MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

3315 West Truman Blvd.,
P.O. Box 58
Jefferson City, MO 65102-0058
www.labor.mo.gov/DWC

INSTRUCTIONS FOR COMPLETING CLAIM FOR COMPENSATION

This form is to be used for accidents, injuries, or occupational diseases occurring on or after January 1, 2014.

Completed copies of the Claim forms may be mailed to the Division of Workers' Compensation, P.O. Box 58, Jefferson City, MO 65102-0058. **[See No. 5 below.]** You also have the option of filing the Claim form with any of the Division's adjudication offices. A list of the Division's adjudication offices may be obtained from the website: www.labor.mo.gov/DWC/contact.
Note that if you decide to file a Claim, the Division must receive the Claim form within the time period explained below:

- Within two years from the date of injury or death, or within two years from the last payment made on account of the injury, or death by the employer or its workers' compensation insurance carrier, whichever is later; OR
- If the employer does not timely file a First Report of Injury with the Division, within three years from the date of injury or death, or within three years from the last payment made on account of the injury or death by the employer or its workers' compensation insurance carrier, whichever is later.

As indicated in §287.063, RSMo, in cases of occupational disease, the statute of limitation does not begin to run until it becomes reasonably discoverable and apparent that an injury has been sustained related to such exposure.

IMPORTANT CONSIDERATIONS:

1. **Updated Claim form to be used:** The Division's form must be submitted as an original document in the most current version. The updated or current version of the Claim for Compensation form WC-21 may be downloaded from the Division's website www.labor.mo.gov/pubs-and-forms. You may also request the Division to mail you the Claim forms by calling the toll free number 800-775-2667 or by calling one of the local offices. The Division reserves the right to reject forms that are not currently approved forms and/or do not reflect the division's official seal. The minimum font size must be 10.
2. **Do not alter the form:** Claims that are submitted to the Division on a form that has been altered in any way will not be accepted for processing. Do not submit a claim form without the Division of Workers' Compensation caption appearing at the top of page one; with the informational boxes shifted to different pages; or with the bottom half cut off any page. If a complete response does not fit within the box provided on the form, complete the response on a separate sheet of paper (noting the box the additional information applies to) and attach the additional sheet(s) to this form.
3. **Legibility:** The Claim form may be downloaded from the Division's website, printed, and completed by handwriting or printing the information in the applicable boxes. If you handwrite or print the information on the Claim form, it must be legible to meet the Division's requirements for the record to be electronically stored. You also have the option of completing the Claim form online, by typing the information needed in each field, printing the form, and mailing it to the Division's Jefferson City office or filing it in one of the adjudication offices.
4. **Amended Claim:** If the Claim, including the Claim that is being filed against the Second Injury Fund, is being amended, the Box containing the amended information must be identified in the Box "BOX NUMBER(S) AMENDED" in order for the Division to process the amendments to the Claim.
5. **Copies:** If you are mailing the Claim form to the Division at P.O. Box 58, Jefferson City, MO 65102-0058, you need to submit the original and 3 copies of the Claim. If the Claim is being filed against more than 3 employers, submit additional copies to enable the Division to forward the Claims to all employers named. If the Second Injury Fund is named as a party, submit an original and 4 copies. You must copy both pages of the Claim form. You should keep one copy for your records.
   If you are filing the Claim form in one of the Division's adjudication offices, submit the Original Claim form. Additional copies of the Claim form are not required to be provided to the adjudication office.
6. **BOX 1D:** If you know the 9-digit ZIP Code, provide it in Box 1D.
7. **BOX 4 [Date of Injury (D/I)]:** For repetitive motion and occupational disease claims, the following guidelines will be used:
   If there are multiple dates indicated – Division will use the last date as the D/I.
   - For example, January 1 - March 17, 2001, is on the Claim, the D/I will be March 17, 2001.
   - If 1/24 - 2/15/02 and 3/14 - 6/26/02 is on the Claim, the D/I will be June 26, 2002.
   - 3/24 - Current, the Division will use the date it receives the Claim as the D/I.
   - 10/2000 - the Division will use the last date of the month, i.e. 10/31/00 as the D/I.
8. **BOX 5:** Provide gross wages earned rather than net wages.
9. **BOX 7:** If you were injured in Missouri, it is very important that Box 7 include the ZIP Code where the accident occurred.
10. **BOX 14:** Fill out the dependent information in Box 14 only if the employee has died.
11. Employee/Claimant must sign **BOX 15** unless represented by an attorney.

