



since 1989

A.I.M. Mutual Insurance Company
Associated Employers Insurance Company
Massachusetts Employers Insurance Company
New Hampshire Employers Insurance Company



Claim **Kit**

in
partnership
with
you



A.I.M. Mutual Insurance Company
Massachusetts Employers Insurance Company
New Hampshire Employers Insurance Company
Associated Employers Insurance Company

On behalf of the A.I.M. Mutual Insurance Companies, I welcome you as a policyholder.

As your new workers' compensation insurance carrier, we ask that you report all accidents to us as soon as possible after they occur. Your prompt notification together with a complete accident report will help us to handle your claims fairly and efficiently. This will also help you avoid fines for late reporting.

Here is a supply of the necessary forms along with instructions for their use. You can also find them online at www.aimmutual.com. Please feel free to contact us at any time with your questions or service requests.

Sincerely,

Laura Parsons, WCLA, FCLA
Director of Claim



54 Third Avenue, Burlington, MA 01803

Workers' Compensation Maine Claim Reporting Options

**In the event of a serious accident, call us immediately at 1-866-270-3354
(toll free 24-hour/7 day a week claim reporting)**

Choose from several different ways to report your workers' compensation claims to us:

On-Line:

Log on to www.aimmutual.com. Select Report A Claim / Report A Claim ME.

You will be prompted to answer a series of questions similar to the information necessary to complete a Form WCB-1. After answering all of the questions and clicking on SEND, you will receive a message stating your claim has been submitted. It will also state that a Claim Acknowledgement letter containing the claim number and assigned claim representative will be mailed to your company after registration has been completed. Click Print for a copy of the information you sent. We will file Form WCB-1 with the State of Maine Workers' Compensation Board. Even if the claim is for first-aid only injury claims, submit the Form WCB-1 to us. We will file this form with the State of Maine Workers' Compensation Board.

By Phone:

Report claims by calling toll free: 1-866-270-3354.

This line is established for reporting new claims only and facilitates the initial claim reporting process. Please have your policy number on hand prior to calling. You will receive a completed Form WCB-1 and a confirmation letter, followed by a claim acknowledgment letter including the name of the Claim Representative assigned to your case. We will file Form WCB-1 with the State of Maine Workers' Compensation Board. Even if the claim is for first-aid only injury claims, submit the Form WCB-1 to us. We will file this form with the State of Maine Workers' Compensation Board.

After the initial claim report: Please direct ongoing claim and service inquiries to your Claim Representative at our toll free telephone number: 1-800-876-2765

By Fax:

For **all** claims, complete and fax the Employer's First Report of Occupational Injury or Disease (Form WCB-1) to us at **1-781-270-5599**. Form WCB-1 should be filed as soon as possible after knowledge of an employee's job-related injury or disease but no later than 72 hours thereafter. We will file Form WCB-1 with the State of Maine Workers' Compensation Board. Even if the claim is for first-aid only injury claims, submit the Form WCB-1 to us. We will file this form with the State of Maine Workers' Compensation Board.

By Mail:

Mail the completed Form WCB-1 to A.I.M. Mutual Insurance Companies, Attn: Claim Department, 54 Third Avenue, P.O. Box 4070, Burlington, MA 01803-0970

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:		6. SOCIAL SECURITY NUMBER (LAST 4 DIGITS): XXX -XX-		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:		8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:		11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:		12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:		16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		
18. DOES EMPLOYEE WORK CONCURRENTLY FOR ANOTHER EMPLOYER? IF YES, GIVE NAME(S): _____ NOTE: THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FOR EACH ADDITIONAL EMPLOYER.			YES <input type="checkbox"/>	NO <input type="checkbox"/>	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS' COMPENSATION? NOTE: THE EMPLOYER SHALL RECALCULATE THE AVERAGE WEEKLY WAGE IF/WHEN FRINGE BENEFITS CEASE (SEE RULE 1.5(2))
			YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>
			NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>

&S" @GH; FCGG95FB-B; G: CF '957 < 'K 99?.

