Accident/Incident Vehicle Packet

Town of Collierville

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ACCIDENT/INCIDENT REPORTING INSTRUCTIONS

If you are involved in an accident or have a liability claim, please follow these steps:

At the Scene of the Accident/Incident:

1) Report accident to your Supervisor immediately.

2) Contact Police Dispatch at 853-3207 to make an official accident report for incidents involving vehicles.

3) Give the "Insurance Claim Contact Information" (Page 2) to the other party involved in the accident/incident.

4) Complete "Accident Form" located on page 4.

5) Take pictures if possible.

Post Accident/Incident Requirements:

1) Supervisor is to email, fax, or deliver the Accident Form/Supervisor's Investigative Report (Page 4-5) containing all the information to insuranceclaims@colliervilletn.gov / 457-2258 / Town Hall within 24 hours of the accident/incident. Include the Police Report and pictures if you have them.

2) The Risk Management office will file the insurance claim (if required).

Out-of-Town Accident/Incident Reporting:

1) If accident/incident occurs outside of Collierville, you should call the local authorities.

2) Go through numbers 1-5 of the "At the Scene of the Accident/Incident" shown above.

3) The Town's Risk Management office will obtain a copy of the jurisdiction's accident report. You have the responsibility of notifying the appropriate representatives in all cases. The Risk Management office will handle the entire insurance claim process. Make no statement without the Town's representative's approval.

Per Human Resources:

1) A completed First Report of Injury (page 7) and Supervisors Investigative Report (page 5) should be forwarded to the H/R Department within 24 hours of the accident/incident. This should be done even if the employee did not sustain a noticeable injury. If you have any questions, please contact the H/R Department at 457-2290.

Revised: 11 September 2019

Workers Compensation Guidelines

1. **First Report of Injury** – The injured employee's supervisor (or supervisor's designee) must fill out the first report of injury form. We have indicated that there are deadlines for Human Resources (HR) to receive this information, but the bottom line is, as soon as HR is put on notice, the sooner Public Entity Partners is on notice, which aids in facilitating treatment and care for the injured employee.

   Scan (sford@colliervilletn.gov) or fax (457-2295) to HR as soon as the form is filled out (ideally by the end of the shift, but no later than 24 hours). Send original copy of first report of injury to HR through interoffice mail.

   ******HR must know at time of First Report submission if employee was transported by ambulance!******

2. **Supervisor's Investigative Report** – Supervisor (or Designee) must fill out this form.

   Scan/fax to HR as soon as report can be filled out.

3. **Employee's Choice of Physician** - The injured employee will choose a physician at the time they report their injury. A physician is chosen even if the employee declines to see a physician at the time of the injury. If an employee is seen in the emergency room, this form will still have to be completed after the ER visit for follow-up care with a panel physician.

   Scan/fax to HR after obtaining the employee's signature at notification of injury and send the original to HR through interoffice mail. **A copy of the signed election needs to be given to the employee.**

4. **Compensation Consent Form** - At the time the first report of injury is done, the employee must indicate whether they want to use their personal leave time for instances where Public Entity Partners does not reimburse wages. This form needs to be completed even if the employee indicates they do not want to seek medical attention at the time of notification of the injury.

   Scan/fax to HR after obtaining the employee's signature at notification of injury and send the original to HR through interoffice mail.

5. **OPTUM** - The injured employee will need to take this form with them to the pharmacy if they see a physician and are issued prescriptions.

   Give this form to the employee at the time of notification of an injury.

6. **Workers' Compensation Procedures/Instructions** - This is a notification to the injured employee of their rights and Town procedures.

   Give this information to the employee at the time of the notification of the injury.

Send all original documents to HR after scanning.

