholders who have had claim activity during the previous month. A Quarterly Report provides a year-to-date summary of all claim activity.

An example of the first section of the Employer Accident Report is shown in Figure 6-1. This report is designed to provide policyholders with an overview of their claims. Open claims which were reported prior to the beginning of the report period, new claims received, and claims closed during the report period are listed under their appropriate heading. The employee name, the SAF claim number, the WCC claim number, and the injury date is displayed for each claim. The report also shows the total amount paid to date for medical expenses, lost time, and other compensation. Any amounts recovered from the Second Injury Fund or third party settlements is shown in the adjustment column. The last column is the projected payout on the claim.

Figure 6-1

This is the estimated total cost of the claim. To determine your remaining reserves, you simply subtract the total paid from the
projected payout. This is the amount which has been reserved to pay for this claim. Reserves are based on historical data.

If there is a question as to whether a claim has been closed, accepted, reopened, or possibly over-reserved during the last month, you can simply review this report. Contact your adjuster if the information in the report does not match your records.

The second section of the Employer Accident Report (Figure 6-2) lists all payments made during the month. Each claim is again identified by the employee's name, the SAF and SC WCC claim numbers, and the date of injury. The report reflects all benefit payments (Medical, Indemnity, Settlements, etc.) made during the reporting period. If you have any questions on whether a bill has been paid, or whether an employee is receiving lost time benefits, you can refer to this part of this report.

The last section of the Employer Accident Report is a list of all employees who are receiving lost-time temporary disability benefits. If an individual is listed on this report and has returned to work, please contact your adjuster immediately. If
neither the employee nor the employer inform us when an individual returns to work, we may inadvertently pay this individual benefits which they are no longer entitled to and create a financial hardship for them in the form of an overpayment.

The Employer Accident Report is designed to assist your claims personnel in monitoring and managing your claims, as well as, allowing you to quickly see and evaluate your claim costs. This report is designed to provide you with the most current information we have on your claims. Please review it and inform SAF of any discrepancies.

A quarterly summary of all claims activity is also provided to all policyholders. There are three sections to this report. The first section (PAYMENT ANALYSIS FOR CURRENT CALENDAR YEAR - Figure 6-3) reflects the actual payments made by category (medical, lost-time, other compensation) and adjustments (Second Injury Fund and Third Party recoveries) for all claims during each quarter of the current calendar year. These are actual costs and do not include reserves. By monitoring this information, you can estimate changes in your Experience Modifier.

Figure 6-3

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>YTD TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADJUSTMENTS</td>
<td>.00</td>
<td>.00</td>
<td>5,965.46</td>
<td>116,482.72</td>
</tr>
<tr>
<td>LOST TIME</td>
<td>.00</td>
<td>.00</td>
<td>129,235.12</td>
<td>75,310.45</td>
</tr>
<tr>
<td>MEDICAL</td>
<td>.00</td>
<td>.00</td>
<td>193,506.36</td>
<td>124,896.43</td>
</tr>
<tr>
<td>OTHER COMP.</td>
<td>.00</td>
<td>.00</td>
<td>38,000.00</td>
<td>65,913.40</td>
</tr>
<tr>
<td>TOTAL</td>
<td>.00</td>
<td>.00</td>
<td>759,667.02</td>
<td>150,376.56</td>
</tr>
</tbody>
</table>
The second section (CAUSE OF INJURY ANALYSIS FOR CURRENT CALENDAR YEAR - Figure 6-4) provides a breakdown of all injuries reported during the year. It also breaks down the actual cost for each category of injury. The amounts in this table are payments made during this calendar year.

**Figure 6-4**

<table>
<thead>
<tr>
<th>CAUSE OF INJURY</th>
<th>CLAIMS</th>
<th>MEDICAL</th>
<th>LOST TIME</th>
<th>OTHER COMP</th>
<th>ADJUSTMENTS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burns/Scald, Hand/Cold Exposure, First or Second Degree</td>
<td>4</td>
<td>$9,310.32</td>
<td>(3,339.46)</td>
<td>0.00</td>
<td>0.00</td>
<td>6,970.86</td>
</tr>
<tr>
<td>Burns/Scald, Hand/Cold Exposure, Third Degree</td>
<td>1</td>
<td>129.00</td>
<td>0.00</td>
<td>0.00</td>
<td>129.00</td>
<td></td>
</tr>
<tr>
<td>Burns/Scald, Hand/Cold Exposure, Electrical, Other than Burns</td>
<td>1</td>
<td>7,375.26</td>
<td>0.00</td>
<td>0.00</td>
<td>7,375.26</td>
<td></td>
</tr>
<tr>
<td>Car, Pedestrian, Injured By, Hit by</td>
<td>1</td>
<td>409.00</td>
<td>0.00</td>
<td>0.00</td>
<td>409.00</td>
<td></td>
</tr>
<tr>
<td>Car, Pedestrian, Injured By, Run Over</td>
<td>1</td>
<td>231.00</td>
<td>0.00</td>
<td>0.00</td>
<td>231.00</td>
<td></td>
</tr>
<tr>
<td>Fall, Slip, Trip, Noc</td>
<td>2</td>
<td>4,470.82</td>
<td>455.92</td>
<td>0.00</td>
<td>0.00</td>
<td>4,926.74</td>
</tr>
</tbody>
</table>

The third section of this report (EMPLOYMENT ANALYSIS FOR CURRENT CALENDAR YEAR - Figure 6-5) provides data on the number of claims broken down by NCCI job classification codes. This table not only provides you with the amounts paid during the current calendar year, but also the total amount paid, the projected payout, and the remaining reserves.