If you have any questions, contact the Division's toll free number 800-775-2667.

Visit the Division's website: www.labor.mo.gov/DWC which contains additional information, including the full text of the applicable Missouri Workers' Compensation Statutes and Regulations, as well as many other forms and brochures.

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
P.O. Box 58
Jefferson City, MO 65102-0058

CLAIM FOR COMPENSATION

INJURY NUMBER

+ ☐☐ - ☐☐☐☐☐☐

NOTE: This form should be used to file a Claim for Compensation for accident or injury including occupational diseases and occupational diseases due to toxic exposure that occur on or after January 1, 2014.

This form should be completed in its entirety and must be typed or hand printed in **black ink**.

SUBMIT AN ORIGINAL AND THREE COPIES.

☐ ORIGINAL CLAIM ☐ AMENDED CLAIM ☐ SECOND INJURY FUND ONLY

Read instructions before completing this form.

BOX NUMBER(S) AMENDED

EMPLOYEE INFORMATION

1. INJURED EMPLOYEE'S NAME LAST FIRST INITIAL OR MIDDLE NAME			1A. MAILING ADDRESS (ALSO INCLUDE STREET ADDRESS)	
1B. CITY	1C. STATE	1D. ZIP CODE	2. SOCIAL SECURITY NO. (Last 4 digits) XXX-XX-	3. DATE OF BIRTH
4. DATE OF ACCIDENT OR OCCUPATIONAL DISEASE	5. AVERAGE WEEKLY WAGE	6. TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT *(City, County, State, Zip)*	

8. Check the appropriate box if you are filing a Claim due to an Occupational Disease due to Toxic Exposure:

- ☐ asbestosis
- ☐ berylliosis
- ☐ coal worker's pneumoconiosis
- ☐ bronchiolitis obliterans
- ☐ silicosis
- ☐ silicotuberculosis
- ☐ manganism
- ☐ acute myelogenous leukemia
- ☐ myelodysplastic syndrome.

☐ Check this box ONLY if you are filing a Claim due to an Occupational Disease due to **toxic exposure resulting in a diagnosis of mesothelioma.**

9. PART(S) OF BODY INJURED

10. DESCRIBE WHAT THE EMPLOYEE WAS DOING AND HOW THE INJURY OCCURRED.

EMPLOYER INFORMATION – If additional employers need to be listed or if you need more space, attach additional sheets.

11. EMPLOYER(S) AGAINST WHOM THIS CLAIM IS FILED. THIS IS THE EMPLOYER IN WHOSE EMPLOYMENT THE INJURY OR OCCUPATIONAL DISEASE OR OCCUPATIONAL DISEASE DUE TO TOXIC EXPOSURE OCCURRED.

EMPLOYER A:	MAILING ADDRESS	
CITY	STATE	ZIP CODE
EMPLOYER B:	MAILING ADDRESS	
CITY	STATE	ZIP CODE
EMPLOYER C:	MAILING ADDRESS	
CITY	STATE	ZIP CODE

DIVISION USE ONLY

Date Stamp

BE SURE TO COMPLETE NEXT PAGE.

INJURY NUMBER

		-						

12. ☐ CHECK THIS BOX IF YOU ARE FILING A CLAIM AGAINST THE SECOND INJURY FUND FOR PERMANENT TOTAL DISABILITY BENEFITS

13. DID INJURY RESULT IN DEATH? ☐ YES ☐ NO 13A. DATE OF DEATH ____/_____/_____

IF DEATH OCCURRED, **EMPLOYEE'S DEPENDENTS (SPOUSE, MINOR CHILDREN, OR OTHER PERSONS DEPENDENT ON EMPLOYEE).**
IF YOU NEED TO LIST DEPENDENTS IN ADDITION TO THESE LISTED BELOW, PLEASE ATTACH A SEPARATE SHEET.

14. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE
14A. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE
14B. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE

CLAIM IS HEREBY MADE FOR ALL COMPENSATION AS PROVIDED UNDER THE MISSOURI WORKERS' COMPENSATION LAW, RELATING TO INJURY OR OCCUPATIONAL DISEASE OR OCCUPATIONAL DISEASE DUE TO TOXIC EXPOSURE (OR DEATH) OF THE EMPLOYEE ARISING OUT OF AND IN THE COURSE OF THE EMPLOYMENT.

