TOWN OF MIDDLETON
Police/Fire Injured-on-Duty Procedures
M.G.L. Ch. 41, Sec. 111F

Injured on Duty Reporting Requirements:

Whenever an officer, on duty or while traveling to a duty assigned, receives an injury regardless of its severity, the officer shall, as soon as practicable, notify the "on duty" Commanding Officer/Officer in Charge and submit a thorough and complete report detailing the nature of the injury, the mechanism or circumstances surrounding the incident which led to the injury, the names of any witnesses and the officer's personal physician, along with any medical specialist(s) to whom the officer may have been referred. This report shall be submitted to the Commanding Officer/Officer in Charge to the Chief of Police.

Reporting Injured-on-Duty Claims:

- Complete a Notice of Claim Form for the injured public safety officer signed by a superior officer
- Complete a Supervisor's Report detailing the events of the employee's injury
- Complete Medical Release form signed by the injured public safety officer
- Complete Wage & Salary Verification Form (if time will be missed)
- Request and obtain a physician's written medical opinion that states the following:
    - That the public safety officer sustained an injury. The physician must identify the injured body part
    - That said injury occurred while the public safety officer was in the performance of his official duties
    - That said injury was sustained without any fault of the public safety officer
    - That said injury has caused the public safety officer to be incapacitated from performing his/her duties and the expected length of incapacity.

- **For Exposure Claims**:
    - Accept the Claim…state "For Reporting Purposes Only" in body of email
      *Note if there was any time off or medical attention received

- Cabot will reimburse Town $1,000 per week for full time firefighters and police officers (Deposit into acct #01135084-479900)

- The Town reserves the right to request additional medical information as needed to investigate the claim for injured on duty benefits.

Employee Responsibilities:

- Report injury immediately to your supervisor
- Promptly complete top portion of Supervisor's Report of Accident Form and sign a Medical Authorization Form

- If medical attention is sought, let the medical provider know that you are being treated for a **"work-related injury"**
- Work with the insurer by providing them with information required
- Provide medical documentation if you cannot return to work
- Regularly keep Supervisor, Occupational Health Nurse and Workers' Compensation Coordinator informed of progress
- Provide Doctor's Notes as need
- Provide final **"Return-to-Work Medical Release"** before fully returning to work.

NO EMPLOYEE SHOULD RETURN TO WORK WITHOUT MEDICAL CLEARANCE

Employer/Supervisor Responsibilities:

- Call 911 when necessary. Provide First Aid.
- Encourage the injured public safety officer to seek medical attention when necessary
- If injury is severe, the employee should be seen at an Emergency Room immediately
- If non-emergency attention is sought, the officer should seek medical attention and let their provider know that they are being treated for a **work-related-injury.**
- Complete **CHUBB Police and Fire Notice of Claim Form**
- Record accurate description of accident and preserve evidence, interview witnesses
- Send all documentation (Notice of Claim Form, Medical Release Form, and Wage Verification Form) to the Workers' Compensation Coordinator (Sharon Bainbridge) within **24 hours** of receipt
- Once claim is received a Claim Number will be provided and an insurance adjuster will be assigned
- Officers who are receiving Workers' Compensation payments must keep their supervisor updated regularly after attending medical appointments. Supervisor will keep Workers' Compensation Coordinator updated after speaking with employee
- Once an officer has medical clearance to return to work, officer **MUST** provide a copy of medical documentation to their supervisor and the Workers' Compensation Coordinator (Sharon Bainbridge)

NO EMPLOYEE SHOULD RETURN TO WORK WITHOUT MEDICAL CLEARANCE

Workers' Compensation Coordinator's Responsibilities:

- Report MIIA/Cabot Risk of injury (Notice of Claim Form, Medical Release Form, Wage Verification and any additional documents)
- Complete a Wage Statement/Report and send to insurer if applicable
- If compensable, notify Payroll Clerk
- Create a confidential file and track all correspondence
- Collect Doctors Notes and documentation related to employee's medical status
- Coordinate coming back to work or modified duties plan
- Confirm employee has been medically cleared to return to work with written documentation

NO EMPLOYEE SHOULD RETURN TO WORK WITHOUT MEDICAL CLEARANCE

Insurer's Responsibilities:

- Contact employer to verify accident or disability
- Contact employee to confirm details
- Verify medical evidence of injury or disability
- Discuss case with medical providers and occupational health nurse
- Determine compensability of claim based on investigation
- Authorize indemnity of medical payments
- Independent medical exam when deemed necessary
- Rehabilitation if needed
- Coordinate a return-to-work plan
- Explore possibilities of modified/light duties

