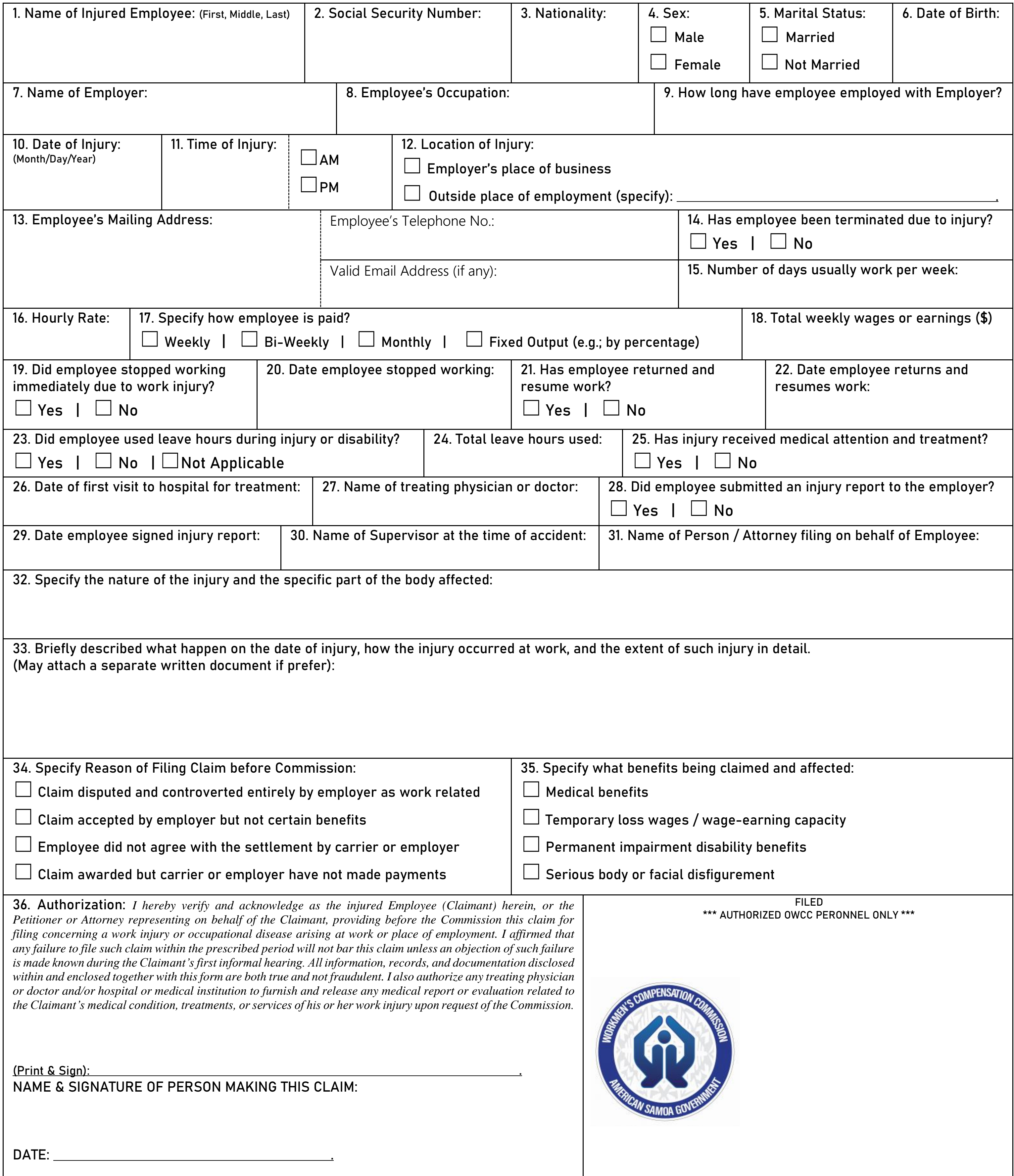
WCC CASE NO.