WK	WEEK ENDING	GROSS EARNINGS	WK	WEEK ENDING	GROSS EARNINGS	WK	WEEK ENDING	GROSS EARNINGS
1			19			37		
2			20			38		
3			21			39		
4			22			40		
5			23			41		
6			24			42		
7			25			43		
8			26			44		
9			27			45		
10			28			46		
11			29			47		
12			30			48		
13			31			49		
14			32			50		
15			33			51		
16			34			K ? 'C: ' -B>I FM		
17			35			&S" HCH5 @95FB-B; G		
18			36			&S"; FCGG5J9F5; 9'K 99? @MK 5; 9		

23. COMMENTS:

24. PREPARER NAME (TYPE OR PRINT):		25. TELEPHONE NUMBER: ()	26. DATE MAILED:
E-MAIL ADDRESS:		TOLL-FREE NUMBER: ()	MM / DD / YYYY

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-2 (eff. 1/1/13)

FRINGE BENEFITS WORKSHEET
STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. EMPLOYEE ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:	

PROVIDE THE COST OF THE FRINGE BENEFIT PAID BY THE EMPLOYER AS OF THE EMPLOYEE'S DATE OF INJURY IF THE EMPLOYEE WAS RECEIVING THE BENEFIT ON HIS/HER DATE OF INJURY (SEE RULE CHAPTER 1(5)(1)).

NOTE: THE AMOUNTS REPORTED ARE SUBJECT TO VERIFICATION BY THE EMPLOYEE AND HIS/HER REPRESENTATIVE AND DOCUMENTATION MUST BE PROVIDED UPON REQUEST.

18. Fringe Benefit	Provided	Continues while Employee is out of work	Date Benefits End	Weekly Cost of Benefits to Employer
Health Benefits (inc. insurance)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Dental Insurance	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Disability Insurance (inc. short and long term)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
401K	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Life Insurance	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Education/Training	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Pension	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Other (please list):	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$
Other (please list):	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		\$

19. PREPARER NAME (TYPE OR PRINT):	20. TELEPHONE NUMBER: ()	21. DATE MAILED:
E-MAIL ADDRESS:	TOLL-FREE NUMBER: ()	MM / DD / YYYY



State of Maine Workers' Compensation Board Limited Release of Medical/Health Care Information

Name:

SSN (last 4 digits): XXX-XX-

Date Birth:

Date of Injury/Illness:

Notice to employer/insurer/employee representative: You may only use forms adopted by the State of Maine Workers' Compensation Board for the release of protected medical/health care information to an employer or its insurer. The Board's forms may NOT be altered. Abuses may result in penalties.

Notice to employee: The employer/insurer contends your health care provider's medical records, regardless of the date of injury, meaning all records relating to the diagnosis, treatment and care, including X-rays, related to the following body part(s) and/or condition(s):

_____ are needed to determine whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

This release authorizes any and all health care providers to release the records, regardless of the date of injury, they have related to the diagnosis, treatment and care, including X-rays, of the body part(s) and/or condition(s) listed above. This release authorizes the release of records dating from _____ until thirty (30) months after the date I sign this form. This release authorizes my health care provider(s) to release records pursuant to a later request after this release is signed through the termination date of this release.

You have 14 days from receipt of this certificate to complete and return it to the employer/insurer. If you do not understand this form, talk with your legal representative. If you do not have a legal representative, a Workers' Compensation Board Claims Resolution Specialist can help you.

Voluntary: I understand I may choose not to complete this form. If I choose not to complete this form, my claim for benefits may be denied.

Limited: I understand this form gives my health care providers permission to release only those health records related to the body part(s) and/or condition(s) listed above. This form does NOT authorize oral communication with or by any health care provider with anyone other than me or my representative.

Redisclosure: I understand the information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

Revocable: I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. Note: You may not cancel this release with respect to medical records already provided.

This authorization does NOT authorize the release of information regarding testing, treatment or counseling related to: Psychological matters; substance abuse; HIV/Aids and sexually transmitted diseases.

I authorize release of my medical records to: _____
(Name of Recipient)

Address of Recipient:

Format Requested (circle one): **Electronically (if available):** _____ Fax to: _____

Mail to : _____

I hereby authorize the above named recipient to obtain from my health care provider(s) subject to the terms of this release.

Employee or Authorized Representative Signature _____ Date: _____

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).