**Figure 6-5**

<table>
<thead>
<tr>
<th>CLASS</th>
<th>DESCRIPTION</th>
<th>CLAIMS</th>
<th>AMOUNT PAID</th>
<th>ADJUSTMENTS</th>
<th>PROJECTED PAYOFF</th>
<th>REMAINING RESERVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3701</td>
<td>Electrical, Machinery or Equipment</td>
<td>26</td>
<td>$35,442.96</td>
<td>(147.36)</td>
<td>$35,295.60</td>
<td>$50,649.94</td>
</tr>
<tr>
<td>5183</td>
<td>Plumbing, Noc &amp; Drivers</td>
<td>1</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>2,557.50</td>
</tr>
<tr>
<td>5403</td>
<td>Carpenters, Noc</td>
<td>3</td>
<td>84.00</td>
<td>.00</td>
<td>84.00</td>
<td>648.00</td>
</tr>
<tr>
<td>5506</td>
<td>Street Craft, Drivers</td>
<td>16</td>
<td>34,192.63</td>
<td>.00</td>
<td>34,192.63</td>
<td>153,197.35</td>
</tr>
<tr>
<td>7280</td>
<td>Drivers, Chaffee &amp; Their Helpful Noc</td>
<td>29</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>1,351,282.97</td>
</tr>
<tr>
<td>7520</td>
<td>Water Operations, Drivers</td>
<td>44</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>258,173.43</td>
</tr>
<tr>
<td>7580</td>
<td>Disposal Plant</td>
<td>3</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>3,248.03</td>
</tr>
<tr>
<td>7701</td>
<td>Firefighters &amp; Drivers</td>
<td>241</td>
<td>158,017.95</td>
<td>.00</td>
<td>158,017.95</td>
<td>2,651,919.74</td>
</tr>
<tr>
<td>7722</td>
<td>Policestaff &amp; Drivers</td>
<td>401</td>
<td>339,017.68</td>
<td>(66,923.16)</td>
<td>274,094.52</td>
<td>3,893,284.31</td>
</tr>
<tr>
<td>8382</td>
<td>Auto Service or Repair</td>
<td>15</td>
<td>10,470.85</td>
<td>.00</td>
<td>10,470.85</td>
<td>50,957.11</td>
</tr>
</tbody>
</table>

The data provided in sections two and three of this report can be used to identify trends and possible opportunities to limit future losses. Many organizations have effectively reduced their losses through safety programs that emphasize education, employee
involvement, and/or job redesign. This information should be passed to your organization’s loss control or safety personnel.

The report is designed to provide a policyholder with a snapshot of their organization’s current status and assist in the identification of possible opportunities for improvement.
Reducing the Cost of Workers’ Compensation

As government strives to become more efficient, additional emphasis is being placed on reducing and/or containing costs. Studies have shown that workers’ compensation premiums can be controlled and in many cases actually reduced.

A workers’ compensation insurance premium reflects the direct costs of delivering benefits to injured workers. Research also suggests that for every $1.00 paid in benefits, employers spend another $10.00 in indirect costs for lost productivity, overtime, and new employee training. Some increases resulting from court decisions or health care expenses are beyond the control of a policyholder. But, an employer can reduce costs, and therefore, premiums.

There’s no magic to the first step: reduce employee injuries. The State Accident Fund has safety professionals on staff to help policyholders provide a safe work environment. The range of services includes inspections, training, and technical assistance. SAF also offers a video library for use by policyholders.

There is no charge for these services. However, it’s the policyholder’s responsibility to ask for the service, act on recommendations, and vigorously enforce safety rules. Professional assistance plus employer commitment leads to lower losses. Studies have shown repeatedly that organizations with effective safety programs, which promote employee involvement and are backed by top management, have fewer and less serious accidents. Eliminating accidents not only reduces premiums, it also cuts indirect costs - damage to equipment, delays, and the lost time of co-workers.

Unfortunately, even the safest work place will be the scene of an accident at sometime or another. The actions taken by an employer will have a direct impact on the cost of the claim. The following is a list of steps an employer can take to help injured employees and minimize the cost of on-the-job injuries:

Expert medical care, including treatment by specialists when necessary, is a wise investment. It can minimize time off the job, reduce the chance of permanent disability and get the employee to think about recovery from the injury, rather than recovering for the injury.
SC law allows the employer/insurance carrier to designate a *designated treating physician*. This ability to control initial medical costs is often overlooked, but is an important factor. Remember, the doctor is directly involved in every step of the claim (treatment, evaluation, rehabilitation, and return-to-work) and will influence the length and cost of the claim. Choose a physician that will provide the best possible care.

The State Accident Fund can not start the claims process until we receive the First Report of Injury (WCC Form 12-A). Delays in reporting can delay the employee's benefit payments. This in turn increases hardship on the employee, impedes recovery, and often leads to dissatisfaction, disputes and litigation. Document every accident, even if no medical treatment is required. When preparing your report, investigate the claim. Provide the State Accident Fund with as much information as possible, including the names and telephone numbers of witnesses. **Utilize SAF's new Internet reporting system at [www.state.sc.us/saf](http://www.state.sc.us/saf)** which allows policyholders to file claims electronically.

An on-the-job injury can be a frightening experience, especially for employees who have little or no knowledge of the workers' compensation process. Any uncertainty about their claim can slow recovery and lead to complications and increased expenses.

Injured employees who are uncertain about their rights may turn to an "expert" i.e., an attorney. If so, that usually means additional expense and delays in getting a claim settled.

Reduce the injured employee's anxiety by explaining that all medical and hospital bills will be paid, as well as, partial wage replacement if they are unable to work. Provide them with a copy of the **SAF Employee Handbook**. Injured workers often need reassurance that their job will be waiting when they return to work, and that they will be treated fairly. Encourage your injured employees to think of recovery and reemployment, not disability.