FORM WC-01

CLAIM FOR WORKMEN'S COMPENSATION (INJURY)



1. Name of Injured Employee: (First, Middle, Last)

2. Social Security Number:

3. Nationality:

4. Sex: ☐ Male ☐ Female

5. Marital Status: ☐ Married ☐ Not Married

6. Date of Birth:

7. Name of Employer:

8. Employee's Occupation:

9. How long have employee employed with Employer?

10. Date of Injury: (Month/Day/Year)

11. Time of Injury: ☐ AM ☐ PM

12. Location of Injury:
☐ Employer's place of business
☐ Outside place of employment (specify): ______.

13. Employee's Mailing Address:

Employee's Telephone No.:

Valid Email Address (if any):

14. Has employee been terminated due to injury? ☐ Yes | ☐ No

15. Number of days usually work per week:

16. Hourly Rate:

17. Specify how employee is paid?
☐ Weekly | ☐ Bi-Weekly | ☐ Monthly | ☐ Fixed Output (e.g.; by percentage)

18. Total weekly wages or earnings ($)

19. Did employee stopped working immediately due to work injury? ☐ Yes | ☐ No

20. Date employee stopped working:

21. Has employee returned and resume work? ☐ Yes | ☐ No

22. Date employee returns and resumes work:

23. Did employee used leave hours during injury or disability? ☐ Yes | ☐ No | ☐ Not Applicable

24. Total leave hours used:

25. Has injury received medical attention and treatment? ☐ Yes | ☐ No

26. Date of first visit to hospital for treatment:

27. Name of treating physician or doctor:

28. Did employee submitted an injury report to the employer? ☐ Yes | ☐ No

29. Date employee signed injury report:

30. Name of Supervisor at the time of accident:

31. Name of Person / Attorney filing on behalf of Employee:

32. Specify the nature of the injury and the specific part of the body affected:

33. Briefly described what happen on the date of injury, how the injury occurred at work, and the extent of such injury in detail.
(May attach a separate written document if prefer):

34. Specify Reason of Filing Claim before Commission:
☐ Claim disputed and controverted entirely by employer as work related
☐ Claim accepted by employer but not certain benefits
☐ Employee did not agree with the settlement by carrier or employer
☐ Claim awarded but carrier or employer have not made payments

35. Specify what benefits being claimed and affected:
☐ Medical benefits
☐ Temporary loss wages / wage-earning capacity
☐ Permanent impairment disability benefits
☐ Serious body or facial disfigurement

36. Authorization: *I hereby verify and acknowledge as the injured Employee (Claimant) herein, or the Petitioner or Attorney representing on behalf of the Claimant, providing before the Commission this claim for filing concerning a work injury or occupational disease arising at work or place of employment. I affirmed that any failure to file such claim within the prescribed period will not bar this claim unless an objection of such failure is made known during the Claimant's first informal hearing. All information, records, and documentation disclosed within and enclosed together with this form are both true and not fraudulent. I also authorize any treating physician or doctor and/or hospital or medical institution to furnish and release any medical report or evaluation related to the Claimant's medical condition, treatments, or services of his or her work injury upon request of the Commission.*

(Print & Sign): ______.

NAME & SIGNATURE OF PERSON MAKING THIS CLAIM:

DATE: ______.

FILED
*** AUTHORIZED OWCC PERONNEL ONLY ***

FORM DISTRIBUTION: Original – Commission | Copy – Employee / Petitioner

INSTRUCTIONS ON FILING THE DISABILITY CLAIM FORM (WC-01):

Complete this form and submit directly to the Commission's Office together with all the documentations and records as required under this form during filing, including payment of the application fee. Please submit and provide only the form portion on top. Electronic submission of the filing application via online is prohibited. Form may be submitted directly to the Commission's Office or be delivered to the following mailing address:

Office of the Workmen's Compensation Commission
P.O. Box 39
Pago Pago, American Samoa 96799

A claim may be filed after the first 7 days of disability following any injury, or within one year from the date of injury. Failing to file a claim within the prescribed period will not bar a claim from filing unless an objection is raised during the claimant's first informal hearing.