The 190th General Court of the Commonwealth of Massachusetts

MGL. Chapter 41, Section 111F

Section 111F. Whenever a police officer or fire fighter of a city, town, or fire or water district is incapacitated for duty because of injury sustained in the performance of his duty without fault of his own, or a police officer or fire fighter assigned to special duty by his superior officer, whether or not he is paid for such special duty by the city or town, is so incapacitated because of injuries so sustained, he shall be granted leave without loss of pay for the period of such incapacity; provided, that no such leave shall be granted for any period after such police officer or fire fighter has been retired or pensioned in accordance with law or for any period after a physician designated by the board or officer authorized to appoint police officers or fire fighters in such city, town or district determines that such incapacity no longer exists. All amounts payable under this section shall be paid at the same times and in the same manner as, and for all purposes shall be deemed to be, the regular compensation of such police officer or fire fighter. This section shall also apply to any member of a fire department who is subject to the provisions of chapter one hundred and fifty-two if he is injured at a fire and if he waives the provisions of said chapter. This section shall also apply to any permanent crash crewman, crash boatman, fire controlman or assistant fire controlman employed at the General Edward Lawrence Logan International Airport, members of the Massachusetts military reservation fire department and members of the 104th fighter wing fire department and, for the purposes of this section, the Massachusetts Port Authority, the Massachusetts military reservation and the Barnes Air National Guard Base shall be fire districts.

Where the injury causing the incapacity of a firefighter or police officer for which he is granted a leave without loss of pay and is paid compensation in accordance with the provisions of this section, was caused under circumstances creating a legal liability in some person to pay damages in respect thereof, either the person so injured or the city, town or fire or water district paying such compensation may proceed to enforce the liability of such person in any court of competent jurisdiction. The sum recovered shall be for the benefit of the city, town or fire or water district paying such compensation, unless the sum is greater than the compensation paid to the person so injured, in which event the excess shall be retained by or paid to the person so injured. For the purposes of this section, "excess" shall mean the amount by which the total sum received in payment for the injury, exclusive of interest and costs, exceeds the amount paid under this section as compensation to the person so injured. The party bringing the action shall be entitled to any costs recovered by him. Any interest received in such action shall be apportioned between the city, town or fire or water district and the person so injured in proportion to the amounts received by them respectively, inclusive of interest and costs. The expense of any attorney's fees shall be divided between the city, town or fire or water district and the person so injured in proportion to the amounts received by them respectively.

Whoever intentionally or negligently injures a firefighter or police officer for which he is granted a leave without loss of pay and is paid compensation in accordance with the provisions of this section shall be liable in tort to the city, town or fire or water district paying such compensation for all costs incurred by such city, town or fire or water district in replacing such injured police officer or firefighter which are in excess of the amount of compensation so paid.

[Paragraph added by 2016, 218, Sec. 60 effective November 7, 2016.]

Notwithstanding the provisions of this section, section 100 or any other general or special law to the contrary, any city, town or district that accepts this paragraph may establish and appropriate amounts to a special injury leave indemnity fund for payment of injury leave compensation or medical bills incurred under this section or said section 100, and may deposit into such fund any amounts received from

insurance proceeds or restitution for injuries to firefighters or police officers. The monies in the special fund may be expended, with the approval of the chief executive officer and without further appropriation, for paying expenses incurred under this section or said section 100, including, but not limited to, expenses associated with paying compensation other than salary to injured firefighters or police officers and providing replacement services for the injured firefighters or police officers, in lieu of or in addition to any amounts appropriated for the compensation of such replacements. Any balance in the fund shall carry over from year to year, unless specific amounts are released to the general fund by the chief executive officer upon a finding that the amounts released are not immediately necessary for the purpose of the fund, and not required for expenses in the foreseeable future.

TOWN OF MIDDLETON
Police & Fire 111F Forms

CHUBB NOTICE OF CLAIM FORM
Complete in full – Signature required *Needed to file claim*
MEDICAL AUTHORIZATION
Signature Required *Needed to access medical records*
MYMATRIXX FORM
Complete if employee seeking medical attention *Used to cover filling first prescriptions* *Give to employee*
WAGE & SALARY VERIFICATION
Submit if employee will be out of work *Signature required*
WORKERS COMP EMPLOYEE FAQS
Explains Workers' Compensation Process *Give copy to injured employee*

Federal Insurance Company Police and Fire Accident Program
NOTICE OF CLAIM

A claim is being filed for: ☐ Medical Benefits ☐ Disability Benefits ☐ Medical and Disability Benefits

Forward Questions/Claims to:

Cabot Risk Strategies LLC
15 Cabot Road, Woburn, MA 01801-1003
Tel. Number 800-222-5963 Fax Number 781-376-9907

Claim Instructions: The Policyholder should: Complete and sign Sections 1, 3 and 5. The Claimant should: Complete and sign Sections 2, 3 and 4.