15. INJURED EMPLOYEE OR CLAIMANT'S SIGNATURE	16. EMPLOYEE/CLAIMANT TELEPHONE NO.	17. DATE		
18. ATTORNEY SIGNATURE	18A. ATTORNEY NAME *(type or print)*	18B. BAR NUMBER		
19. ATTORNEY PHONE NUMBER	19A. ATTORNEY FAX NUMBER	19B. ATTORNEY E-MAIL ADDRESS		
20. ATTORNEY MAILING ADDRESS	20A. CITY	20B. STATE	20C. ZIP CODE	

21. ADDITIONAL STATEMENTS –Use this Box to add any further information that will assist you in filing your Claim.

Do not submit Confidential Documents at the time of filing the Claim for Compensation.

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

REPORT OF INJURY

P.O. Box 58
Jefferson City, MO 65102-0058

(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*

CARRIER ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)*

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*

POLICY PERIOD

to

CHECK IF APPROPRIATE

☐ SELF INSURANCE

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

CARRIER FEIN

INSURANCE POLICY NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)*

DATE OF BIRTH

SOCIAL SECURITY #

DATE HIRED

STATE OF HIRE

ADDRESS *(INCLUDE ZIP)*

SEX
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS
☐ UNMARRIED
SINGLE DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION JOB TITLE

EMPLOYMENT STATUS

PHONE #

OF DEPENDENTS

NCCI CLASS CODE

WAGE

RATE

PER ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER

OF DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY / ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME PHONE NUMBER

TYPE OF INJURY ILLNESS

PART OF BODY AFFECTED

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

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

ZIP CODE OF THE LOCATION WHERE THE 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 RETURN TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*

HOSPITAL *(NAME & ADDRESS)*

INITIAL TREATMENT
☐ 0 - NO MEDICAL TREATMENT
☐ 1 – MINOR: BY EMPLOYER
☐ 2 – MINOR CLINIC HOSPITAL
☐ 3 – EMERGENCY CASE
☐ 4 – HOSPITALIZED > 24 HOURS
☐ 5 – FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

NOTE: This form constitutes the detailed report of injury required by §287.380, RSMo, and rules applicable thereto. An injury that requires immediate first aid, but does not result in further medical treatment or lost time from work, need not be reported to the Division. Employers should report all injuries to their workers' compensation insurance carrier or third-party administrator (TPA) within five days of the date of the injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. See §287.380, RSMo. If the employer has been granted self-insurance authority by the Division pursuant to §287.280, RSMo, and rules applicable thereto, please report all injuries to your TPA or Service Company to enable them to file this report with the Division.

PRINT QUALITY: All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division MUST be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

Data Element Dictionary for Hard Copy Report of Injury

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Employer (Name & Address)	The name of the employer where the employee was employed at the time of the injury.	This is the name the employer does business under followed by the FULL address including mailing address, city, state and zip code.	M
Industry Code	The code which represents the nature of the employer's business which is contained in the North American Industry Classification System Manual published by the Federal Office of Management and Budget. See implementation note below: The industry code selected should represent the primary nature of the employer's business. If the employer is assigned multiple industry codes, use the code that relates to the specific business operation for which the employee was employed at the time of the injury. The data element may contain an SIC code or NAICS Code. SIC code will be identified with the characters 'SC' as the last two characters of the data element. If SC is not present, the code is presumed to be NAICS.	This is the Standard Industrial Classification Code for the employer. SIC/NAICS codes can be found at www.census.gov/epcd/www/naics.html	M
Employer FEIN	The FEIN of the employer where the employee was employed at the time of the injury.	Must be the primary FEIN for the Employer listed above.	M
Report Purpose Code (RPC)	Defines the specific purpose of the report being filed with the state of Missouri. 00 = Original FROI 02=Change CO=Correction AQ=Acquired Report of Injury AU=Acquired Unallocated Report of Injury	The Report of Injury that the employer is required to file with the Division of Workers' Compensation (Division) through the insurance carrier or third party administrator (TPA).	M
Claims Administrator's Number	Identifies a specific claim within a claim administrator's claims processing system.	Number used by the organization adjusting the claim (insurance company, third party administrator, etc.).	M
Jurisdiction	The governing body or territory whose statute applies.	This must always be Missouri.	M
Jurisdiction Claim Number		The injury number assigned by the Division upon receipt of the First Report of Injury with all mandatory information provided. The reporting entity is to leave this field blank.	