Get injured employees back to work - before they've completely recovered - by modifying the work assignment. You'll need the doctor's cooperation, but that's another reason for selecting physicians who understand industrial injuries. Employees with strained backs can be assigned to tasks which do not require lifting until they are able to return to their regular duties.
Light duty programs assure injured workers they are wanted and needed. Otherwise, they may feel no one cares or the employer is mad at them for having been injured at work. Left alone at home, injured workers become easy prey for TV ads promising large financial rewards for work-related injuries. Light duty programs get employees back to work before boredom, anxiety, and thoughts of unrealistic financial settlements set in.

Remember no injury is "minor" if it happens to you. Injured employees frequently turn to an attorney because the employer or supervisor was indifferent and not helpful. Understanding the employee's concerns and maintaining ongoing communications during recovery is not only the right thing to do, it can also reduce litigation and claim costs.

Establish a safety committee to investigate and analyze all accidents, no matter how minor. Identify and correct any hazards found. Maintain complete records, including statements of witnesses, but emphasize prevention, not fault.

Lower workers' compensation premiums don't just happen. They are the result of your efforts to reduce the frequency and cost of claims.
ACORD - Term used to refer to the Employer’s First Report of Injury (ACORD 4 or WCC 12-A Form).

Authorized Treating Physician - The doctor who has been approved (either by SAF or the employer) to provide medical care to an injured employee.

Average Weekly Wage (AWW) - A claimant’s average weekly salary (including bonuses & overtime) at the time on an on-the-job injury. The AWW is verified & averaged for one (1) year prior to the accident using the WCC Form 20. The AWW may include wages from a second job.

Change of Condition - Any change in the physical condition, related to the original work-related injury suffered by an injured employee. Usually, this situation is only an issue when the condition has changed for the worse, within the one year period following an Order or WCC Form 16 settlement.

Claims Mediator - A classified employee of the SC Workers’ Compensation Commission who is authorized to appear on behalf of a commissioner at Informal Conferences to review a proposed Form 16 settlement. A Claims Mediator may not appear on behalf of a commissioner at a Clincher Conference requested for the review of an Agreement and Final Release.

Clincher Agreement - An agreement to settle a claim on a final basis. This type of settlement does not allow the injured employee any opportunity to have the claim reopened due to a change of condition. It is officially called an “Agreement and Final Release.” A clincher can be used for both accepted and disputed claims. The agreement usually includes payment for permanent partial disability and an additional amount to cover future medical expenses.

Commission - The South Carolina Workers’ Compensation Commission. The SC WCC is the administrative, regulatory, and judicial body responsible for enforcing the provisions of the SC Workers’ Compensation Act (SC Title 42.)

Commissioner - Any one of seven (7) members of the SC WCC, appointed by the Governor with the advice and consent of the Senate for terms of six (6) years and until their successors are appointed and qualify. They hear and determine all contested cases brought before the SC WCC, as well as, conduct informal conferences, approve settlements, hear applications for full Commission reviews, and handle other matters that may come before the Commission for judicial disposition.

Compensability - The decision as to whether a claim meets the legal
requirements for coverage under SC workers’ compensation law.

Compensation Rate - Two-thirds (66.67%) of a claimant’s average weekly wage, subject to a minimum & maximum amount set by law. This amount is the basis of all temporary and permanent compensation payments.

Disfigurement - Any serious scarring to the face, head, neck, or other area normally exposed in employment.

Employer/Carrier - Either the employer or their workers’ compensation insurance carrier, such as SAF. Under SC workers’ compensation law, the employer and the carrier are considered one and the same.

Experience Modifier (E-Mod) - An premium adjustment reflecting the difference between a policyholder’s expected losses and actual claims history over a three-year period. Generally, a high E-Mod results in a higher-than-normal premium.

WCC Form 12-A (Employers’ First Report of Injury) - The form (completed by the employer and submitted to the insurance carrier) used to report and document an employee’s on-the-job injury.

WCC Form 15 (Temporary Compensation Report) - Part I: Used to start compensation. Part II: Used to terminate compensation within 150 days of notification. Part III: Used by the injured worker or their legal representative to request a hearing if they do not agree with the termination of compensation.

WCC Form 16 (Agreement for Permanent Disability/Disfigurement Compensation) - The form used as part of a settlement reached during an Informal Conference. Compared to a Clincher, a Form 16 retains a claimant’s right to request additional benefits within one year from the date of the settlement if an adverse change of condition occurs.

WCC Form 17 (Receipt of Compensation) - The form terminates compensation on claims after the 150 day period. It is submitted to the claimant or their attorney for signature after the claimant has returned to work for fifteen calendar days or fifteen calendar days from the date the claimant was able to return to work, with or without restrictions.

WCC Form 19 (Status Report and Compensation Receipt) - This form is a summary of all benefits paid to or on behalf of the injured employee (i.e. Medical, Temporary Total, Temporary Partial, Temporary Partial Disability, etc.). The completion of this form is very important in Form 16 settlements because, generally, the twelve (12) month change of condition period begins on the date the claimant signs the form.

WCC Form 20 (Statement of Earnings of Injured Employee) - This form (completed by the employer) verifies all wages earned by an
employee for a 12-month period prior to a workplace injury or illness.

**Full Commission Review** - A three (3) member review panel of the SC WCC who review the appeal of an Order issued by an individual commissioner.

**Hearing** - An administrative review conducted by the SC WCC to resolve a dispute between a claimant and their employer/carrier.

**Informal Conference** - A non-binding arbitration meeting attended by the claimant, the employer/carrier representative, and either a commissioner or claims mediator, for the purpose of reaching a Form 16 settlement for permanent disability. All parties must agree to the settlement, which must also be approved by a commissioner.