Section 1 – Policyholder Information – To be completed by commanding officer

Policyholder Name	Policyholder Number	
Policyholder Address	Commanding Officer Phone Number	
Claimant (Injured Party) Name	Claimant Date of Birth	Claimant Social Security Number
Claimant Insured Person Status ☐ On-Call Volunteer ☐ Junior Officers ☐ Auxiliary ☐ Career Police ☐ Career Fire Fighter		
Claimant Address (Street, City, State and Zip Code)	Claimant Phone Number	
Date of Accident _____ (mm/dd/yyyy)	Time of Accident _____ ☐ AM ☐ PM hh:mm	Place of Accident
Complete description of Accident		
Indicate injured body part(s)		
Nature of sickness (if applicable)	Date sickness first commenced	

Note – Please also include a copy of the Incident Report, if available.

Policyholder Certification Signature Required:
I hereby certify the claimant is a member of the group insured under the above Policy and the injury/sickness was sustained under adequate supervision while participating in an official Covered Activity.

Title of Commanding Officer	Signature of Commanding Officer	Date

Section 2 – Claimant Information – To be completed by claimant

If filing a claim for Medical Benefits: Submit itemized medical bills to address referenced above and sign the Claimant Certification statement listed below.

Claimant Certification Signature Required:
I hereby certify the above information to be true and accurate to the best of my knowledge.

Signature of Claimant	Date

CHUBB®

Section 2 – Claimant Information (continued)

[If filing a claim for Disability Benefits: Fully complete all items in this section and submit to address referenced on page 1.]

Primary Occupation	Primary Occupation Work Hours	Name of Primary Occupation Employer
Address of Primary Occupation Employer	Contact Phone Number	Contact Fax Number
Contact Name for Primary Occupation Employer	Exact duties unable to perform – Primary occupation	
Date last worked Primary Occupation Employer	Date returned to work – Primary Occupation Employer ☐ Full Duty ☐ Light Duty	
Verification of Earnings *(Submit Primary Occupation pay stubs for the last 3 months. If self-employed, send copy of your prior year's tax return)*		
Attending Physician's Name	Attending Physician's Address	
Attending Physician's Phone Number	Attending Physician's Fax Number	
Do you have disability (loss of wages) coverage through? (Check all that apply) ☐ Regular Occupation Policy ☐ Workers' Compensation ☐ Other		
Claimant Certification Signature Required: I hereby certify the above information to be true and accurate to the best of my knowledge. Signature of Claimant ____ Date		

Section 3 – Fraud Warning Statement – To be signed by policyholder and claimant

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

Signature of Policyholder (Commanding Officer) ____ Date

Signature of Claimant ____ Date

CHUBB®

Section 4 – Medical Records Release

Forward Documentation to:

Cabot Risk Strategies LLC
15 Cabot Road
Woburn, MA 01801-1003
Tel. Number 800-222-5963
Fax Number 781-376-9907

Date of Injury _____
(mm/dd/yyyy)

Nature of Injury

I hereby authorize any hospital, physician or other person who has attended me to furnish to Cabot Risk Strategies LLC and Chubb Group of Insurance Companies all information with respect to this illness or injury and the resulting hospital or medical records, consultations, treatments or prescriptions. A copy of this authorization shall be considered as effective and valid as the original.

_____
Name (Print)

_____ _____
Signature Date

Section 5 – Wage and Salary Verification

Forward Documentation to:

Cabot Risk Strategies LLC
15 Cabot Road
Woburn, MA 01801-1003
Tel. Number 800-222-5963
Fax Number 781-376-9907

Date	Our Policyholder	Date of Injury	Claim Number

EMPLOYER'S NAME AND ADDRESS	EMPLOYEE'S NAME AND ADDRESS
	Social Security No.:

OCCUPATION:

DATES OF EMPLOYMENT: From _____ through _____

Gross Earnings during 52-week period ***PRIOR*** to Accident: $ _____

Wage or salary as of date of Accident:

a) $ _____ ☐ Per Week ☐ Per Month

b) Usual number of days worked per week: _____

Dates Absent Following Accident:

a) Date Disability began: _____

b) Date returned to work _____

Was Employee paid during this absence: ☐ YES ☐ NO If YES, amount paid: $ _____

Is Employee entitled to benefits under a wage or salary continuation plan? ☐ YES ☐ NO

a) If YES, amount paid or available: $ _____ ☐ PER WEEK ☐ PER MONTH

b) If YES, Are cash or traditional retirement credits reduced under your plan by amount of benefits paid?