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Insured Report Number	A number used by the insured to identify a specific claim.		O
Employer's Location Address	List the physical address of where the employee sustained the accident or illness if that location is different from where the employer wishes to have correspondence sent.		O
Insured Location Number	A code defined by the insurer/employer, which is used to identify the employer's location of the accident.		O
Phone Number	List a phone number of the employer location where the employee worked at the time of the accident.		O
Carrier (insurer) Name & Address	The name and mailing address of the carrier or self-insured entity assuming the employer's financial responsibility for the workers' compensation claim.	If the employer is **individually** self-insured, the **individual** self-insured employer's name and mailing address would be indicated in this field. The FEIN and Name must match. **If the employer is self-insured by a trust, the trust's name would be submitted in this field.**	M
Carrier (insurer) FEIN Number	The FEIN of the carrier or self-insured assuming the employer's financial responsibility for the workers' compensation claim(s).		M
Carrier Policy Number	The number assigned to the contract/policy for the employer or association group.	A number assigned by the **insurance company, *(Not a number assigned by a TPA)*** for the specific workers' compensation policy for that employer. Not a required field for Division approved self-insureds.	M
Policy Period	List the effective and expiration dates of the contract/policy.	The date that the policy became effective and the date the policy expires or is no longer in effect. No date is required in this field if the injury falls within the Division approved self-insurer's self-insurance period.	M
Self-Insured Indicator	An indicator that identifies the employer as one who is authorized by the state of Missouri to retain the risks arising from their operations and bears the financial responsibility. Y=Yes, N=No	Condition – Must indicate Y(Yes) ONLY for an individual employer or a member of a self-insured trust authorized by the Missouri Division of Workers' Compensation to self-insure under § 287.280, RSMo. It does not include uninsured employers or employers under deductible insurance policies.	C
Claim Administrator (TPA) Name & Address	The name and mailing address of the Third Party Administrator (TPA), independent administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	Name and mailing address of the Third Party Administrator (TPA), independent adjuster, contracted to adjust the claim and phone number of the office adjusting the claim. If there is not a TPA, independent adjuster/administrator, contracted to adjust the claim please leave blank.	C

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Claim Administrator (TPA) FEIN Number	The FEIN of the Third Party Administrator (TPA), independent adjuster/administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	FEIN number for the company hired as a TPA. Note: If there is no Third Party Administrator, please leave blank.	C
Agent Name & Code Number	List the name and code number of the carrier or claim administrator agent who administers the workers' compensation claims for the employer.		O
Employee Name	The injured worker's legally recognized name which is used on legal documents, employment, Social Security, banking, records, etc.	Name to include last, first and middle initial.	M
Employee Date of Birth	The date the injured worker was born.	Must be a valid date.	M
Social Security Number	A number assigned by the Social Security Administration used to identify the employee.	If a SSN is not available please call 573-526-3542.	M
Date of Hire	The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.	Must be valid date.	O
State of Hire	List the state where the employer hired the employee.		O
Employee Address	The mailing address used by the injured worker.	The address should not be listed as unknown. Please include the last known address provided by the injured worker that is on file with the employer.	M
Employee Phone	A telephone number where the injured worker can be reached.	This is an optional field, although if the employer or insurance company has this information, **please** report it to the Division. This will improve communication between the parties. This will be a numeric field only *5736367777.*	O
Gender Code	The code which indicates the sex of the employee. Gender of employee F=Female M=Male U=Unknown		M
Number of Dependents	The number of dependents as defined by the administrating jurisdiction.	Spouse, minor children or others if known. Required if date of death is entered. Numeric field 0-9.	C
Marital Status Code	The code, which indicates the marital status of the employee. U = Widowed, divorced, single, unmarried, M = Married, S = Separated, K = Unknown		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Occupational/ Job Title or Description	Identifies the primary occupation of the employee at the time of the accident or injurious exposure.		O
Employment Status Code	Indicate the employee's primary work code status at the time of the injury with the covered employer.		O
NCCI Class Code	A code, which, corresponds to the primary occupation in which the employee was engaged at the time of the accident/injury or injurious exposure.	MO uses NCCI codes.	M
Wage	The reported employee's pre-injury wage for the wage period. Implementation Note: This amount may include commission, piecework earnings, and other forms of income converted to a normal scheduled work week, plus the estimated value of lodging, food, laundry and other payments in kind; and concurrent employment earnings, as prejurisdictional requirement.	"Gross Wages" includes, in addition to money paid by the employer for services rendered by the employee, the reasonable value of board, rent, housing, lodging or similar advance by the employer, except if it continues to be provided to the employee for the period of disability, it is not included in calculating the average weekly wage. "Wages" also includes gratuity received in the course of employment from individuals other than the employer that are reported for income tax purposes. "Wages" does not include fringe benefits such as retirement, pension, health and welfare, life insurance, training, Social Security or other employee or dependent benefit plan provided by the employer. **Please See Special Notes #1**	M
Wage Period	A code indicating the time period during which the wage was earned.	Please use the weekly wage rate paid to the employee.	M
Number of Days Worked	The number of the employee's regularly scheduled workdays per week.		O
Full Wages Paid for the Date of Injury Indicator	Indicates whether full wages for the date of the accident/injury or illness were paid by the employer.		O
Salary Continued Indicator	The employer has paid or is paying the employee's salary in lieu of compensation during an absence caused by a work-related injury.	Did the employer continue to pay salary to the employee after the injury? N=No Y=Yes	O
Time Employee Began Work	Time at which the employee began work on the day of the accident/injury or illness.		O
Date of Injury/Illness	For traumatic injury, the date on which the accident occurred. For occupational disease or cumulative injury, the date of injury is the date of last injurious exposure to the cause or substance creating the condition, unless otherwise defined by statute.	Date that injury/illness occurred or became known to employee; whichever is later.	M

