

On The Job Injuries

1. Upon notice of an injury, (verbal, written or otherwise) supervisors shall obtain and employees will complete, a First Report of Injury. Forms are located on BHSSC's website (bhssc.org) and may be obtained from the Business Office. BHSSC has seven (7) days to submit a First Report of Injury to our Insurance Company, therefore completed; original forms must be submitted to the main office *within* three (3) days of the injury.
2. Employees can direct specific questions regarding their claim to West River Insurance. West River Insurance may contact the supervisor, employee and any witness involved in a workers compensation claim.

West River Insurance

PO Box 13369

Springfield, IL 62791

Fax: 217-726-6943

Phone: 1-866-263-7400 – please reference company name and policy number below

Company Name on Policy: BH Special Services

Policy Number: WCMRIC100156102

3. ReliaMax may request timesheets for documentation on claims. Any time missed from work due to a workers compensation claim should be documented by the employee. Workers Compensation payment is not made for lost work time unless an employee is incapacitated for seven (7) consecutive days.

GENERAL INSTRUCTIONS

EMPLOYEE

1. Notify employer immediately of injury, as required by SDCL 62-7-10.
2. Complete all questions in the EMPLOYEE and INJURY/TREATMENT sections.
3. Sign the form.
4. Submit this form to your employer within three (3) business days after the injury.

South Dakota Employer's First Report of Injury

E M P L O Y E E	SSN: _____ Date of Birth: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Dependents: _____ Name: (Last) _____ (First) _____ (Middle Initial) _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Telephone No.: _____ Employee Signature: (X) _____ Date: _____	Education: Check One
		<input type="checkbox"/> Less than High School <input type="checkbox"/> GED or High School <input type="checkbox"/> Beyond High School
I N J U R Y / T R E A T M E N T	Date of Injury: _____ Time of Injury: _____ <input type="checkbox"/> am <input type="checkbox"/> pm Fatality Date (if applicable) _____ County Where Injury Occurred: _____ Was Safety Equipment Provided: <input type="checkbox"/> yes <input type="checkbox"/> no Time Work Day Began on Date of Injury: _____ <input type="checkbox"/> am <input type="checkbox"/> pm Was Safety Equipment Used: <input type="checkbox"/> yes <input type="checkbox"/> no Date Returned to Work (if applicable): _____ Did Injury Occur on Employer Premises? <input type="checkbox"/> yes <input type="checkbox"/> no Address or Location of Injury: _____ Description of Injury - What happened to cause injury? _____ _____ Date Employer Notified of Injury: _____ Injury Reported to: _____ Witness: _____	(See all dropdown boxes) Body Part Injured _____ _____ _____ _____ Nature of Injury (use dropdown box) _____ Cause of Injury (use dropdown box) _____ _____
	Type of Treatment (use dropdown box) <u>No Treatment</u>	Doctor, Clinic or Hospital Name: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Telephone No. : _____
EMPLOYER/EMPLOYMENT INFORMATION		
Federal ID No.: 46361575 # of Employees 500+ Black Hills Special Services Cooperative (BHSSC) PO Box 218, Sturgis, SD 57785 Telephone 605-347-4467 County Where Employer Located: Meade County		Employment Type: <input type="checkbox"/> Regular <input type="checkbox"/> Temporary Employment Status: FT Date Employee Hired: _____ Employee's Position: _____ Employee's time in Current Position: _____ Employee's Hours Per Week: _____ Employee's Current Wage: \$ _____
CLAIM OFFICE INFORMATION		Check if Claim Office is same as Insurance Provider If not, you must complete the following UNDERLYING INSURANCE PROVIDER INFORMATION
NAICS for Employer Being Insured (Nature of Business): _____ Carrier Code _____ FEIN (Claim Office) _____ Claim Office _____ Claim Office Address _____ City _____ State _____ Zip Code _____ Telephone _____ Email Address _____ Claim Office Claim # _____ Date Notified _____ Date to DOL _____		Carrier Code (If applicable) _____ FEIN (Insurance Provider) _____ Represented Entity Name _____ Address _____ City _____ State _____ Zip _____ Code _____
		Policy Number _____ Effective Dates _____ Adjuster / Contact Person _____

South Dakota Employer's First Report of Injury

GENERAL INSTRUCTIONS

EMPLOYEE

5. Notify employer immediately of injury, as required by SDCL 62-7-10.
6. Complete all questions in the EMPLOYEE and INJURY/TREATMENT sections.
7. Sign the form.
8. Submit this form to your employer within three (3) business days after the injury.

BODY PART CODES – on dropdown lists

02	Blindness one eye	44	Chest, including ribs sternum, soft ribs	78	Ring finger at metacarpal bone
03	Blindness both eyes	48	Internal organs-other than heart, lungs	79	Ring finger at proximal joint
04	Deafness both ears	49	Heart	80	Ring finger at middle joint
05	Deafness one ear	51	Hip	81	Ring finger at distal joint
10	Multiple head injury	52	Upper leg	82	Little finger at metacarpal bone
11	Skull	53	Knee	83	Little finger at proximal joint
12	Brain	54	Lower leg	84	Little finger at middle joint
13	Ear(s)	55	Ankle	85	Little finger at distal joint
14	Eye(s)	56	Foot	86	Great toe metatarsal bone
17	Mouth	57	Toe (other than greater)	87	Great toe at proximal joint
19	Face (facial bones)	58	Toe (greater)	88	Great toe at distal joint
20	Multiple neck injury	60	Lungs	90	Multiple injury
21	Vertebrae	61	Groin	92	Other toe metatarsal bone
22	Disc	67	Thumb metacarpal bone	93	Other toe at proximal joint
24	Other	68	Thumb at proximal joint	94	Other toe at middle joint
31	Upper arm	69	Thumb at distal joint	95	Other toe at distal joint
32	Elbow	70	Index finger at metacarpal bone	96	Little toe metatarsal bone
33	Lower Arm-forearm	71	Index finger at proximal joint	97	Little toe at distal joint
34	Wrist	72	Index finger at middle joint		
35	Hand	73	Index finger at distal joint		
37	Thumb	74	Middle finger at metacarpal bone		
38	Shoulder	75	Middle finger at proximal joint		
41	Upper Back	76	Middle finger at middle joint		
42	Lower Back	77	Middle finger at distal joint		

Cause of Injury Codes			
01	Body reaction/over reaction (includes chemicals)	70	Striking against or stepping on
03	Temperature extremes	78	Struck or injured by moving parts of machine
13	Caught in/under/between	81	Struck or injured, includes knife or sharp object, kicked, bit, etc. – struck by object, worker, patient, etc.
25	Fall from elevation	89	Hostile attack-person in act of crime
29	Fall from same level	90	Other than physical cause of injury
50	Motor vehicle	94	Repetitive motion – callous, blister, etc.
56	Bending/Lifting	97	Repetitive motion-carpal tunnel syndrome, etc.
65	Machinery/Equipment	99	Other

Nature of injury codes	
00	Not applicable
01	Allergy
02	Disfigurement
71	Occupational disease
72	Hearing loss