TML IS NOW PUBLIC ENTITY PARTNERS (PE PARTNERS)

Packet Revision 8/2024

Town of Collierville

(Give to other party involved)

INSURANCE CLAIM CONTACT INFORMATION:

General Services Department

Attn: Jennifer Benjamin, Risk Management and Safety Program Coordinator

500 Poplar View Parkway

Collierville, TN 38017

Email: insuranceclaims@colliervilletn.gov

T: (901) 457-2250

F: (901) 457-2258

INSURANCE IDENTIFICATION CARD

STATE
TENNESSEE

COMPANY
PUBLIC ENTITY PARTNERS

COMPANY NUMBER
NA-RISK POOL

POLICY NUMBER
PLI-0070-25

EFFECTIVE DATE
07/01/2024

EXPIRATION DATE
07/01/2025

DESCRIPTION OF AUTOMOBILE
ALL OWNED OR HIRED VEHICLES OPERATED BY THE INSURED

AGENCY
DIRECT WITH PUBLIC ENTITY PARTNERS
562 FRANKLIN ROAD SUITE 200
FRANKLIN TN 37069

INSURED
TOWN OF COLLIERVILLE
500 POPLAR VIEW PKWY
COLLIERVILLE TN 38017

An insurance policy has been issued that satisfies the requirements of Tennessee Financial Law

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THIS CARD SHOULD BE KEPT IN THE INSURED VEHICLE AND PRESENTED UPON DEMAND

IN CASE OF ACCIDENT: Report all accidents to your agent or Public Entity Partners as soon as possible.

Always obtain the following information at the accident scene:

1. Name and address of each driver involved in the accident.
2. Name of insurance company and policy number for each vehicle involved.
3. Name and badge number of responding police officer.
4. Police accident report number if available.

The insured may duplicate this card as needed to supply any covered auto.

Ed. 7/1/2012

ACCIDENT FORM

DATE: _____ NAME: _____

DEPARTMENT: _____VEHICLE #: _____ TIME OF ACCIDENT: _____

TOC POLICE REPORT FILE #: _____

LOCATION OF ACCIDENT: _____

_____

(PLEASE USE THE BACK OF THIS FORM FOR DIAGRAM DRAWINGS)

OTHER VEHICLE INFORMATION

NAME OF DRIVER: _____D/L#: _____

NAME OF OWNER: _____

ADDRESS OF OWNER: _____

_____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE:_____

INSURANCE INFORMATION

COMPANY: _____

POLICY #: _____

ADDRESS OF INSURANCE COMPANY: _____

_____

WITNESS INFORMATION

NAME: _____

ADDRESS: _____

_____

NAME: _____

ADDRESS: _____

_____

USE ADDITIONAL SHEETS IF MORE WITNESSES ARE AVAILABLE

REVISED: 13 May 2013

AP-060

SUPERVISOR'S INVESTIGATIVE REPORT

NAME _____ **AGE** _____ **TIME** _____ **DATE** _____

DEPARTMENT _____ **SHIFT** _____ **JOB** _____ **HOW LONG** _____

WHAT HAPPENED? Describe what took place or what caused you to begin this investigation.

WHY IT HAPPENED? Get all the facts by studying the job and situation involved. Question WHAT – WHERE – WHEN – WHO - HOW

WHAT SHOULD BE DONE?

Determine which of the 12 items Under EMP require attention:
(Select all that apply)

EQUIP	MATERIAL	PEOPLE
☐ Arrange	☐ Place	☐ Place
☐ Use	☐ Handle	☐ Train
☐ Maintain	☐ Process	☐ Lead

WHAT HAVE YOU DONE THUS FAR? Take or recommend action depending upon your authority. Follow-up – was the action effective?

WILL THIS IMPROVE OPERATIONS? Objective: Eliminate job hindrance.

FILED BY: _____ **DATE:** _____

REVIEWED BY: _____ **DATE:** _____

For Reference Only

APPbig\ BILITY OF FINANCIALRESfONSJI ILUY LAW TQ criY OWNED MOTOR VEHIC LE$.

T.C.A. 55-12-139(b)(3) provides in.part "the motor vehicle being operated at the tirne of the violation was owned by ... this state or any political subdivision thereof, .and that such motor vehide was being operated with the owner's consent."

Our interpretation of this subsection is that an operator of a motor vehicle may comply with the statute by providing evidence of ownership by the municipality such as a vehicle registration.

In the unlikely event that this evidence does not satisfy the officer, subsection (e) provides that "on or before the court date, the person so charged may submit evidence of compliance with this section at the time of the violation" and the charge of failure to provide evidence of financial responsibility may be dismissed.

The clear intent of this statute is to exempt vehicles owned by the state and its political subdivisions, including municipalities, from the documentation requirements set out in subsections (b)(l) and (2).