**Injured Employee** - An employee injured as the result of an accident or occupational disease, arising out of and in the course and scope of his/her employment. Also called the “claimant.”

**Keloid Scar** - A mass of firm, raised scar tissue. Usually occurs after trauma, surgery, burns, or severe skin diseases.

**Maximum Medical Improvement (MMI)** - The point at which additional medical treatment will not tend to lessen disability or no other medical treatment is recommended. This objective determination is made by a physician.

**Non-Binding Arbitration** - Advice and recommendations from a commissioner or claims mediator, as to matters resolved during an Informal Conference. These recommendations are not binding on either party unless all parties agree and sign the Form 16.

**Notice of Election Form** - This document indicates a SC state government employee’s preference to use sick/annual leave or receive temporary disability benefits.

**Order** - A ruling made by the SC WCC as a result of a hearing held to resolve disputed issues between a claimant and their employer/carrier, subject to appeal by either party.

**Permanent Partial Disability (PPD)** - The impact of a permanent impairment on an employee’s ability to meet personal or occupational demands. It is the gap between what a person can do and what the person needs or wants to do. Disability is a subjective determination, and is ultimately decided by the SC WCC.

**Permanent Impairment** - The loss of functional use of a specific body part(s), as determined by a physician. Most physicians issue this
percentage rating once a claimant reaches maximum medical improvement, using the A.M.A. Guide for the Evaluation of Permanent Impairment.

**Reserves** - A calculation of the anticipated amount of total liability on a claim. This amount is usually adjusted during the life of the claim to reflect current and future expenses.

**Running Award** - The automatic generation of weekly temporary disability checks to a claimant while that employee is unable to work.

**Second Injury Fund (SIF)** - A state agency that reimburses employers or their insurance carriers for a part of their workers’ compensation claims costs involving disabled employees who are injured on the job.

**Temporary Total (TT) Benefits** - Weekly compensation paid to an employee who is unable to work due to a work-related injury or illness. These benefits begin after a 7-day waiting period.

**Temporary Partial (TP) Benefits** - Weekly compensation paid to an employee who has returned to work in a limited capacity after a work-related injury and is earning less than two-thirds of their pre-accident income.

**Third Party (TPY) Subrogation** - The legal process by which an employer/insurance carrier recovers workers’ compensation claims costs from a third party when they are the cause of an on-the-job injury or illness.

**Viewing** - Informal Conference conducted for the purpose of examining the injured employee for serious disfigurement.
Claim Process

First Report is Received

- Entered into system and claim number assigned
- A letter acknowledging receipt of the claim is sent to the employer and the injured worker

Investigation Required?

- Yes
  - Claim Sent to Investigations

- No
  - Adjuster Receives Claim, Reviews and Gathers additional Information if Needed.

Adjuster Receives Claim, Reviews and Gathers additional Information if Needed.

- Yes
  - Investigation completed; Recommendation sent to Adjuster

- No
  - Claim Accepted?

Claim Accepted?

- Yes
  - Begin Payment of Benefits

- No
  - Claim Presented to Claim Review Team for Denial

Claim Presented to Claim Review Team for Denial

- Team Disagrees and Accepts Claim?

  - Yes
    - Manage Claim
      - When all Benefits are Paid and Settlement Approved by WCC Close Claim
      - Conclude Third Party or Second Injury Fund Recovery if Applicable.

  - No
    - Claim Denied
      - Denial Letter Sent to Employer, Injured Worker, and Medical Providers if applicable.

Letter Sent to Employer and Injured Worker

Note: At anytime during the process a hearing maybe requested. When a hearing is requested the Litigation Process begins.

Appendix A
**Premium Calculation Process**

*Note: The Experience Modifier Data Base is constantly updated as reserves are set and released, bills are paid, and claims initiated and closed. The data is evaluated and the Experience Modifier determined on October 1 for counties and cities, and on April 1 for state agencies.*
### ACORD WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

**Employer (Name & Address incl Zip):**

**Carrier/Administrator Claim Number:**

**Report Purpose Code:**

**JURISDICTION:**

**JURISDICTION CLAIM NUMBER:**

**Insured Report Number:**

**Employer's Location Address (If Different):**

**Location #:**

### Carrier/Claims Administrator

**Carrier (Name, Address & Phone No):**

**Policy Period:**

**Claims Administrator (Name, Address & Phone No):**

**Policy/Self-Insured Number:**

**Administrator FEIN:**

**Agent Name & Code Number:**

### Employee/Wage

**Name (Last, First, Middle):**

**Date of Birth:**

**Social Security Number:**

**Date Hired:**

**State of Hire:**

**Address (Incl Zip):**

**Sex:**

**Marital Status:**

**Occupation/Job Title:**

**Marital Status:**

**M** Male

**U** Unmarried

**S** Single/Divorced

**F** Female

**M** Married

**U** Unknown

**S** Separated

**Unknown**

**NCCI Class Code:**

**Rate:***

**Per:**

**Day**

**Month**

**# Days Worked/Week**

**FULL Pay for Day of Injury?**

**Yes**

**No**

**Did Salary Continue?**

**Yes**

**No**

### Occurrence/Treatment

**Time Employee Began Work AM:**

**Date of Injury/Illness AM:**

**Time of Occurrence:**

**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:**

**How Injury or Illness/Abnormal Health Condition Occurred. Describe the Sequence of Events and Include Any Objects or Substances That Directly Injured the Employee or Made the Employee Ill:**