REQUIRED DOCUMENTATIONS TO FURNISH & SUBMIT WITH FORM WC-01 DURING FILING:

(a) Employee's medical report concerning injury from all medical institutions.

(b) Medical certificate orders issued by the doctor on injury or disability.

(c) Sick and annual leave slips approved by the employer due to the employee's injury or disability as proof of leave hours being used.

(d) Employee's Personnel Form-303 (for ASG Employees)

(e) Record of employment status from employer (for Private Sector Employees)

(f) Employee's check stubs issued since the date of injury.

(g) Submission of names and written statements from at least 3 witnesses - if any.

(h) Remaining or outstanding medical billings for payment (e.g. morgue fees, embalm fee, etc.). If such billings have been paid out-of-pocket, valid receipts must be provided as proof for reimbursement.

(i) Colored photos of injury taken during injury from various angles (if available).

(j) Travel Authorization - if injury related.

(k) Other documentations, reports, and records requested by the Commission.

DESCRIPTION OF WORKMEN'S COMPENSATION BENEFITS

MEDICAL BENEFITS:

- Payment of outstanding or remaining medical expenses incurred for the treatment of the employee's work injury.
- Reimbursement of related medical expenses paid out of pocket by the employee.
- Reimbursement of other medical travel expenses allowable by the Commission (complete and enclosed FORM WS-01).

  Unallowable Travel Expenses for Reimbursement:

  - Meals and groceries purchased by the employee.
  - All telecommunication expenses.
  - Medical expenses paid under LBJ Off-Island Referral Program, Medicaid, or other governmental or non-profit assistance program in which the employee is deemed eligible and qualified under.

TEMPORARY TOTAL DISABILITY BENEFIT (TTD):

- TTD compensation is used when the employee suffers any time loss or loss in temporary wages during injury or disability. For the compensation of TTD payments, only 66-2/3% of the claimant's average weekly wages shall be paid during the continuance thereof. Leave Without Pay (LWOP) or missing hours while under disability is also considered for TTD compensation. No TTD payments shall be issued unless full wages are discontinued (or all leave hours have been exhausted).

TEMPORARY PARTIAL DISABILITY BENEFIT (TPD):

- TPD is used when an employee suffers a loss of actual earnings whereby such earnings fairly and reasonably represent his or her wage-earning capacity. TPD covers two-thirds of the difference between the claimant's average weekly wages before the injury and the claimant's wage-earning capacity after the injury in the same or another employment. TPD compensation cannot be longer than 5 years. TPD payments may also be suspended if the claimant's wage-earning capacity has been restored or returned to the same level or has increased.

PERMANENT IMPAIRMENT DISABILITY BENEFIT:

- Permanent impairment benefit compensation is used when an employee suffers a permanent impairment due to the injury. The employee is required to provide and furnish a permanent impairment evaluation conducted only by a certified and designated doctor approved by the Commission. If an impairment is found, the evaluating doctor assigns a percentage rating to quantify how much of such impairment the employee has incurred due to the injury – if any. All logistics to facilitate an impairment examination with a qualified doctor is the sole responsibility of the employee whom is also required to provide the evaluating doctor FORM ME-02. The employee may facilitate an impairment evaluation at any time before filing a claim or upon request of the Commission.

- Permanent impairment is classified either as a Permanent Partial Disability (PPD) or Permanent Total Disability (PTD). An injury can only be evaluated and issued as either PPD or PTD – not both. PPD injuries mainly range between 1% and 99% while PTD is constitutes a 100%. In addition, any loss or loss of use of either both hands, arms, legs, eyes, or any two thereof is constituted as PTD. Whole body or whole person impairment ratings are not accepted unless the examiner controverts such rating to reflect each rating for each bodily part or area affected. A scheduled of injuries and weeks of compensation allow under PPD are specified and determined under A.S.C.A. §32.0609(a). For all other injuries not included or specified within that schedule shall be compensated under §32.0609(b) whereby the employee is required to prove a loss in wage-earning capacity.

- Disfigurement compensation includes serious disfigurement to the face, body, and head such as amputation of limbs, or any permanent scars incurred to such areas due to the work injury or from medical and surgical treatments.