CITY OF AUSTIN

Rolling Owner Controlled Insurance Program VII

(INSERT PROJECT DESCRIPTION)

LOCATION CODE: (INSERT PROJECT #)

AUSTIN, TEXAS

ROCIP VII
CLAIMS KIT
TEMPLATE

Presented By:

MARSH

(INSERT MONTH, YEAR)

IX. ACCIDENT REPORTING AND CLAIMS PROCEDURES

A. GENERAL PROCEDURES:

This section describes basic procedures for reporting various types of Claims:

- **Workers' Compensation** (Worker/Employee Injury)
- **General Liability** (Third Party Bodily Injury or Property Damage)
- **Automobile** (notice only) and **Pollution** (notice only).

The immediate reporting of all accidents or circumstances which might lead to or involve a Claim is required. Report all injuries, occupational-related illnesses, third party bodily injury or property damage to the ***General Contractor Claim Contact*** immediately. All Parties will instruct employees and other personnel to report, in writing, within 24 hours *all* Accidents and Occurrences of any type to the ***General Contractor Claim Contact***.

Overview of Claims Reporting Process

Action Required:	Responsible	Form:
1. Accident/Injury occurs		
2. On-Site Supervisor is notified	Parties involved	
3. Claim form is completed	On-Site Supervisor	GL or WC Claim Report
4. If injury, worker is sent for medical treatment with authorization form	On-Site Supervisor,	Authorization for Medical
5. Claim form is provided to GC Claim Contact within 24 hours	On-Site Supervisor	GL or WC Claim Report
6. GC Claim Contact reports claim to insurance carrier immediately by **phone** to: **Liberty Mutual** **1-800-362-0000** **Account Number for ROCIP VII: 42404**	GC Claim Contact	GL or WC Claim Report
7. Completed form **faxed** to: **Anthony Pleasant, ROCIP Safety @ 512-974-3411** **Kevin McClelland, ROCIP Claim Advocate @ 214-303-8330**	GC Claim Contact	GL or WC Claim Report

Please refer to section B. Workers' Compensation and C. General Liability for step-by-step procedures on the following pages.

The ***General Contractor Claim Contact*** will immediately contact the **ROCIP VII Safety Representative, Anthony Pleasant and , Kevin McClelland, ROCIP Claim Advocate** in the event of any of the following "serious accidents", incidents and injuries:

Any injury for which an ambulance is called

- **Injury to head or neck**
- **Possible injury to back or spinal cord**
- **Unconscious employee**
- **Possible blindness**
- **Amputation of limbs**
- **Fatality**
- **Heart attack or stroke**
- **Hospitalization**
- **Property damage estimated over $1,000**

Investigation Assistance:

All Parties will assist in the investigation of any accident or occurrence involving injury to persons or property. All Enrolled Parties will cooperate with the companies involved in adjusting any claim by securing and giving evidence and obtaining the participation and attendance of witnesses required for the investigation and defense of any claim or suit.

When in doubt, refer all questions regarding the reporting of a claim to the ***General Contractor Claims Contact*** and/or ***ROCIP VII Claim Advocate***

(INSERT GENERAL CONTRACTOR (GC) CLAIM CONTACT)
(INSERT GC NAME)
(INSERT GC ADDRESS)

(INSERT GC CITY, STATE, ZIP)
Phone: (INSERT CONTACT PHONE #)
(INSERT GC CONTACT EMAIL)

Kevin McClelland
Marsh USA, Inc.

1717 Main St., Ste 4400
Dallas, TX 75201-7357
Phone: 214-303-8330
Cell: 214-926-5983
kevin.mcclelland@marsh.com

B. WORKERS' COMPENSATION CLAIMS REPORTING PROCEDURES:

These procedures apply to ALL employees covered by ROCIP VII for this project.

Immediately notify the ROCIP VII Safety Representative in the event of a serious injury or accident.

Contractors' on-site personnel will follow these procedures if any employee is involved in an accident or occurrence resulting in bodily injury:

1. **Contact the Injured Worker's On-Site Project Supervisor immediately and transport the injured worker to the on-site first aid or medical facility, as necessary. An *Authorization for Medical Treatment Form* is to be sent with the Injured Worker prior to the first medical treatment, which includes the request for mandatory post accident drug testing.**

2. **Report all injuries or occupational-related illnesses to the *General Contractor Claim Contact* immediately.**

3. **Project Supervisor must complete a *WC Claim Report Form* and return to the *General Contractor Claim Contact* within 24 hours of employee's notice of injury/claim. The *General Contractor Claim Contact* will call the injury/claim into the Insurance Carrier immediately.**