**Cause of Injury Code:**

**Date Returned to Work:**

**If Fatal, Give Date of Death:**

**Were Safeguards or Safety Equipment Provided?**

**Yes**

**No**

**Were They Used?**

**Yes**

**No**

**Physician/Health Care Provider (Name & Address):**

**Hospital (Name & Address):**

**Witnesses (Name & Phone #):**

**Date Administrator Notified:**

**Date Prepared:**

**Preparer's Name & Title:**

**Telephone Number:**

**ACORD 4 (2/95) SEE BACK FOR IMPORTANT STATE INFORMATION/SIGNATURE & ACORD CORPORATION 1993**

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**Appendix B**

**WCC Form 12-A REV. DATE 3/96**

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B-1
South Carolina Workers' Compensation Commission
P.O. Box 1715  1612 Marion Street
Columbia, South Carolina  29202-1715
(803) 737-5700

WCC File #: 
Carrier File: 
Carrier Code #:  500-SF 
Employer FEIN #: 

Form 15

Claimant Name
Claimant SSN
Employer Name

Claimant Address, City, State, Zip
Employer Address, City, State, Zip

Claimant Home Phone
Claimant Work Phone

Preparer’s name:

Date of injury:
State Accident Fund, Insurance Carrier
Date of notice to employer of injury:

I. Payment of Temporary Compensation (choose A, B, or C) ( ) Initial period ( ) Additional period ( ) Corrected 

A. Temporary Total at the compensation rate of $  per week. For this period of disability, disability began on  and the date of first payment was  .

B. Temporary Partial at the compensation rate of $  per week. Note: When Temporary Partial compensation rate will vary, report first payment here. Supplement throughout the period of Temporary Partial compensation by filing Form 15S with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. For this period of disability, disability began on  and the date of first payment was .

Calculation of Temporary Partial rate: 
Average weekly wage before injury $  
MINUS Current weekly wage $  
Difference in wages before injury and now $  
Temporary Partial Compensation Rate $  

C. Salary in lieu of Temporary compensation in the amount of $  per week. For this period of disability, disability began on  and the date of first payment was  .

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF THE INJURY, ATTACH DOCUMENTATION AS TO THE REASON FOR THE TERMINATION.

II. Termination of Temporary Compensation. Temporary compensation payments were stopped on __________ for the following reason:

( ) Claimant has returned to work at least 15 days and no temporary partial compensation is due.
( ) Claimant agrees he/she is able to return to work and has signed a Form 17.
( ) Based on a good faith investigation, the claim is denied. Reason for denial:
( ) Claimant has been released to return to work without restrictions and employment has been offered.
( ) Claimant has been released to return to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
( ) Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

Signature of Claims Administrator
Date

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:
The employer’s representative may stop temporary compensation within 150 days of the date of notice for the above reasons. However, if you believe that temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to the SCWCC Judicial Department at the address at the top of the form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: Form 15(I) □ has □ has not been recovered.

Signature of claimant or legal representative
Date

Employer’s representative must complete and file Form 15 with Claims Department within ten days after compensation begins or is terminated. Employer’s representative must serve the Form 15 on the claimant when compensation begins per R.67-211. Employer’s representative must prepare and serve Form 20 within thirty days of beginning compensation per R.07-1603. Employer’s representative must serve per R.67-211 two copies of the Form 15 on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the Form 15 and filing it with Judicial Department.

WCC Form # 15  Rev Date 3/97

Temporary Compensation Report

Appendix B

15

B-2
The above named parties agree to pay and accept compensation based on the following facts.

On , the treating physician, ______ assigned a ______ percent permanent impairment to the ______. The parties agree that the Claimant reached maximum medical improvement on ______ and has sustained _____ percent permanent disability to the _____ and/or _____ weeks disfigurement as a result of his/her injury. The Employer's Representative agrees to pay and the Claimant accepts ______ weeks of compensation at the rate of $ __________, which is based on the Claimant's average weekly wage of $ __________. The estimated award is $ __________, which is subject to verification by the Commission.

This agreement is binding on approval by the Commission. A claim for additional compensation based on a worsening of claimant's condition must be filed no later than one (1) year from the date of the last payment of compensation. Only medical care authorized by the employer's representative, or specific medical care detailed herein, will be paid under the terms of this agreement.

Claimant's Signature ___________________________ Employer's Representative ___________________________

Witness □ Claimant's Attorney

Commissioner ___________________________

Date Agreement Signed ___________________________ Date Approved ___________________________

Refer to R.67-801 through R.67-804 for instructions regarding the Form 16.
### South Carolina Workers' Compensation Commission

#### P.O. Box 1715
1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

---

**Claimant Name**

**Claimant SSN**

**Employer Name**

**Employer Address, City, State, Zip**

**Claimant Address, City, State, Zip**

**Claimant Home Phone**

**Claimant Work Phone**

**Preparer’s name:**

---

**Date of injury:**

---

1. **Temporary Compensation Paid:**

<table>
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<tr>
<th>Number of Weeks</th>
<th>From</th>
<th>To</th>
<th>Amount</th>
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</table>

2. **File #:**

3. **Carrier Code #:**

4. **Employer FEIN #:**

---

**State Accident Fund, Insurance Carrier**

---

**File this form with the Claims Department no later than 31 days from the date the claimant returned to work without restriction or agreed he or she was able to return to work. The employer’s representative is to insert the WCC File Number, Carrier Code Number, Carrier File Number, and the Employer’s FEIN. Refer to R.67-504 for additional information.**

---

**WCC FORM # 17**

**REV. DATE 3/96**

**17 RECEIPT OF COMPENSATION**

---

**Appendix B**
# South Carolina Workers' Compensation Commission

## Preparer's name:

<table>
<thead>
<tr>
<th>Compensation Paid</th>
<th>Number of Weeks</th>
<th>From</th>
<th>To</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>1. Number of weeks T.T.</td>
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<td>2. Number of weeks T.P.</td>
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<td>3. Number of weeks P.P.</td>
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<td>4. Disfigurement</td>
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<td>5. Agreement and Final Release</td>
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<td>$______</td>
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</table>