Is Employee eligible for any individual/group health insurance/HMO/other benefits? ☐ YES ☐ NO

Date: _____ Print Name & Title: _____

Telephone No.: _____ _____

Signature

Thank you for your cooperation.

Section IV – Medical Records Release

Cabot Risk Strategies LLC
15 Cabot Road
Woburn, MA 01801-1003
Tel. Number 800-222-5963
Fax Number 781-376-9907

MEDICAL RECORDS RELEASE

DATE OF INJURY _____

NATURE OF INJURY _____

I hereby authorize any hospital, physician or other person who has attended me to furnish to Cabot Risk Strategies LLC and Chubb Group of Insurance Companies all information with respect to this illness or injury and the resulting hospital or medical records, consultations, treatments or prescriptions. A copy of this authorization shall be considered as effective and valid as the original.

_____
Name (Print)

_____ _____
Signature Date

myMatrixx®
good medicine for business

MIIA Members Services
Workers' Compensation Prescription Information

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

	MIIA
MIIA Member:	
Employee Name:	
Group#:	10602826
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:
MIIA Members Services has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

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

Pharmacist:
Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation 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.

NOTE: 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

TOWN OF MIDDLETON
Workers' Compensation
FAQs for Employees

What is Workers' Compensation?

- Workers' compensation is a form of insurance purchased by employers to protect workers who are injured in the course and scope of employment. If you suffer an injury that is determined to be work-related, workers compensation may cover the reasonable and necessary medical expenses you incur to treat the injury. Each state sets its own rules and regulations regarding workers' compensation benefits

Who do I report my injury to?

- An injury or suspected injury should be reported to your Department Head/Supervisor as soon as possible, and your employer will in turn file a claim with the Town's Workers' Compensation Coordinator. If your injury is determined to be work-related, the goal is to get you the medical care you need and get back to work as soon as possible.

What types of benefits are available?

- Medical benefits for reasonable and necessary medical treatment that is related to the injury as a result of a work-related incident.
- Wage loss replacement benefits if your injury causes you to lose time from work.
- Your employer pays the premium for insurance coverage and there are no out-of-pocket expenses to you for covered injuries.

How does my claim adjuster help me throughout the process?

- The role of the adjuster is to ensure you receive timely, appropriate medical care that restores you to your pre-injury status and allows you return to work safely. Your claim adjuster will be in touch with you throughout the claim process to make sure things are progressing. You should feel free to contact your adjuster if you have any questions.

What is the role of a nurse case manager?

- Nurse case managers will work in collaboration with your assigned adjuster to assist with medical management and a safe return to work

What is the eligibility waiting period for my workers' compensation benefits?

- There is no waiting period for medical benefits. For wage replacement benefits if you are losing time from work, each state has established laws governing what the waiting period and time frame are. Visit the U.S. Department of Labor Website (www.dol.gov) for detail

Can I see my primary care physician?

- You may select your own medical doctor, unless otherwise required by the Town.

How do I obtain my prescription medications?

- For prescription medications related to our work injury, your employer has a first fill card (**MyMatrixx Form**) available for you to use to fill your prescriptions so that you will not incur any out-of-pocket expenses for medications.

If my physician prescribes medication for my work-related injury, do I need to fill my prescription at a specific pharmacy?

- You will receive a packet from our pharmacy benefits manager, Caremark. Caremark processes medications electronically directly. Visit their website for a list of participating pharmacies at: www.caremark.com.

How are my medical bills paid? What should I do if I receive a bill from my doctor?

- Medical bills related to your work injury are paid by MIIA/Cabot Risk. Medical bills should be submitted to your Workers' Compensation Coordinator to process or directly to MIIA/Cabot Risk. When submitting by mail or fax, be sure to include your claim number on all documents you send. You should also provide the claim number to your medical provider/doctor and clarify that you are treated for a work-related injury and bills should be forwarded directly to MIIA/Cabot Risk.

What are transitional or modified job duties? Why are they helpful to me?

- Transitional or modified duties are alternate work tasks that are lighter in nature than your pre-injury job tasks. If your physician feels you are capable of work with restrictions, we encourage you to discuss this with your employer and determine if your employer is able to accommodate those restrictions. Transitional or modified work provides you with an opportunity to quickly and safely return to the workplace before you are ready to perform your pre-injury job, and allows you to gradually work back up to full time duties and allows you to maintain communication with your employer and co-workers.

How long do transitional/modified duties last?

- The type and duration of your physical limitations is determined by a physician. It is also up to your employer to determine how long they are able to accommodate these duties.

Who can I contact if I have questions?

- For questions contact your Claim Adjuster or the Workers' Compensation Coordinator for the Town: Sharon Bainbridge, PH: 978-777-4966, FX: 978-774-3682, sharon.bainbridge@middletonma.gov.