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Time of Occurrence	The time at which the accident occurred.	To the extent that the time of the occurrence of the accident/injury is available, you should provide it to the Division. Please indicate a.m. or p.m.	O
Date Last Day Worked	The last paid workday prior to the initial date of disability as defined by jurisdiction.	Must be valid date.	O
Date Employer Notified	The date that the injury was reported to a representative of the employer.		M
Date Disability Began	The first day on which the employee originally lost time from work due to the occupational injury or disease or as otherwise defined by jurisdiction.	**Date of disability must be greater than Date of Injury.** First date employee starts losing time from work after the date of injury. This is the day after the date of injury or the first day of work missed, if later. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days. **Please See Special Notes #2**	C
Contact Name & Phone Number	List the name and phone number for a representative of the employer.		C
Type of Injury/Illness	List the type of injury/illness sustained by the employee.		O
Part of Body Affected	List the part of body to which the employee sustained injury.		O
Employer Premises Indicator	An indicator to denote whether the accident occurred at the employer's address provided.	If the injury/illness occurred on the employer's property indicate "YES." If it occurred elsewhere indicate "NO."	M
Type of Injury/Illness Code	The code, which corresponds to the nature of the injury sustained by the employee.	Choose from the list of code numbers, which corresponds with the nature of the injury. A list of codes with description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx **Please See Special Notes #2**	M
Part of Body Affected Code	The code, which corresponds to the part of the body to which the employee sustained injury.	Choose from the list of code numbers, which corresponds with the part of body injured. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx	M