4. **The *General Contractor Claim Contact* will fax a copy of the *WC Claim Report Form* to Anthony Pleasant, ROCIP VII Safety Representative at 512-974-3411 and Kevin McClelland, ROCIP Claim Advocate at 214-303-8330.**

5. **An accident investigation is to be completed as soon as possible by all contractors involved in the accident. An *Incident Investigation Report* must be completed by the General Contractor Supervisor and provided to Anthony Pleasant and Kevin McClelland, ROCIP Claim Advocate at 214-303-8330.**

6. **All "serious accidents", incidents and injuries will be reported immediately by phone to Anthony Pleasant at 512-632-3333 and Kevin McClelland, ROCIP Claim Advocate at 214-303-8330.**

7. **If possible, Contractor and its lower-tier Subcontractor(s) may provide for Modified Alternate Duty based upon the work abilities given to the Injured Party from the treating physician.**

8. **Immediately send all subsequent return to work notes, inquiries or correspondence about an Injured Party to the *General Contractor Claim Contact.***

9. **No Injured Party will be allowed on a job site unless they have provided the *General Contractor Claim Contact* with the proper return to work note, either full duty or modified duty, as well as verification that post accident drug testing was completed.**

C. GENERAL LIABILITY & PROPERTY DAMAGE CLAIM REPORTING PROCEDURES:

Contractors must immediately report all Accidents at the Project Site involving death, injury, or damage to property of non-employee personnel (the public, tenants, and visitors) to the ***General Contractor Claim Contact.*** As soon as the onsite personnel become aware of the accident or occurrence, they must:

1. **Take appropriate emergency measures to prevent additional injury or damage, including contacting police and fire authorities as required by law.**

2. **Complete and submit a *GL Claim Report Form* to the *General Contractor Claim Contact* within 24 hours of the incident. The *General Contractor Claim Contact* will call the claim into the Insurance Carrier immediately.**

3. **The *General Contractor Claim Contact* will fax a copy of the *GL Claim Report Form* to Anthony Pleasant, ROCIP VII Safety Representative at 512-974-3411 and Kevin McClelland, ROCIP Claim Advocate at 214-303-8330.**

4. **An accident investigation is to be completed as soon as possible by all contractors involved in the accident. An *Incident Investigation Report* must be completed by the General Contractor Supervisor and provided to Anthony Pleasant and Kevin McClelland, ROCIP Claim Advocate at 214-303-8330.**

5. **All Serious accidents, incidents and injuries will be reported immediately by phone to the City of Austin ROCIP VII Safety Representative, Anthony Pleasant, at 512-632-3333 and Kevin McClelland, ROCIP Claim Advocate at 214-303-8330.**

6. **Immediately send all subsequent inquires or correspondence about an insured loss or claim, including a summons or other legal documents, to the *General Contractor Claim Contact* immediately.**

The first five thousand dollars ($5,000) of any insurable general liability property damage loss will be the responsibility of and paid by the Contractor and deducted from the contract amount.

D. AUTOMOBILE LIABILITY CLAIMS PROCEDURES:

No coverage is provided for automobile accidents under the ROCIP VII. It is the sole responsibility of each Party to report accidents/claims involving their automobiles to their own insurers.

However, all accidents occurring in or around the Project site must be reported to the ***General Contractor Claim Contact***. Accident investigations will occur and focus on liability arising out of the Project construction activities that could result in future claims (i.e. due to the conditions of the roads, etc.). Each Party shall cooperate in the investigation of all automobile accidents.

E. POLLUTION CLAIMS PROCEDURES:

No coverage is provided for pollution incidents under the ROCIP VII. It is the sole responsibility of each Party to report accidents/claims involving pollution coverage to their own insurers. However, all accidents occurring in or around the Project site must be reported to the ***General Contractor Claim Contact***. Accident investigations will occur and focus on liability arising out of the Project construction activities that could result in future claims involving Bodily Injury or Property Damage not deemed to have been caused by a pollution event. Each Party shall cooperate in the investigation of all pollution incidents.

F. LOSS RUNS:

An enrolled contractor may obtain loss runs for their own on-site experience by requesting, in writing on their company letterhead, directed to the ROCIP VII Administrator. Please note that the loss information is also available from the ROCIP VII Insurance Carrier.

G. ALCOHOL & DRUG TESTING:

Please refer to the City of Austin Capital Improvements Program ROCIP Project Safety Manual for the Controlled Substances Safety Policy & Procedures.