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)

CLAIMS ADM CLAIM # (INSURER CLAIM #)

OSHA LOG CASE #

CLAIM TYPE CODE
- ☐ MED ONLY
- ☐ INDEMNITY
- ☐ BECAME LOST TIME
- ☐ BECAME MED ONLY
- ☐ NOTIFY ONLY
- ☐ TRANSFER

NAME OF INSURANCE CARRIER: Public Entity Partners

CARRIER FEIN: 62-1074045

CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)

FEIN OF CLMS ADM: 59-2863407

CLAIMS ADJUSTER NAME: Carrier Fax # (615) 370-0593

CLMS ADJ PHONE #: (615) 371-0049

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2: 562 Franklin Rd, Suite 200

CITY: Franklin | STATE: TN | ZIP: 37069

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE TENNESSEE WORKERS' COMPENSATION LAW AND MUST BE COMPLETED AND FILED WITH YOUR INSURANCE CARRIER IMMEDIATELY AFTER NOTICE OF INJURY.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS' COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

IF YOU HAVE QUESTIONS, THE STATE NOW HAS A BENEFIT REVIEW SYSTEM WHERE A WORKERS' COMPENSATION SPECIALIST CAN PROVIDE ASSISTANCE. CALL 1-800-332-2667 (TDD).

EMPLOYER

EMPLOYER NAME: Town of Collierville

EMPLOYER FEIN: 62-6000268

SIC CODE

PHONE NUMBER: (901) 457-2290

EMPLOYER ADDRESS LINE 1 AND LINE 2: 500 Poplar View Pkwy

NATURE OF BUSINESS: Municipality

CITY: Collierville | STATE: TN | ZIP: 38017

INSURED REPORT #

EMPLOYER LOCATION

POLICY

INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)

POLICY NUMBER

SELF INSURED? ☐ YES ☐ NO

EFF DATE

EXP DATE

EMPLOYMENT STATUS CODE
- ☐ FULL TIME/REGULAR
- ☐ PART TIME
- ☐ PIECE WORKER
- ☐ SEASONAL
- ☐ VOLUNTEER
- ☐ APPRENTICE FULL TIME
- ☐ APPRENTICE PART TIME

EMPLOYEE

EMPLOYEE LAST NAME

PHONE INCL AREA CODE

FIRST | MI

DEPARTMENT REGULARLY WORKED

GENDER
- ☐ MALE
- ☐ FEMALE
- ☐ UNKNOWN

ADRRESS LINE 1 & 2

OCCUPATION DESCRIPTION

CITY | STATE | ZIP

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

NCCI CLASS CODE

SSN | DATE OF BIRTH | DATE OF HIRE

WAGE

WAGE $

PERIOD
- ☐ HOURLY
- ☐ DAILY
- ☐ WEEKLY
- ☐ BI-WEEKLY
- ☐ MONTHLY

NUMBER OF DAYS WORKED PER WEEK

SALARY CONTINUED IN LIEU OF COMPENSATION ☐ YES ☐ NO

FULL WAGES PAID FOR DATE OF INJURY ☐ YES ☐ NO

ACCIDENT/INJURY

DATE OF INJURY

TIME OF INJURY ☐ AM ☐ PM ☐ COULD NOT BE DETERMINED

TIME EMPLOYEE BEGAN WORK ON INJURY DATE ☐ AM ☐ PM

DATE EMPLOYER NOTIFIED OF INJURY

BODY PART AFFECTED CODE

NATURE OF INJURY CODE

CAUSE OF INJURY CODE

DATE CLAIM ADM NOTIFIED OF INJURY

HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.

DATE LAST DAY WORKED

DATE DISABILITY BEGAN

RETURN TO WORK DATE (IF APPLICABLE)

DATE OF DEATH (IF APPLICABLE)

IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP
- ☐ WIDOW
- ☐ WIDOWER
- ☐ MOTHER
- ☐ FATHER
- ____ DAUGHTER
- ____ SON
- ____ SISTER
- ____ BROTHER
- ____ HANDICAPPED CHILD

