

CENTRAL PA CONFERENCE OF THE UNITED METHODIST CHURCH

EFFECTIVE AUGUST 1, 2009

PLEASE NOTE CHANGE

WORKERS' COMPENSATION CLAIM REPORTING NOTICE

1. POST the Workers' Compensation Claim (LIBC 500) NOTICE.

The Department of Labor and Industry requires the Workers' Compensation Claim Notice be displayed in the work area of each Conference and Church location that is included in the Group Workers' Compensation Self-Insurance Program. It needs to be posted where other employee-related information may be posted.

Print off the new LIBC 500 Notice, which is also found on this website, and **post effective 8-1-2009.**

2. TO REPORT A WORKERS COMPENSATION CLAIM –

Complete the attached form with as much information as available

FAX COMPLETED FORM TO GARY SMITH, CONFERENCE TREASURER

FAX # 717-766-7696

OFFICE # 717-766-5275

TYPE OF INJURY CODE PART OF BODY AFFECTED CODE CAUSE OF INJURY CODE (ENTER CODES, IF KNOWN)

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES? IF OUT OF STATE, SPECIFY STATE OF INJURY WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING 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 DIRECTLY RESPONSIBLE

IF FATAL, GIVE DATE OF DEATH

- INITIAL TREATMENT:
[] NO MEDICAL TREATMENT
[] MINOR BY EMPLOYEE
[] CLINIC / HOSPITAL
[] PANEL PHYSICIAN
[] EMPLOYEE PHYSICIAN
[] EMERGENCY CARE
[] HOSPITALIZED MORE THAN 24 HOURS

PHYSICIAN/HEALTH CARE PROVIDER
FIRST NAME: LAST NAME:
STREET
CITY STATE ZIP

HOSPITAL NAME:
STREET
CITY STATE ZIP

POLICY PERIOD FROM:
MONTH DAY YEAR

POLICY PERIOD TO:
MONTH DAY YEAR

POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:
NAME:
TITLE:
PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)
NAME: Inservco Claims Service Office
STREET P.O. Box 3899
CITY Harrisburg STATE PA ZIP 17105-3899
BUREAU CODE: FEIN: 23-2145732

DATE PREPARED
MONTH DAY YEAR



Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.