**Total Compensation Paid**

$______

6. **Total Medical Benefits**<sup>*</sup> Paid

$______

7. **Funeral Benefits**

$______

( ) **Case Denied**

**Date of Injury:**

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: ___________________________ By: ___________________________ Date: ____________

Claimant

Employer’s Representative

---

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: ___________________________

---

**Report of additional Fees and Recoupment**

A. **Carrier Reimbursement by Third Party**

$______

B. **Attorney’s Fee Paid by Employer**

$______

C. **Attorney’s Fee Paid by Claimant**

(Non contingent fees, only)

$______

---

*Do not include as medical costs fees paid for expert testimony, fees for determining carrier’s liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within sixteen days of final payment of compensation. Form 19 must be filed when a claim is denied.
STATE WORKERS’ COMPENSATION FUND

EMPLOYER’S SUPPLEMENTAL REPORT OF INJURY

W. C. C. File No. ____________
State Fund No. ____________

This form must be completed and submitted to the State Accident Fund whenever an employee is losing time from work and when an employee returns to work after a period of disability.

1. Name of Employer ____________________________
2. Name of Injured Worker ____________________________
3. Date of Injury __________________________________
4. Date Disability Began ____________________________
5. List Dates Injured worker was Paid:

   ____________________________
   ____________________________
   ____________________________
   ____________________________
   ____________________________

6. List Dates Injured Worker was on Leave without Pay:

   ____________________________
   ____________________________
   ____________________________
   ____________________________
   ____________________________

7. Date Injured worker Returned to Work Full Time ____________________________
8. Date Injured worker Returned to Work Part Time ____________________________
   Hourly Wage ____________________________

List Part Time Hours Worked Each Week and Weekly Amount Injured Worker is being Paid

   ____________________________
   ____________________________
   ____________________________
   ____________________________
   ____________________________

DATE OF REPORT ____________________________ SIGNED BY: ____________________________

Form Rev. 10/90 SF-B 500

Appendix B
South Carolina Workers' Compensation Commission  
P.O. Box 1715 • 1612 Marion Street  
Columbia, South Carolina 29202-1715  
(803) 737-5700

Claimant Name ___________________________  Claimant SSN __________  Employer Name ___________________________
Claimant Address, City, State, Zip ___________________________  Employer Address, City, State, Zip ___________________________
Preparer's name: ___________________________  State Accident Fund, Insurance Carrier ___________________________

A. Total Wages Paid

1. Check Applicable Method:
   ( ) Report of earnings of injured employee based on four completed quarters.
   ( ) Report of earnings of injured employee who did not complete four quarters based on actual time worked.
   ( ) Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire date: _______.
   ( ) Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just. (Attach documentation to show how average weekly wage and compensation rate were calculated.)

2. List total wages paid as reported to Employment Security Commission on the Employer Quarterly Contribution and Wage Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Ending Date</th>
<th>Total Wages Paid</th>
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<tbody>
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<td>1st</td>
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<td>4th</td>
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<td>Total Paid: 2._____</td>
</tr>
</tbody>
</table>

3. List total value of other allowances of any character made in lieu of wages during four quarters above.  3._____

4. Add lines 2 and 3

TOTAL WAGES PAID: 4._____

5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred.  5._____

B. Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5).

AVERAGE WEEKLY WAGE: 6._____

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667. Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate.  7._____

8. The compensation rate is as follows (choose one):
   ( ) When average weekly wage (line 6) is less than $75.00, the compensation rate is the average weekly wage.
   Enter average weekly wage on line 8.
   ( ) When the estimate compensation rate (line 7) is less than $75.00 and average weekly wage (line 6) is more than $75.00, the compensation rate is $75.00. Enter $75.00 on line 8.
   ( ) When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
   ( ) Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8:

The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.

WEEKLY COMPENSATION RATE: 8._____

Employer's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803)737-5723

WCC FORM # 20  REV. DATE 3/97

Appendix B
STATE ACCIDENT FUND
800 DUTCH SQUARE BLVD., SUITE 160
COLUMBIA, SC 29221-5000
P.O. BOX 102100
1-800-521-6576

POLICYHOLDER'S VOLUNTEER EMPLOYEE REPORT
WORKERS' COMPENSATION INSURANCE

STATE ACCIDENT FUND WILL PROVIDE COVERAGE FOR THE FOLLOWING VOLUNTEER EMPLOYEES:
FIREMEN, FIRST RESPONDERS (E.M.T.), AUXILIARY POLICEMEN, ELECTED OR APPOINTED OFFICIALS

POLICY PERIOD
FROM __/__/__ TO __/__/__

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<tr>
<th>NAME</th>
<th>SS#</th>
<th>JOB DESCRIPTION</th>
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IF NECESSARY, PLEASE MAKE ADDITIONAL COPIES OF THIS FORM AND ATTACH TO ORIGINAL

THE UNDERSIGNED HEREBY CERTIFIES THAT THIS PAYROLL AND CLASSIFICATIONS ARE CORRECT FOR THE PERIOD STATED

DATE___________________ POLICYHOLDER___________________
SIGNATURE___________________ TITLE___________________
POLICYHOLDER CODE_____________ TELEPHONE NUMBER_____________
FEDERAL I.D._____________ PAGE_______ OF ________
APPLICATION FOR DRUG AND ALCOHOL FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: __________________________

Date Program Implemented: __________________________

This form must be completed by you and returned to your carrier with a copy of applicable documentation as proof of compliance before the premium credit of five percent (5%) can be established and processed. A program must be certified during each year the employer receives credit. Failure to do so will remove you from eligibility for this credit.

