

# **Excess Workers' Compensation – US Specialty Underwriters**

## **Claim Reporting Requirements**

Report Claims to:

**Midlands Claim Administrators**  
**US Specialty Underwriters Division**  
Email: mcaussu@midman.com

Phone: 866-223-8253

Fax: 405-767-2058

The insured, his agent or claims administrator shall give immediate notice to Midlands Claim Administrators upon learning of any of the following regardless of whether or not compensability or coverage is being contested:

- a) any claim, suit or proceeding that potentially involves indemnity by the Company;
- b) any occurrence, claim, award, or judgment in which the incurred is half the retention amount or greater.
- c) any occurrence which causes serious injury to two or more employees;
- d) any case involving:
  - 1) amputation of a major extremity;
  - 2) brain or spinal cord injury;
  - 3) death;
  - 4) disability for a period of one year or more;
  - 5) permanent total disability as defined in the Workers' Compensation Act of the applicable state named in the Declarations;
  - 6) any second or third degree burn of 25% or more of the body;
  - 7) Multiple or serious fracture;
  - 8) Loss of sight or hearing;
  - 9) Crushing or massive internal injury
- e) the reopening of any case in which further award might involve liability of the Company; and
- f) Hospitalization of more than one (1) month.
- g) claims involving asbestosis, pollution, mold, electromagnetic fields, tobacco, lead poisoning or silica exposure.

Authority is required for all reserve changes and settlements when the total incurred exceeds the retention amount. The Workers' Compensation Report form should be used to request this authority.

The Insured shall make no voluntary settlement involving loss to the Company except with the written consent of the Company or Midlands Claim Administrators.

The insured, agent or claims administrator shall forward promptly to Midlands Claim Administrators any information it may request on the individual occurrences, claims or cases. The Insured, agent or claims administrator shall render to Midlands Claim Administrators within 45 days of the end of the contract period, an experience report on a form satisfactory to Midlands Claim Administrators, showing in detail the amounts disbursed during the contract period in settling claims and the estimated future payments on, or reserves for, outstanding claims.

The Company, at its own election and expense in addition to any indemnity for claims expenses provided by this Policy, shall have the right but not the duty to participate with the Insured in, or to assume in the name of the Insured control over the investigation, settlement defense or appeal of any claim, suit or proceeding which might involve liability of the Company.

Please make certain that all persons responsible for claims reporting activity in your firm are entirely familiar with these provisions.

Attached are forms to be used in reporting claim data to Midlands:

1. **WORKER'S COMPENSATION REPORT** used to initially report a claim, used as an interim report, used to request reserve/settlement authority and used to close a claim.
2. **CLAIMS RESERVE WORKSHEET** to be used to advise initial as well as updates of reserve estimates.
3. **EXCESS CLAIM REIMBURSEMENT REQUEST** to be used when specific layer of coverage has been reached.

Should you have any questions on these criteria or any other areas regarding the reporting of claims, please call Louis Pippin at Midlands Claim Administrators, US Specialty Underwriters Division, 866-223-8253.

**WORKERS' COMPENSATION REPORT - US SPECIALTY UNDERWRITERS**

DATE: \_\_\_\_\_

TO: Midlands Claim Administrators  
US Specialty Underwriters Division

email: mcaussu@midman.com  
Fax: 405-767-2058

**STATE OF JURISDICTION:**

**TYPE OF REPORT**

- |  |   |
|--|---|
| <input type="checkbox"/> INITIAL         | <input type="checkbox"/> AUTHORITY ONLY                         |
| <input type="checkbox"/> INITIAL & FINAL | <input type="checkbox"/> EXCESS ONLY (3 Months)                 |
| <input type="checkbox"/> INTERIM         | <input type="checkbox"/> 1 <sup>st</sup> DOLLAR PROGRAM (6 MOS) |
| <input type="checkbox"/> FINAL           |   |