State of Maine Workers' Compensation Claim Reporting Procedures

IT IS IMPORTANT THE INSTRUCTIONS IN THESE PROCEDURES BE FOLLOWED EXACTLY AS OUTLINED. Prompt filing of the correct forms with all the necessary information helps speed necessary claim investigations and the proper payments of benefits when due. **LATE FILINGS OR LATE PAYMENTS MAY ALSO RESULT IN PENALTIES IMPOSED ON YOUR COMPANY AND/OR A.I.M. MUTUAL INSURANCE COMPANIES AS YOUR INSURER.**

Keep in mind:

- **If it's a serious accident, call us immediately: 1-866-270-3354**
- **We will file the Employer First Report of Injury (Form WCB-1) with the State of Maine Department of Labor.**

If you need additional forms, they may be requested from A.I.M. Mutual Insurance Companies at 1-800-876-2765, Claim Services Department or downloaded from www.aimmutual.com or the State of Maine Workers' Compensation Board website: <https://www.maine.gov/wcb/forms/index.html>

Applicable Forms include:

For any job-related claim:

- | | | |
|----|------------|-----------------------------------|
| 1. | Form WCB-1 | Employer's First Report of Injury |
|----|------------|-----------------------------------|

Additional forms for any lost time claim:

- | | | |
|----|--------------|---|
| 1. | Form WCB-220 | Workers' Compensation Medical Authorization |
| 2. | Form WCB-2 | Wage Statement |
| 3. | Form WCB-2B | Fringe Benefit Worksheet |

Reporting First Aid Injuries and/or Loss of Time Claims

Complete Employer's First Report of Occupational Injury or Disease (Form WCB-1)

You need to complete the Employer's First Report Injury (Form WCB-1) as soon as possible after knowledge of an employee's job-related injury or disease, but no later than 7 days thereafter. The timing of the filing of Form WCB-1 is very important. **Please file this report with us within 7 days of the injury or disease, or immediately upon your receiving notice. We will file Form WCB-1 with the State of Maine Workers' Compensation Board. If you phone in or report a new claim over the Internet, a completed Form WCB-1 will be sent to you. Report a claim at www.aimmutual.com**

(If a first-aid claim only claim becomes a lost time claim, notify A.I.M. Mutual immediately. You will then be required to complete a Wage Statement (Form WCB-2) which we will then file with the State of Maine Workers' Compensation Board.

Mail or Fax to:

A.I.M. Mutual Insurance Cos. Claim Department
54 Third Avenue
P.O. Box 4070
Burlington, MA 01803-0970
Fax: 781-270-5599

For lost time claims, be sure to give the injured employee a completed copy of Form WCB-1.

Employers' Responsibility for Reporting an Injury State of Maine Workers' Compensation Board

1. You must report any injury that results in medical care or an absence of work within 7 days of notice of the injury to A.I.M. Mutual Insurance Companies (A.I.M. Mutual, AEIC). Filing a First Report does not make you liable for the injury.
2. First-aid only injury claims also must be reported using Form WCB-1. Complete and submit Form WCB-1 to A.I.M. Mutual Insurance Companies and we will report the claim to the State of Maine Workers' Compensation Board on your behalf.
3. A.I.M. Mutual will assign an adjuster to investigate your claim and either accept or deny it within 21 days of your having notice or knowledge of the injury. Send any information that you have regarding the injury or incident directly to your A.I.M. Mutual adjuster to assist him or her in the investigation.
4. Once you have been notified that the injured worker has a work capacity, keep A.I.M. Mutual aware of any available work that you have for the injured employee. **Be sure to notify A.I.M. Mutual as soon as the injured employee returns to work.**

Express Scripts Pharmacy Program for Injured Workers

As part of our workers compensation medical management services, we ask injured workers to use a pharmacy program through Express Scripts, Inc. (ESI). ESI is a pharmacy benefit management company that is uniquely set up to provide prescription medications for work-related injuries.

Injured employees will be notified by mail about the pharmacy program and how it works shortly after their claim has been approved. They will also receive a prescription identification card; **the card is valid only for prescriptions related to the specific, approved work injury.** Injured employees will be asked to use an Express Scripts affiliated pharmacy to fill their injury-related prescriptions.