TOTAL # DEPENDENTS

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

ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES) CITY STATE ZIP

COUNTY OF INJURY

TREATMENT

PHYSICIAN NAME

HOSPITAL OR OFF SITE TREATMENT NAME

ADDRESS LINE 1 AND 2

ADDRESS LINE 1 AND 2

CITY | STATE | ZIP

CITY | STATE | ZIP

INITIAL TREATMENT
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYER
- ☐ MINOR BY CLINIC/HOSPITAL
- ☐ HOSPITALIZED > 24 HRS
- ☐ EMERGENCY CARE
- ☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

DATE PREPARED

PREPARER'S NAME & TITLE

PREPARER'S COMPANY NAME: Town of Collierville

PHONE NUMBER

WORKERS' COMPENSATION PROCEDURES/INSTRUCTIONS
WC02-01

You have the right to a safe workplace!

You have the right to raise a safety concern with the Town of Collierville or confidentially with OSHA directly or report a work-related injury or illness without being retaliated against. You have the right to receive information and training on job hazards, including all hazardous substances in your workplace. You have the right to request an OSHA inspection of your workplace if you believe there are unsafe or unhealthy conditions, and OSHA will keep your name confidential. You have the right to file a complaint with OSHA within 30 days if you feel you have been retaliated against for using your rights. You have the right to see any citations issued to the Town of Collierville by OSHA and you can request copies of your medical records, tests that measure hazards in the workplace, and the workplace injury and illness log.

IT IS YOUR RESPONSIBILITY TO NOTIFY YOUR SUPERVISOR(S) OF ANY INJURY THAT HAS OCCURRED DURING YOUR WORKING HOURS.

If you are injured while on duty and follow the procedures outlined here, your initial and follow-up visits will be paid by our Workers' Compensation Carrier, Public Entity Partners (PEP).

- It is your responsibility to notify your supervisor of any injury that you experience while on duty. You must report all accidents, injuries, illnesses, or near misses while at work to your supervisor/department director as soon as possible, but no later than two (2) hours after the occurrence.

- It is the responsibility of your supervisor, or other department designee, to complete the First Report of Injury form and to give you the following documents: Employee's Choice of Physician form, Compensation Consent form, OPTUM pharmacy information, Workers' Compensation Procedures/Instructions.

- It is your responsibility to keep your supervisor notified regarding your work status. Whenever you have the ability, you are to bring any time off, status, or return-to-work statements to your supervisor. You are expected to keep your supervisor advised daily of your status.

Completion of the First Report of Injury and Employee's Choice of Physician forms does not mean that you must see a physician. However, failure to follow the proper guidelines as set forth in this notice could affect your claim status. Filling out the forms means you have been injured in your regular course of duty and you are notifying the proper authorities that an injury has occurred.

Should a problem with your injury not immediately surface, and the effects not be felt until later, you will have already gone through the correct procedures to have your injury recognized by PEP.

Failure to make a timely initial notification could result in your claim being denied, or investigated for denial, by PEP.

PRESCRIPTIONS

Do not present your health insurance card for prescriptions.

If you are issued a prescription from one of the panel physicians, refer to the OPTUM pharmacy information. You may use any pharmacy in that provider network (listed on the OPTUM instruction document) and give the pharmacy your name, social security number and date of injury. The pharmacy will keep the document from your packet, and you may return to that same pharmacy for any subsequent prescriptions or refills related to your injury, at no charge to you. Do not present your health insurance card for prescriptions. Your health insurance and your workers' compensation coverage are two separate plans.

If you are unable to use one of the pharmacies in the network you must pay for the prescription in full and file for reimbursement from PEP. Failure to manage your prescriptions in either of these manners could result in your prescriptions not being covered by PEP.

SPECIALISTS

If your panel physician indicates that you need a specialist or physical therapy, have that doctor fax their order to Human Resources at (901) 457-2295, or you may bring the order to HR. That order will be sent to PEP, and they will assign a panel of specialists for you to choose from. PEP will make all specialist appointments. In most cases a nurse case manager will be assigned to coordinate your care with the specialist.

This includes when an injury requires surgery or a surgery consultation. Most of your information regarding appointments, surgeries, place of surgery, etc., will be supplied by PEP and the nurse case manager.

EMERGENCY ROOM

In a true emergency, either Baptist Collierville or Methodist Germantown may be used.

If you are seen in the emergency room and are told to see your "regular/normal" physician for follow-up care, that means you are to use one of the panel approved physicians for any follow-up care needed.