( ) 1) Substance Abuse Policy Statement:
Any policy must be designed to help employees who need substance abuse assistance while, at the same time, sending a clear message that the abuse of drugs and alcohol is not compatible with employment in that employer's workplace. The policy statement must evidence both the employer's respect for its employees and the employer's need to maintain a safe, productive, substance-abuse-free environment.

( ) 2) Employee Notification:
In order to protect the individual rights of each employee and to begin the employee education process necessary for a well-defined, well-managed workplace drug and alcohol abuse prevention program, each existing employee and each new employee hired after program implementation must be given a clear, concise, readable notice of the program, the program's requirements, the policy statement, and the employer's expectations under the program. Notification should be, and should remain, posted in employee common areas, in addition, each existing employee and each new employee must be given, by mail or by in-person delivery, a copy of the notice. Delivery may be accomplished by inclusion of the notice within the employee's paycheck package or any similarly important-to-the-employee correspondence or benefits delivery.

( ) 3) Testing Procedure:
The testing procedure must include a provision for random sampling of all persons who receive wages and compensation in any form from the employer and must provide for a second test to be administered within thirty minutes of the administration of the first test. Positive test results must be provided in writing to the employee within twenty-four hours of the time the employer receives the test results. Each employer receives the test results. Each employer must keep records of each test for up to one year.

( ) 4) Test Results Confidentially Protocols:
Test results, information, interviews, reports, statements, and memorandums received by the employer must be considered confidential and may not be used, received, or discovered in civil, criminal, or administrative proceedings. The burden to protect against unauthorized release is placed not only upon the employer and any laboratory, medical review officer, or rehabilitation program or their agents, but also upon the underwriting insurer. Employers, laboratories, medical review officers, insurer, drug or alcohol rehabilitation program, and employer drug prevention programs, and their agents who receive or have access to information concerning test results shall keep all information confidential. Release of such information under any other circumstance shall be solely pursuant to a written consent form signed voluntarily by the employee tested or his designee unless the release is completed through disclosure by an agency of the State in a civil or administrative proceeding, order of a court of competent jurisdiction or determination of a professional or occupational licensing board in a related disciplinary proceeding. The consent form must contain at a minimum:

1) the name of the person who is authorized to obtain the information;
2) the purpose of the disclosure;
3) the precise information to be disclosed;
4) the duration of the consent; and
5) the signature of a person authorizing release of the information.

Information on last results shall not be released for or used or admissible in any criminal proceeding against the employee.

I certify that the above information is accurate and that I may be subject to an additional premium charge if it is determined that there is any misrepresentation of the established drug and alcohol free workplace program criteria. This is a true and factual depiction of my current program.

__________________________
Employer Name

__________________________
Date

__________________________
Officer/Owner Signature

__________________________
Title

__________________________
Notary Public's Signature

__________________________
Date

__________________________
Exp. of Commission

B-9


Appendix B

FORM 39-1
STUDENT PAYROLL REPORT FORM

FOR POLICY PERIOD __________ TO __________.

Students for this payroll report are students of state technical schools and state supported colleges and universities while engaged in off campus work study, distributive education, or apprentice programs.

PLEASE RETURN THIS FORM WITH YOUR PAYROLL REPORT.

<table>
<thead>
<tr>
<th>Number of Students</th>
<th>Class Name &amp; Number</th>
<th>Off Campus Hrs Per Week</th>
<th>Weeks Per Semester</th>
<th>Semesters Per Year</th>
<th>Total Hours Per Year</th>
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Total Total Total Total Total Total

If necessary, please make additional copies of this form and attach to original.

DATE __________ COLLEGE/UNIVERSITY ____________________________

SIGNATURE ____________________________ TITLE ____________________________

POLICYHOLDER CODE ____________________________ PHONE # ____________________________

PAGE __________ OF __________

COMPLETE AND RETURN THE ORIGINAL COPY TO THE STATE ACCIDENT FUND

Please call A. L. Menie at 1-800 521-6576 or 803 896-5854, if there are questions.
TO: POLICYHOLDERS

FROM: PREMIUM DEPT

DATE:

RE: AIRCRAFT-PASSENGER SEAT SURCHARGE FORM

PLEASE PROVIDE THIS OFFICE WITH THE REQUESTED INFORMATION BELOW REGARDING AIRCRAFT ASSIGNED TO YOUR ORGANIZATION FOR THE POLICY PERIOD _____________ TO ______________.

PLEASE RETURN THIS FORM WITH YOUR PAYROLL REPORT

POLICYHOLDER AIRCRAFT-PASSENGER SEAT SURCHARGE FORM

POLICYHOLDER NAME;

AIRCRAFT MAKE:

AIRCRAFT MODEL:

NUMBER OF ENGINES:

SEATING CAPACITY:

USE/PURPOSE:

TYPICAL COMPLEMENT OF CREW:

TYPICAL COMPLEMENT OF PASSENGERS:

DETAILS ON EACH OF THE PILOTS (name, experience, certificates, licenses, etc.)

Attach additional sheets if necessary:

Appendix B
RE: ______________________ vs. ______________________

Employee Name: ______________________
Employer: ______________________

Employee Social Security Number: _______-_____-_______

SAF# ______________________
State Accident Fund Claim Number if known (If submitted with First Report Leave Blank)

Date of Accident ____________

IMPORTANT NOTICE TO INJURED WORKER

You have the right to recover for your injuries from the person who caused the accident. Please review and elect which of the following three ways you wish to handle this claim.

CIRCLE ONE NUMBER below to indicate the statement which expresses your choice. Please sign, date and return this form to us as soon as possible.

1) I wish to settle my claim directly with the person who caused the accident and not file a workers' compensation claim.

2) I wish to accept workers' compensation benefits and file a claim against the person who caused the accident. I understand that I must have approval from your office before I finalize settlement and that my failure to get approval will result in a denial of further workers' compensation benefits. I also understand that if I choose this option, when a settlement has been reached, your office will have a lien on any money paid out by the third party.