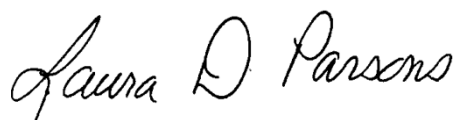
Express Scripts also offers a mail service program, which employees will find convenient for refilling maintenance (long-term) prescription medications. I'm sure you are familiar with the cost benefits of a mail order prescription program, and we ask that you encourage injured workers to take advantage of this service. Most prescriptions are filled within 48 hours of receipt and mailed directly to the injured employee's home. Injured employees can sign up for the mail service program through ESI by phone or by mail.

Additional benefits of the program include 24-hour access to a registered pharmacist via a toll-free number and an extensive network of pharmacies to choose from. Express Scripts offers significant savings of up to 35% over fee schedules and usual and customary charges, and the program will expedite claim processing and payment. Injured employees will incur no out-of-pocket expenses.

Injured workers will receive a condensed list of chain pharmacies in the network on their prescription card information sheet. Most major pharmacies such as CVS, Walgreens and Rite Aid are affiliated with Express Scripts. For a full listing, injured workers can go to www.express-scripts.com/NATPLSNOFORM/index.html or call Express Scripts at 1-800-945-5951. While injured employees may use a non-affiliated pharmacy, we strongly recommend they use a pharmacy within the Express Scripts network and the mail order service to realize the program benefits.

Please call the Express Scripts Workers Compensation Service Center at 1-800-945-5951 with any questions you may have. The toll free service is available 24 hours a day, seven days a week. As always, thank you for working with us to enhance our claim service.

Sincerely,



Laura Parsons, WCLA, FCLA
Director of Claim

Workers' Compensation Temporary Prescription ID Card

»» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 800.945.5951.

»» To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

- Step 1: Enter bin number 003858
- Step 2: Enter processor control A4
- Step 3: Enter the group number as it appears above
- Step 4: Enter the injured worker's nine-digit ID number
- Step 5: Enter the injured worker's first and last name
- Step 6: Enter the injured worker's date of injury
(enter in PA field in the format YYYYMMDD)

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____

MM/DD/YYYY

Group #: AIM WORKS

Employee Date of Birth: _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

»» **To the Supervisor:** Please fill in the information requested for the injured worker.

Employee Information

First M Last

Street Address or PO Box

City State ZIP

Employer Name



Participating Retail Network Pharmacies

A & P	Drug Emporium	Major Value	Schnucks
Acme Pharmacy	Drug Fair	Marsh Drugs	Scolari's
Albertson's	Drug Town	Medic Discount	Sedano
Albertson's/Acme	Drug World	Medicap	Shaw's
Albertson's/Osco	Eckerd	Medistat	Shop 'N Save
Albertson's/Sav-On	Econofoods	Meijer	Shopko
Amerisource	EPIC Pharmacy	Minyard	ShopRite
Bergen	Network	NCS HealthCare	Snyder
Anchor Pharmacies	FamilyMeds	Neighborcare	Stop & Shop
Arrow	Farm Fresh	Network	Sun Mart
Aurora	Farmer Jack	Pharmaceuticals	Super Fresh
Bartell Drugs	Food City	Northeast	Super Rx
Bigg's	Food Lion	Pharmacy Services	Target
Bi-Lo	Fred's	Osco	Texas Oncology
Bi-Mart	Gemmel	P & C Food	Srvs
BJ's Wholesale	Giant	Markets	The Pharm
Club	Giant Eagle	Pamida	Thrifty White
Brooks	Giant Foods	Park Nicollet	Times
Brookshire Brothers	Hannaford	Pathmark	Tom Thumb
Brookshire Grocery	Harris Teeter	Pavilions	Tops
Bruno	H-E-B	Price Chopper	Ukrop's
Carrs	Hi-School	Publix	United Drugs
Cash Wise	Pharmacy	Quality Markets	United
Coborn's	Hy-Vee	Raley's	Supermarkets
Costco	Jewel/Osco	Randalls	Vons
Cub	Kash n Karry	Rite Aid	Waldbaums
CVS	Keltsch	Rosauers	Walgreens
D&W	Kerr	Rx Express	Wal-Mart
Dahl's	Kmart	RXD	Wegmans
Dierbergs	Knight Drugs	Safeway	Weis
Discount Drugmart	Kroger	Sam's Club	Winn Dixie
Doc's Drugs	LeaderNet (PSAO)	Sav-On	
Dominicks	Longs Drug Store	Save Mart	

NOTE: This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.



EXPRESS SCRIPTS®