PAYMENTS

You are not responsible for any payments to the providers when you are being seen for a workers' compensation injury. Remember, this coverage is totally separate from your current health care coverage. **DO NOT** submit your health insurance card to any provider that you see for a workers' compensation injury.

USE OF PERSONAL LEAVE

You will indicate on the Compensation Consent Form your decision to use your personal leave totals for the periods of time that you do not receive workers' compensation payments. Some of the instances that you could use personal leave are as follows:

- The date of your injury, and the first 7 calendar days following your injury that are not compensable through PEP.

- Personal leave can be used for the 33 1/3% that PEP does not pay. PEP only compensates an injured worker at 66 2/3 % of the employee salary. That will leave approximately 15 hours per week unpaid if you choose not to supplement with your personal leave totals.

- Any doctor appointments, physical therapy appointments, and out-patient testing appointments made and kept during work hours after you've been returned to work are not compensable through PEP.

OTHER INFORMATION

Your time off work will run concurrently with FMLA, whether paid or unpaid.

ALSO REMEMBER -- You are prohibited from engaging in secondary employment while on light duty or removed from duty. Personnel Policies and Procedures Manual, Chapter 14, Section 3, #5: "Approval for outside employment is revoked during an employee's disability or limited duty status". Strict adherence to this rule is required or you will be subject to disciplinary action.

Failure to comply with any of these instructions could result in your workers' compensation benefits being denied.

If you have any questions regarding these procedures, you are welcome to discuss them with your supervisor. If they wish to verify a procedure, they will either contact Human Resources or have you come directly to Human Resources for your information.

FORM C-42

TENNESSEE
BUREAU OF WORKERS' COMPENSATION

EMPLOYEE'S CHOICE OF PHYSICIAN
Medical Panel

Employer

- List at least three physicians and provide this panel to employee upon the report of a workplace injury.
- Keep the completed original form on file and send a copy to the employee for their records.
  - Do *not* send this form to the State unless requested.

Employee

- Fill out the bottom portion of this form to indicate which physician you choose.
  - If you refuse to accept medical services from the chosen physician, your rights to benefits may be delayed.
  - Traveling more than 15 miles (one way) to (or from) medical treatment? Employees may seek reimbursement of their travel expenses from the insurance carrier.
- Send completed form back to your employer.

TO BE COMPLETED BY THE **EMPLOYER:**

Employee Name _____ Date Panel Provided _____

Employer **TOWN OF COLLIERVILLE** Date of Injury _____

Employer Contact **Shanda Ford** Phone **(901) 457-2290** Email **sford@colliervilletn.gov**

Physician 1	Physician 2	Physician 3	Physician 4
Name: **Joseph Holley** First Choice Care	Name: **Mark Fowler** Baptist Urgent Care	Name: **Hamad Ahmad** People First Urgent & Primary Care	Name: **Monica Griffin** Baptist Minor Medical
Phone: **(901) 854-5771** Address: **472 W Poplar Ave #201 Collierville TN 38017**	Phone: **(901) 860-0536** Address: **397 New Byhalia Rd Collierville TN 38017**	Phone: **(901) 673-1240** Address: **853 W Poplar Ave Collierville TN 38017**	Phone: **(901) 753-7686** Address: **670 N Germantown Pkwy #18 Cordova TN 38018**
Hours: Mon and Fri: 8am to 6pm Tue, Wed, Thur, Sat: 8am - 6pm Sun: Closed	Hours: Mon-Fri: 8am to 8pm Sat: 9am to 5pm Sun: 1pm to 5pm	Hours: Mon-Fri: 8am to 6pm Sat: 8am to 5pm Sun: Closed	Hours: Mon-Fri: 8am to 5pm Sat and Sun: Closed
Is Telehealth available with Physician 1? Yes No	Is Telehealth available with Physician 2? Yes No	Is Telehealth available with Physician 3? Yes No	Is Telehealth available with Physician 4? Yes No
Web address: firstchoicecarecollierville.com	Web address: baptisturgentcare.net	Web address: peoplefirsturgentcare.com	Web address: baptistonline.org

(Optional) Telehealth-Only **Physician 5** Name _____ Phone _____

Telehealth Provider email address _____ Web address _____

TO BE COMPLETED BY THE **EMPLOYEE:**

I have selected the following physician from the list provided to me by my employer:

Physician Name _____ Appt Date/Time _____

I select: In-person treatment ☐ or Treatment by Telehealth ☐ Were you offered in-person treatment? Yes ☐ No ☐

Employee Signature _____ Date _____

FORM C-31

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation

MEDICAL WAIVER AND CONSENT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, _____ having filed a claim for workers' compensation benefits, do hereby authorize

_____
(Name of Medical Provider)

To furnish to my employer or my employer's representative, and/or the Division of Workers' Compensation any information or written material reasonably related to my work-related injury for which I am claiming compensation.
I further authorize the release of the same information to me or my attorney.

The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

A photocopy of the authorization may be accepted in lieu of the original.

Dated: _____ ,20 _____

_____ _____
Patient Social Security last four numbers

_____
Witness

LB-0379 (REV 08/09) RDA 10183

COMPENSATION CONSENT FORM *(03/01/2023)*

Employee	Department	Date

Please be advised that your workers' compensation absence(s) from work will be managed in the following manner:

- The first 7 days off work after your injury will be unpaid.
- Days 8 until the date you return-to-work will be reimbursed through Public Entity Partners at a rate of 66 2/3% of your wages.
- After day 14, the time off for the first 7 days after your injury will be reimbursed by Public Entity Partners at a rate of 66 2/3%. The day of your injury will never be reimbursed by Public Entity Partners.

If you have sick, vacation or compensatory time leave balances, you may use these totals to make up the difference in wages. If you choose to use your leave balances to supplement your pay, that will apply to Days 1-7 at 100%. For Days 8 until you return to work, your department will submit leave hours to payroll based on your standard work week. You will be paid for those hours through the Town's payroll and the hours will be deducted from your leave balances.

Example: If your standard work week is 40 hours, 3 hours per day (15 per week) will be used from leave totals.

Leave balances will be used in the following order with no deviations: 1st sick, 2nd vacation and, 3rd compensatory time.

Your Public Entity Partners' temporary disability benefits checks (wage replacement) are issued bi-weekly based on date of injury. Generally, you would receive the first check 14-21 days after your date of injury. Your check from the Town for any leave balances (if you choose to use them) will be issued on the Town's normal pay dates.

At any time you are in a non-pay status through the Town's payroll (i.e., you elect not to use your leave totals or you exhaust all your accrued time), **you will be responsible for paying your insurance premiums to Human Resources on the Town's normal pay dates.** Human Resources will contact you with details. Non-payment of premiums could result in coverage/claims being pended, and in some instances your coverage could be cancelled.

◯ **I authorize the use of my leave totals to supplement my pay during my workers compensation absence.**

Signature: _____ Print Name: _____ Date: _____

◯ **I do not authorize the use of my leave totals to supplement my pay during my workers compensation absence.**

Signature: _____ Print Name: _____ Date: _____

How do you want to receive your Public Entity Partners temporary disability benefit check?

◯ Mail it to my home address ◯ I will pick it up from Human Resources in Town Hall.

Current mailing address: _____

* *Your choice to authorize or not authorize the use of leave totals to supplement your pay may not be changed.*
* *Leave balances will be deducted based on standard work week hours and will represent approximately 33 1/3% of your pay.*
* *Workers' compensation absences run concurrently with FMLA (See Chapter 9 of the Personnel Policies and Procedures.)*

OPTUM®

PUBLIC ENTITY PARTNERS

Optum
PO Box 152539
Tampa, FL 33684-2539

Approved Pharmacies:
Walmart
Kroger
Target/CVS
Walgreens
Benevere

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below. *Please note this First Fill card is valid for 10 days from initial use. However, if your claim is accepted and set up with Public Entity Partners, you will need to process your prescriptions using your permanent pharmacy card, even if it is within that 10 day period.*

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-940-4459 or visit www.tmesys.com.

If you have any questions or need assistance, please contact or have the pharmacy contact Optum at:

1-866-940-4459

OPTUM

PUBLIC ENTITY PARTNERS

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Public Entity Partners Workers' Compensation Program — CARRIER/TPA

TOWN OF COLLIERVILLE — EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER — DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-866-940-4459

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	PEPFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®