3) I wish to accept workers' compensation benefits and not file a claim against the person who caused the accident, allowing YOU to file a claim against the person who caused the accident.

Witness' Signature: ______________________ Injured Worker Signature: ______________________

Date: ______________________ Date: ______________________

IF YOU ARE REPRESENTED BY AN ATTORNEY, PLEASE CONFER WITH HIM/HER ABOUT THIS OPTION LETTER AND PROVIDE US WITH HIS/HER NAME, ADDRESS AND TELEPHONE NUMBER.
The SC Second Injury Fund (SIF) is a state agency that reimburses insurance carriers, such as SAF, for a part of their workers' compensation claims costs involving disabled employees who are injured on-the-job. SIF is funded by mandatory contributions made by all insurance carriers and self-insureds providing workers' compensation coverage in SC.

SIF's purpose is to encourage the hiring and retention of disabled employees by protecting employers from excessive workers' compensation costs when a disabled individual suffers an on-the-job injury. SIF reimbursements are extremely important to you as a policyholder because they directly reduce the cost of your workers' compensation program.

A private company, REIMBURSEMENT CONSULTANTS, INC. (RCI) has been contracted by SAF to ensure that policyholders maximize their level of reimbursement.

**SIF REIMBURSEMENT REQUIREMENTS**

The employee must have a prior condition or disability, regardless of cause or origin, which is both permanent and of such seriousness as to constitute a hindrance to employment or re-employment if the employee should become unemployed.

A variety of pre-existing conditions generally qualify for coverage, including diabetes, arthritis, ruptured disks, cardiac disease, and hemophilia. SIF makes the final determination as to whether a specific individual's condition is covered, based on established criteria.

The employer must have actual knowledge of the employee's prior condition before the occurrence of a work-related injury. SIF will waive the knowledge requirement if the employer can show that:

- the employee’s pre-existing condition was unknown to the employee, or
- the pre-existing condition was known to the employee, and after being asked by the employer, the employee withheld information about the disability.

The employee must sustain a subsequent occupational injury which:

- results in disability that is substantially greater because of the pre-existing condition than that which would have resulted from the new injury alone; or
- would probably not have occurred "but for" the presence of the prior condition; or
- results in the death of the employee, which probably would not have occurred except for the prior condition.
When a claim qualifies for:

- all disability payments
- all medical expenses

In cases where medical expense reimbursement will reimburse 50% following the employer's prior disability, SIF will reimburse the first 78 weeks following the injury.

The RCI reviews claim files for all policyholders to verify knowledge requirements.

In most cases, the employer has been estimated to have filed SIF reimbursements of approximately 50% of claims filed for SIF reimbursement.

Since the employer must have communication, communication between the employer and RCI is an important ingredient necessary for success. Develop a program to identify prior disabilities in newly hired personnel, as well as, those which develop in the current workforce. This program must comply with the Americans with Disabilities Act (ADA.)

It is also important to remember that, when filing a workers' compensation claim, the employer should advise SAF of any pre-existing conditions.

For additional information contact your claims adjuster or REIMBURSEMENT CONSULTANTS, INC. (RCI) at (803) 345-5716.
# Telephone Numbers and Email Addresses

## Executive Team
<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parker, Pete</td>
<td>(803) 896-5875</td>
<td><a href="mailto:PParker@saf.state.sc.us">PParker@saf.state.sc.us</a></td>
</tr>
<tr>
<td>Adkins, Gwen</td>
<td>(803) 896-5870</td>
<td><a href="mailto:GAdkins@saf.state.sc.us">GAdkins@saf.state.sc.us</a></td>
</tr>
<tr>
<td>Gamble, Ross</td>
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<td><a href="mailto:RGamble@saf.state.sc.us">RGamble@saf.state.sc.us</a></td>
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## Claim Adjusters
<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Benjamin, Sherman</td>
<td>(803) 896-5904</td>
<td><a href="mailto:SBenjamin@saf.state.sc.us">SBenjamin@saf.state.sc.us</a></td>
</tr>
<tr>
<td>Black, Debra</td>
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<tr>
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<tr>
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<tr>
<td>Collins, Suzy</td>
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<td><a href="mailto:SCollins@saf.state.sc.us">SCollins@saf.state.sc.us</a></td>
</tr>
<tr>
<td>Green, Kathy</td>
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<tr>
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<tr>
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<tr>
<td>James, Beth</td>
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<tr>
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<tr>
<td>Mack, Connie</td>
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<tr>
<td>Mack, Sharon</td>
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<tr>
<td>McNair, Shelia</td>
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<tr>
<td>Miller, Margie</td>
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<tr>
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<tr>
<td>Peppers, Robert</td>
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<tr>
<td>Ramsdell, Lora</td>
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<tr>
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<tr>
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## Claim Supervisors
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<tr>
<td>Highsmith, Willie</td>
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<td><a href="mailto:WHighsmith@saf.state.sc.us">WHighsmith@saf.state.sc.us</a></td>
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<tr>
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<tr>
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## Attorneys
<table>
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<tr>
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<tr>
<td>McGregor, Rose Mary</td>
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<td><a href="mailto:RMcGregor@saf.state.sc.us">RMcGregor@saf.state.sc.us</a></td>
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<tr>
<td>Polk, Cynthia</td>
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## Policyholder Services (Premium and Audit)
<table>
<thead>
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<tbody>
<tr>
<td>Holman, Shawn</td>
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## Safety and Loss Control
<table>
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<tr>
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<tr>
<td>Berry, Michelle</td>
<td>(803) 896-5935</td>
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<td>Rush, Russell</td>
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</table>
State Accident Fund
P.O. Box 102100
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