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Zip Code of the Location Where Accident or Illness Exposure Occurred	The zip (postal code) that corresponds to the location where the injury occurred.	The code is required to assist with docket setting if needed.	M
All Equipment Using	List all the equipment; materials or chemicals the employee was using at the time of the accident/injury or illness exposure occurred.		O
Specific Activity Engaged In	Describe the specific activity that the employee was doing at the time the accident/injury or illness exposure occurred.		O
Work Process Engaged In	Describe the work process the employee was doing when the accident/injury or illness exposure occurred.		O
How the Injury or Illness Occurred	A free form description of how the accident occurred and the resulting injuries.	Describe how the injury/illness occurred. Please include the events that led to the injury/illness and any objects or substances that directly injured the employee or made the employee ill. Maximum of 150 characters, including spaces. *For example: Employee was on ladder putting away product, fell on chemical barrel breaking lower arm; arm lacerations; exposed to chemical liquid and fumes (141 characters).*	M
Cause of Injury Code	The code which corresponds to the cause of injury.	Choose from the list of code numbers, which corresponds with the cause of the injury. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx (Struck by, fell, auto accident, exposure, etc.)	M
Date Returned to Work	The first date on which the employee returned to work following the injury.	Must be a valid date. Must be entered if employee lost days of work and returned to work before first report of injury is filed.	C
Employee Date of Death	The date the injured worker died.	Must be a valid date.	C
Safeguards	Indicate whether safeguards or safety equipment was provided by checking “Yes” or “No.”		O
Were They Used	Indicate whether the safeguards or safety equipment was used by the employee by checking “Yes” or “No.”		O
Physician/Health Care Provider	List the name and address of the physician or health care provider who provided initial medical treatment to the injured employee after the accident/injury or illness.		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Hospital	List the name and address of the hospital where the employee received initial medical treatment.		O
Initial Treatment	A code used to identify the extent of medical treatment received by the employee immediately following the accident. 0= No medical treatment 1= Minor on-site remedies by employer medical staff 2= Minor clinic/hospital medical remedies and diagnostic testing 3= Emergency evaluation, diagnostic testing, and medical procedures 4= Hospitalization > 24 hours 5= Future major medical/lost time anticipated	First Aid includes the administration of immediate and temporary medical aid to the employee that a lay person may provide, such as the application of Band-Aid to treat a minor scratch or the removal of a splinter that would not result in the need for a referral to a doctor or other health care professional for additional medical treatment or would not result in further lost-time from work. The on-site company nurse or physician may be the individual that provides the first aid. If the company nurse or physician provides service beyond first aid, then the injury must be reported even if the treatment occurs on-site. **Please see Special Notes #2**	M
Witness	List the name and address of all witnesses who were present when the employee sustained the accident/injury or illness.		O
Date Reported to Claims Administrator	The date the claim administrator who is processing the claim received notice of the loss or occurrence.		M
Date Prepared	List the date that the representative for the claims administrator prepared this report of injury.		O
Preparer's Name and Title	List the name and title of the claims administrator's representative who prepared this report of injury.		C
Phone Number	List the phone number of the representative preparing this report of injury.		C

M – Mandatory – Cases missing mandatory information will NOT be accepted by the Missouri Division of Workers' Compensation system.

C – Conditional – Data Elements with Conditional fields indicate a value is required based on another Data Element or pre-existing condition.

Examples: When a death case is reported then the death date would be required.
If the employee has returned to work prior to the report being filed, the date of return to work would be entered.

O – Optional – Data Elements identified as Optional may be entered but are not required.

Special Notes

1) Wage Instructions

A) Missouri Notes: Report the wage information as the average weekly wage (AWW) of the employee. These rules apply for calculating the average weekly wage.

1) If the employee's wage is fixed by the year, the AWW is the yearly wage divided by 52;

2) If the employee's wage is fixed by the month, the AWW is the monthly wage multiplied by 12 and divided by 52;

3) If the employee's wage is fixed by the week, that amount is the AWW;

4) If the employee's wages are fixed by the day, hour or output, the numerator is the actual gross wages earned by the employee in the last thirteen calendar weeks immediately preceding the week in which the injury occurred; and the denominator is 13 to calculate the AWW.

i) The formula is: Actual gross wages earned in prior 13 weeks/13=AWW. *For example, the employee's hourly wage is $9.00/hour. The overtime rate is $13.50/hour. The employee works 40 hours per week at $9.00 an hour plus occasional overtime. Employee worked overtime of 44 hours in the 13-week period immediately preceding the week of the injury. The employer has employed the employee for 2 years.*

The gross wages are $9.00 X 40 hours X 13 weeks = $4,680. You also need to include the overtime 44 hours. Therefore, $13.50 X 44 hours = $594. The total wages are $4,680 plus $594 = $5,274. The AWW is $5,274/13=$405.69.