City of Austin ROCIP VII - (INSERT PROJECT # AND DESCRIPTION)

Contractor Reports to General Contractor Claim Contact
1. General Contractor Reports to Liberty Mutual @ 1-800-362-0000

Liberty Account Number for ROCIP VII: 42404

Liberty Mutual

WC

CLAIM INFORMATION

Date/Time of Injury: ☐ A ☐ M	After the call, write claim number here: **WC**
Is this claim work related? Yes No	Will the employee miss time from work? ☐ Yes ☐ No
Employer Name:	

EMPLOYEE INFORMATION

Employee's Social Security Number:		Employee's Name:	
Home Address: (Street)	(City)	(State)	(Zip)
Home Phone Number:		Male ☐ Female ☐	
Hire Date:		Number of Dependents:	Dependents under 18:
Occupation:		Department Name:	
State Hired:	Supervisor Name & Phone:		
Current Weekly Wage:	Hourly Wage:	Hours Worked per Day:	
Days Worked per Week:	Hours Worked per Day:	Employment Status:	
Employer Report No:	Employee ID No:	Was Salary Continued:	
Was Employee Paid in Full for Date of Injury:		How often is Employee Paid:	
Education Level:	Any Prior WC Injuries:	OSHA Reference No:	

EMPLOYER INFORMATION

Contact Name, Telephone Number, and Title:			
Work Location: (Street)	(City)	(State)	(Zip)
Mailing Addr: (Street)	(City)	(State)	(Zip)
Employer Location Code:		Employer SIC.:	
Employer FED ID:		Employer Code:	
Nature of Business:			
Contract Number:			

ACCIDENT INFORMATION

Did the Accident Occur at the Work Location? Yes ☐ No ☐	If No, Where Did the Accident Occur?		
Project Name:	Project Site Code:		
Accident Address: (Street)	(City)	(State)	(Zip)
Nature of Accident:			
Give a Full Description of the Accident: (Be as Complete as Possible)			

Are Other WC Claims Involved? Yes ☐ No ☐	Date and Time Reported to Employer:
Person Reported To:	

INJURY INFORMATION

Injury Description:

Date of Death (*if applicable)*:	Is Employee Hospitalized? Yes☐ No☐
Lost Time? Yes ☐ No ☐	If Yes, What was First Full Day Out:
Date Last Day Worked:	Date Disability Began:
Date Returned to Work:	**OR** Estimated Return to Work Date:

Time Workday Began:

Which Part of the Body was Injured? (e.g. Head, Neck, Arm, Leg)?	Nature of Injury: (e.g. Laceration, Bruise, Fracture)
Part of Body Location: (e.g. Left, Right, Upper, Lower?)	Source of Injury:

MEDICAL INFORMATION

Safeguards Provided? Yes ☐ No ☐ Safeguards Utilized? Yes ☐ No ☐

Initial Medical Treatment: (Select One) ☐ ER Treated and Released ☐ Hospitalized ☐ Physician/Clinic ☐ Minor/Onsite ☐ No Medical Treatment

Hospital - Name, Address, Phone:

Clinic/Doctor - Name, Address, Phone:

WITNESS INFORMATION

Were there any Witnesses? Yes No

If Yes, List Names and How to Contact Them:

ADDITIONAL COMMENTS & INFORMATION

REPORT PREPARED BY

Name:	Title:
Signature:	Phone:

City of Austin ROCIP VII - (INSERT PROJECT # AND DESCRIPTION)

1. Contractor Reports to General Contractor Claim Contact
2. General Contractor Reports to Liberty Mutual @ 1-800-362-0000

Liberty Account Number for ROCIP VII: 42404

GL

Date of Accident	Time

POLICYHOLDER

Insured Name	Insured Phone	Project Name	Project Site Code

Insured Address, City, State, Zip

Mailing Address, City, State, Zip (If Different)

DESCRIPTION OF ACCIDENT

Address Where Accident Occurred (Street, City, State, Zip)

Exact Location of Accident (i.e.: AISLE 1, PRODUCE DEPT.)

Accident Description (be as specific as possible)

Was there a 3rd Party Involved? Yes No	Name of 3rd Party

WITNESS

Witness Name	Address, City, State, Zip	Phone
Witness Name	Address, City, State, Zip	Phone
Witness Name	Address, City, State, Zip	Phone

PROPERTY DAMAGE

Name of Owner	Home Phone	Business Phone

Address, City, State, Zip

Type of Property Damage

PERSONAL INJURY

INJURED PARTY 1

Name of Person Injured	Sex

Name of Parent or Guardian of Under 18 yrs.

