# IMPORTANT

## Keep your policy in a safe place. Read your policy carefully . . .

### If you have any questions, contact your representative who will be happy to help you.

**To file a claim:**

As soon as possible, within one business day, report your claim to Church Mutual. Prompt claims reporting is important because it helps facilitate proper care of the injured person and ultimately, reduces the dollar cost of the claim. Lower claims costs help keep down the cost of insurance.

If an employee was injured at work and *has* ***not*** *yet* sought medical care, call Church Mutual's Nurse Hotline powered by Medcor® at:

Phone: (844) 322-4662

If an employee has already sought medical care, please report the claim to Church Mutual by calling:

Phone: (800) 554-2642, Option 2

For workers' compensation claims, you may also need to submit a state-specific First Report of Injury notice. These forms are

available in the Claims section of w ww.churchmutual.com and from

our workers' compensation claims handlers.

**If an injury is life threatening or fatal, call 911.**



**Church Mutual Insurance Company** 3000 Schuster Lane

Merrill, WI 54452

(800) 554-2642

[www.churchmutual.com](http://www.churchmutual.com/)

A Mutual Company Nonassessable Policy

WORKERS' COMPENSATION POLICY

UN 505 CW (03-17)

# IMPORTANT NOTICE REGARDING INJURY TO AN EMPLOYEE

Your state requires you, as an employer, to notify us immediately following any work-related injury even if the employee does not seek immediate medical attention.

Prompt claims reporting is important not only because it's the law, but also because it helps facilitate proper care of the injured person and ultimately, reduces the dollar cost of the claim. Lower claims costs help keep down the cost of insurance.

In order to satisfy your obligation under state law, you are required to complete a form that can be obtained by either of the following methods:

1. Visit the Claims Center at w ww.churchmutual.com
2. Contact us at (800) 554-2642, select Option 2, then 1.

If your claim requires the completion of additional forms, we will notify you. Forward completed forms to:

**CHURCH MUTUAL INSURANCE COMPANY PO BOX 342**

**MERRILL WI 54452-0342**

**Fax: (715) 539-4651**

**Email:** **claims@churchmutual.com**

**FAILURE TO REPORT CLAIMS IMMEDIATELY**

**COULD RESULT IN STATE-IMPOSED FINES FOR YOUR ORGANIZATION.**

UN 853 (04-14)

**WORKPLACE HEALTH AND SAFETY CONSULTATION SERVICES**

(Risk Control)

Church Mutual Insurance Company offers workplace health and safety consultation services at no additional charge. This service, performed by a Risk Control Representative, can help you develop and/or refine your employee safety program. The service includes analysis of workers' compensation loss history, site inspection, and evaluation of potential hazardous conditions or practices. Safety recommendations will be submitted in writing.

Requests for risk control consultation should be directed to:

Church Mutual Insurance Company Risk Management Department 3000 Schuster Lane

Merrill, WI 54452

Phone: 1-800-554-2642, Extension 4459

Fax: 715-539-4650

E-mail: riskmanagement@churchmutual.com

UN 682 (07-13) **CHURCH MUTUAL INSURANCE COMPANY**



TO THE EMPLOYER: THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE UPON YOUR PREMISES.

**NOTICE**

**REGARDING WORKERS’ COMPENSATION INSURANCE**

**ALL WORKERS EMPLOYED BY THE UNDERSIGNED ARE HEREBY NOTIFIED THAT THE EMPLOYER HAS COMPILED WITH THE LAW AS TO SECURING THE PAYMENT OF COMPENSATION TO HIS EMPLOYEES AND THEIR DEPENDENTS, IN ACCORDANCE WITH THE PROVISIONS OF THE WORKER’S COMPENSATION LAW.**

Date:

Employer:

Employer’s Authorized Agent:

An Employee receiving an injury by accident must immediately notify his/her supervisor, superintendent, or the undersigned, who will provide medical attendance.

Claim for compensation must be made in writing and given to the employer. Forms for giving notice of injury and making claim for compensation will be furnished by the employer; by the surety,

or upon application, by the Industrial Commission in Boise, Idaho.

ICREV 11/94.EMP

## WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

Employer (Name & Address incl. zip) Carrier/Administrator Claim Number Report Purpose Code

### Enriched Senior Living, LLC 31 McKercher Blvd

Jurisdiction

Jurisdiction Claim No.

### Hailey ID 83333

**General**

NAICS Code Employer FEIN

47-3170744

Carrier (Name, Address & Phone Number)

Insured Report No.

Employer’s Location Address (if different) Location No.

### Same

Phone No.

Policy Period Claims Admin (Name, Address & Phone Number)

### Church Mutual Insurance Company 3000 Schuster Lane

**Carrier/Claims Admin**

Merrill, WI 5442

To

12/01/18

12/01/17

Check if self insured

Carrier FEIN

Agent Name & Code Number

Policy Number or Self-Insured Number

0325770 07 085868

Administrator FEIN

Propel Insurance 360-562-4818

Legal Name (Last, First, Middle) Birth Date Social Security Number Date Hired State of Hire

Address (Incl. Zip)

**Employee**

Phone

Sex Male

Female Unknown

No. of Dependents

Marital Status

Unmarried/ Single/Div. Married Separated Unknown

Occupation/Job Title

Employment Status NCCI Class Code

Wage Rate

### $

Day Week

Month Other

# Days Worked/WK

# Hrs Worked per Day

Full Pay for Date of Injury? Did Salary Continue?