ii) If the employee misses nonconsecutive workdays during the 13-week period in multiples of 5 those days shall be subtracted from the denominator. *For example: if the employee misses 5 days, one week is subtracted from 13 and the denominator becomes 12; if the employee misses 10 days, two weeks are subtracted from 13 and the denominator becomes 11; and so on.*

iii) Partial weeks of time missed by the employee do not count to change the denominator. *For example: if the employee misses 4 days, the denominator is 13; if the employee misses 6 days, one week is subtracted from 13 and the denominator becomes 12; and so on.*

iv) If the employee works less than 13 weeks but more than 2 weeks, the AWW is the same formula with the numerator as the gross wages calculated for the number of weeks of employment and the denominator is the number of weeks of employment. *For example, the employee worked for the employer 8 weeks prior to the week of the injury. The employee was paid $9.00 per hour and worked 40 hours per week. The employee worked 13 hours of overtime. The overtime rate is $13.50. The gross wages are $9.00 X 40 hours X 8 weeks plus $13.50 X 13 hours = $3,055.50. The AWW is $3,055.50/8=$381.94.*

5) If the employee works less than two weeks the AWW shall be equivalent to the AWW for the same or similar employment. However, if the employer has agreed to a certain hourly wage, then the hourly wage agreed upon multiplied by the number of weekly hours scheduled shall be the employee's AWW.

B) **When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.**

C) When Initial Treatment Code is reported as equal to 00, 01 or 02, the case will be considered as a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed. When the Initial Treatment Code is reported as equal to 03, 04 or 05, the case will be considered as an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

2) Initial Treatment Code, Date Disability Began and Date Returned to Work:

A) When Initial Treatment Code is reported as 00, 01 or 02, the case will be considered a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed.

B) When the Initial Treatment Code is reported as 03, 04 or 05, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

1) When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

C) The following are examples of First Aid treatment:

a) Use of non-prescription medication at non-prescription strength.

b) Cleaning, flushing or soaking wounds on the surface of the skin.

c) Using wound coverings such as bandages, Band-Aids, gauze pads, etc. or using butterfly bandages or Steri-Strips. (Other wound closing devises such as sutures, staples, glues, etc. are considered medical treatment.)

d) Use of any non-rigid means of support such as an elastic bandage, wrap, or non-rigid belt. (The use of devices with rigid stays or other systems designed to immobilize body parts is considered medical treatment.)

e) Use of temporary immobilization devices (e.g., splints, slings, neck collars, etc.) while transporting an accident victim.

f) Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs, or other simple means.

g) Use of finger guards.

h) Drinking of fluids for relief of heat stress.

3) Mesothelioma Liability: Several changes to the Workers' Compensation Law went into effect January 1, 2014. Pursuant to §287.200.4, RSMo, employers may elect to accept mesothelioma liability in one of the following ways:

a. Insuring their liability by purchasing a workers' compensation policy;

b. Meeting the requirements of the Division of Workers' Compensation to qualify as a self-insurer;

c. Joining a Group Insurance Pool that complies with §287.223. (An employer may become a member of the Missouri Mesothelioma Risk Management Fund);

d. Rejecting *mesothelioma* liability under the Missouri Workers' Compensation Law.

Please note that if an employer has rejected *mesothelioma* liability coverage under the Workers' Compensation Law, the exclusive remedy provision of the Workers' Compensation Law, §287.120, RSMo, does not apply.

4) **Occupational diseases:** Occupational diseases due to toxic exposure have been defined effective January 1, 2014. The "occupational diseases due to toxic exposure" includes the following: asbestosis, berylliosis, coal worker's pneumoconiosis, bronchiolitis obliterans, silicosis, silicotuberculosis, manganism, acute myelogenous leukemia and myelodysplastic syndrome. The reporting requirements relating to other occupational diseases such as carpal tunnel syndrome, etc. remains the same.

MARKEL®

WAGE VERIFICATION FORM

Employer:_____ Claim Number:_____

Injured Worker:_____ Date of Injury:_____

Completed By:_____ Date:_____

Markel works to take a pro-active approach to handling claims. Accordingly, this document has been enclosed in the event your employee has sustained lost time from work prescribed by a physician as a result of a work related injury.

Pursuant to Missouri Workman's Compensation law, we are required to obtain wages paid for 13 weeks prior to the date of injury or duration of employment if less than 13 weeks. Failure to provide all requested information may cause unnecessary delay in issuance of wage loss benefits.

If you have any questions, please contact Markel at 888-500-3344

FAX COMPLETED FORM TO 877-444-6806

PAY PERIOD BEGIN/END DATES		HOURS WORKED	HOURLY WAGE	OVERTIME HOURS	GROSS PAY	CHECK DATE

Completed By:_____ Title:_____

Signature:_____ Date:_____

Markel
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