Address, City, State, Zip

Home Phone	Business Phone

D.O.B.	Age	Social Security Number

Description of Injuries

Medical Treatment (i.e.: Hospital/Clinic Name, Address, Phone)

INJURED PARTY 2

Name of Person Injured	Sex

Name of Parent or Guardian of Under 18 yrs.

Address, City, State, Zip

Home Phone	Business Phone

D.O.B.	Age	Social Security Number

Description of Injuries

Medical Treatment (i.e.: Hospital/Clinic Name, Address, Phone)

ADDITIONAL COMMENTS

CITY OF AUSTIN
ROCIP VII
AUTHORIZATION FOR MEDICAL TREATMENT

SEND WITH INJURED WORKER OR FAX TO MEDICAL PROVIDER PRIOR TO THE FIRST MEDICAL TREATMENT

FACSIMILE TRANSMITTAL SHEET

TO: *Medical Provider* **FAX NUMBER:**

FROM: **PHONE:**

TOTAL NO. OF PAGES INCLUDING COVER: **DATE:**

RE: *Injured Worker*

CITY OF AUSTIN ROCIP VII

Project Name & Site Code: (INSERT PROJECT # AND DESCRIPTION)

Enrolled Contractor Name & Address:

_____**Contractor WC Policy Number:** _____

Contractor Main Contact Person:_____**Phone:** _____

Employee Name/Injured Worker:_____**DOB:** _____

Date of Incident:_____**Description of Incident:** _____

Which of the following test(s) will be administered to the injured worker?

__**Drug Screen Breath Alcohol** **X Drug Screen & Breath Alcohol** **Urine Collection Only**

ALL DRUG SCREEN/BREATH ALCOHOL TEST RESULTS & BILLS WILL BE SENT TO:
(INSERT GC CLAIM CONTACT INFO – FROM CLAIM CONTACT SECTION)

TO MEDICAL PROVIDER:

Send **Medical Bills only** and **Reports** to ROCIP VII Insurance Carrier:

Liberty Mutual Group
Central Billing Unit
P.O. Box 7203
London,KY 40742

Phone: 1-800-300-0110 for inquiries or pre-authorization
ROCIP VII Account Number: 42404

City of Austin ROCIP VII
Incident Investigation Report

This form must be completed within 24 hours after the incident

1. Company:	2. Project Name: (INSERT PROJECT # AND DESCRIPTION)	3. Project Site Code: **(INSERT PROJECT #)**
4. Company Contact:	5. Phone Number:	
6. Exact Location of Incident:	7. Date of Incident:	
	8. Time:	
	9. Date Reported:	
City/State:	10. Job-Site Phone Number:	

11. Type of Loss: D WC D Environmental D Liability D Property D Fire D Crime D CIP D Other

Injury or Illness	Property Damage (Vehicle, Building, Equipment)	Other Incidents
12. Name of Injured		
13. Company		
14. Age and Years Experience		
15. Part of Body Affected		
16. Nature of Injury/Illness		
17. Object/Equip/Substance Inflicting Injury		
18. Person with Most Control		
19a. OSHA Recordable D Yes D No	19b. Lost Time D Yes D No	19c. Days Lost

20. Person Injured:

Date of Birth:_ Social Security #:_____ Marital Status: ___

Date of Hire:_ Job Title: _____

_____ Address: _____

_____

Telephone No:_____ Return to Work Date: ___

Name of Medical Provider: _____

21. Describe clearly how the incident/accident occurred

22. Identify improper acts and/or condition that were the primary causes:

23. Why did the unsafe acts or conditions in 22 above occur?:

Fax All Forms to: Anthony Pleasant @ 512-974-3411
City of Austin ROCIP Safety Representative

Evaluation: Check the Severity and Recurrence Potential for a similar incident/accident.	
24. Severity Potential D Major D Serious D Minor	25. Recurrence Potential D Frequent D Occasional D Rare
26. Have similar incidents occurred previously? D Yes D No	
27. Comments on reason for occurrences:	
28. **Steps to prevent recurrence** List those steps that have or must be taken to prevent a recurrence:	**Follow-up Action** Intermediate Action Taken-Date: / Completion Date:
29. Did this involve a defective machine, tool, vehicle or product? D Yes D No	

30. Witness:	Name:
	Address:
	City, State, Zip:
Attach Witness Statement	
Witness:	Name:
	Address:
	City, State, Zip:
Attach Witness Statement	
Witness:	Name:
	Address:
	City, State, Zip:
Attach Witness Statement	

31. Police Dept. Responding Name:

Precinct: Shield Number:

32. Investigated by:	Date:	Reviewed by:	Date:
33. Report Completed By:		Title:	