ACCOUNT / PROGRAM: \_\_\_\_\_ TPA: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ FILE #: \_\_\_\_\_  
EMPLOYEE: \_\_\_\_\_  
SS#: \_\_\_\_\_  
D/A: \_\_\_\_\_

\*EMPLOYER POLICY #: \_\_\_\_\_ \* DATE CLAIM RECEIVED: \_\_\_\_\_  
\*POLICY PERIOD: \_\_\_\_\_ \* RETENTION: \_\_\_\_\_

**RESERVES:**

	Compensation	Medical	Legal	Other	Totals
Paid to Date:					
Outstanding:					
Total Incurred:					

Rsrv. Increase:					
NEW TOTAL:					

**APPROVAL:**

Settlement Request: \_\_\_\_\_  
APPROVAL: \_\_\_\_\_

**\*EMPLOYEE INFORMATION:**

Occupation: \_\_\_\_\_ DOB: \_\_\_\_\_  
Hired: \_\_\_\_\_ AWW: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ CR: \_\_\_\_\_  
Dependents: \_\_\_\_\_ ( ) Multiple Claim \_\_\_\_ of \_\_\_\_ claims.

**\*OCCURRENCE:**

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**MEDICAL:**

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**ATTENDANT CARE:**

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**RECOVERY:**

Possible Subrogation:                YES                        NO  
Explanation:

Possible SIF:                        YES                        NO  
Explanation:

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**OUTSTANDING ISSUES, PLAN OF ACTION, AND ESTIMATED DATE OF RESOLUTION:**

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We will provide an update in 3 months.

Completed by: \_\_\_\_\_

Date: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

# CLAIM RESERVE WORKSHEET

Date: \_\_\_\_\_

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INSURED

Claimant(s)

DOL: \_\_\_\_\_

## Claimant Data

Age of Claimant:		Age of Spouse:	
Life Expectancy:		Life Expectancy:	
Ages of Dependents:		Years to Maturity:	
Type of Job:		Average Weekly Wage:	
Comp Rate:		Maximum Annual Benefit:	
Claimant Attitude:			
Education/Retrain Ability:			
Psychological Problems:			

## Medical

Treatment (Doctors, Therapy, Surgery):	
Hospitalization:	
Rehabilitation:	
All Other Medical (Drugs, Durable Medical Equipment):	
Total Future Medical:	
Total Medical Paid to Date:	
Total Medical Incurred:	

## Indemnity

TTD ( _____ Weeks X \$ _____ Rate):	
TPD ( _____ Weeks X \$ _____ Rate):	
PPD ( _____ Weeks X \$ _____ Rate):	
PTD:	
Death Benefits:	
All Other:	
Total Future Indemnity:	
Indemnity Paid to Date:	
Total Indemnity Occurred:	



# EXCESS CLAIM REIMBURSEMENT REQUEST

Date: \_\_\_\_\_

Insured: \_\_\_\_\_

Claimant: \_\_\_\_\_ DOL: \_\_\_\_\_

TOTAL AMOUNT PAID TO DATE: \_\_\_\_\_

LESS RETENTION OF: \_\_\_\_\_

LESS PRIOR EXCESS CLAIM PYMTS: \_\_\_\_\_

EXCESS CLAIM AMOUNT: \_\_\_\_\_

Claim Payment  
To Be Made Payable To: \_\_\_\_\_

Return to:  
Midlands Claim Administrators  
US Specialty Underwriters Division  
P. O. Box 238812  
Oklahoma City, Oklahoma 73123  
email: mcaussu@midman.com  
Fax: 405-767-2058

DOCUMENTATION OF PAYMENTS MADE TO DATE  
SHOULD BE ATTACHED WITH THIS REQUEST.

## RESERVE INFORMATION (MUST BE COMPLETED)

	PAID TO DATE	OUTSTANDING RESERVES	TOTAL INCURRED
MEDICAL			
INDEMNITY			
EXPENSE			
<b>TOTAL</b>			

Name of Person Completing Report: \_\_\_\_\_  
Telephone Number(s) \_\_\_\_\_