Yes No

Yes No

Time Employee Began Work

AM Date of Injury

PM or Illness

Time Occurred

AM Last Work Date PM

Date Employer Notified

Date Disability Began

Employer Contact Name/Phone Number

Type of Illness/Injury

ype of Illness/Injury Code

Part of Body Affected

Did Injury/Illness Exposure Occur on Employer’s Premises?

**Occurrence**

Yes No

Type of Illness/Injury Code

Part of Body Affected Code

Department or location where accident or illness exposure occurred All Equipment, Materials, or Chemicals Employee Using upon Occurrence

Specific Activity Employee Engaged in at Time of Occurrence Work Process the Employee Was Engaged in at Time of Occurrence

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 Returned to Work

If Fatal, Date of Death

Were Safeguards or Safety Equipment Provided? Were they used?

Yes No

Yes No

Physician/Health Care Provider (Name & Address)

**Treatment**

Signature of Injured Employee, or Signature on File, Date

**Other**

Hospital (Name & Address)

Witness to Accident (Name & Phone Number)

Initial Treatment

1. No Medical Treatment
2. Minor: By Employer
3. Minor Clinic/Hosp
4. Emergency Care
5. Hospitalized – 24 hr.
6. Anticipated Major Med/Lost Time

Date Administrator Notified

Date Prepared

Preparer’s Name & Title

Preparer’s Phone Number

Filing this report is not an admission of liability. This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made. Idaho Industrial Commission, P.O. Box 83720, Boise, ID 83720-0041 IC Form IA-1 (08/2013)



**Employer:**

**Church Mutual**

**Prescription Information**

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

|  |  |
| --- | --- |
|  |  |
| Employee Name: |  |
| Group#: | 10602812 |
| Member ID (SSN): |  |
| Date of Injury: |  |
| Processor: | myMatrixx |
| Bin#: | 014211 |
| Day supply is limited to 30 days for a new injury. |
| myMatrixx Help Desk: (877) 804-4900 |

**Employee:**

Church Mutual Insurance Company has partnered with ***myMatrixx*** to make filling wor

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

**IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900**

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**Pharmacist:**

Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the ensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

N OTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

**FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900**

UN 896 (05-14)

**Church Mutual Insurance Company 3000 Schuster Lane, P.O. Box 342**

**Claim No.** Insured: Date of Loss: Claimant:

**Merrill, WI 54452-0342**

**Telephone No. (800) 554-2642, Option 2**

**Fax No. (715) 539-4651**

[**www.churchmutual.com**](http://www.churchmutual.com/)

**WAGE STATEMENT**

**Report of Employee's Gross Wages for Period of Weeks Days**

**If possible, state employee's past wages for one year previous to date of injury.**

Date of Hire Last Day Worked ( ) Full-Time ( ) Part-Time

Number of Hours Per Week Rate Paid by ( ) Hour ( ) Day ( ) Week ( ) Month Housing, Transportation, or Utility Allowance Other Discounts or Allowances

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Pay Period | Amount Paid Excluding Overtime or Extra Work | Overtime or Extra Work | GROSS Amount Paid Employee for Each Period |  | Pay Period | Amount Paid Excluding Overtime or Extra Work | Overtime or Extra Work | GROSS Amount Paid Employee for Each Period |
| From | To | Year | From | To | Year |
| 1 |  |  |  |  |  |  | 27 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  | 28 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  | 29 |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  | 30 |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  | 31 |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  | 32 |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  | 33 |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  | 34 |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  | 35 |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  | 36 |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  | 37 |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  | 38 |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  | 39 |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  | 40 |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  | 41 |  |  |  |  |  |  |
| 16 |  |  |  |  |  |  | 42 |  |  |  |  |  |  |
| 17 |  |  |  |  |  |  | 43 |  |  |  |  |  |  |
| 18 |  |  |  |  |  |  | 44 |  |  |  |  |  |  |
| 19 |  |  |  |  |  |  | 45 |  |  |  |  |  |  |
| 20 |  |  |  |  |  |  | 46 |  |  |  |  |  |  |
| 21 |  |  |  |  |  |  | 47 |  |  |  |  |  |  |
| 22 |  |  |  |  |  |  | 48 |  |  |  |  |  |  |
| 23 |  |  |  |  |  |  | 49 |  |  |  |  |  |  |
| 24 |  |  |  |  |  |  | 50 |  |  |  |  |  |  |
| 25 |  |  |  |  |  |  | 51 |  |  |  |  |  |  |
| 26 |  |  |  |  |  |  | 52 |  |  |  |  |  |  |
|  | Total |  |  |  |  |  |  | Total |  |  |  |  |  |

**I hereby certify that the above is a true and correct account, as taken from our payroll records, of the wages paid to the above-named claimant for the periods indicated.**

For your protection, Idaho requires the following wording to appear on this form:

Any person who knowingly and with intent to defraud or deceive any insurance company files a statement containing any false, incomplete, or misleading information is guilty of a felony.

**Name of Employer Signature of Employer Position Date**

CL 506 (03-09) - ID

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