Northern Illinois University
Human Resource Services

Workers' Compensation Information Overview and Reporting Packet

For any incident resulting in a serious or life-threatening injury, immediately call 911, and/or seek prompt medical care, then proceed with the reporting process.

An employee with a compensable injury arising out of and in the course of employment, or who endures an injury or illness which may occur from toxic exposure or from repetitive/cumulative use, which are caused, in whole or part, by the employee's work, may be eligible for Workers' Compensation benefits in accordance with the provisions of the Illinois Workers' Compensation and Occupational Diseases Acts.

Northern Illinois University is subject to the Illinois Workers' Compensation Act 820 ILCS 305/Workers' Compensation Act. (ilga.gov) and the Occupational Diseases Act 820 ILCS 310/Workers' Occupational Diseases Act. (ilga.gov). The State of Illinois is self-insured for workers' compensation. Failure to follow provisions of the Act and university filing procedures may affect the employee's rights for compensation and/or for reimbursement of incurred expenses.

Nearly every employee who is hired or whose employment is localized in the State of Illinois may be covered by workers' compensation if injured, in whole or in part, by the employee's work. The employee may be covered from the moment they begin the job. Additional information regarding workers' compensation benefits is contained in the Handbook on Workers' Compensation and Occupational Diseases published by the Illinois Workers' Compensation Commission and is available on the IWCC website at Handbook - About (illinois.gov).

Employees who miss more than three (3) days of work due to a work-related injury or illness will be placed on FMLA and the worker's compensation time and the FMLA will run concurrently. There is no need for an employee to request the FMLA; your Worker's Compensation Coordinator will automatically enroll you.

If your time off work due to a work-related injury or illness lasts more than 60 days, you may be eligible for SURS disability or other disability coverage if you are already enrolled. It is the employee's responsibility to review their policies with outside insurance carriers (e.g.: Prudential, health insurance plans, etc.) to determine whether eligible for additional benefits. If so, additional steps may be required by the outside insurance carrier and the employee should make necessary contacts.

Who to Ask

Employees and their supervisors can contact the Workers' Compensation Coordinator (WCC) regarding work-related injuries, illnesses, and how to report them:

- **Bridgett Davis** by email workerscomp@niu.edu or by phone at 815-753-6318

Northern Illinois University
Human Resource Services

Responsibilities and Reporting of Injuries/Illnesses:

Who	When and What	How	Why
Injured employee	Report any injury or illness arising out of and in the course of employment to Gallagher Bassett Risk Management **within 48 hours** or as soon as it is realized that an injury or illness has occurred.	Report to Gallagher Bassett/State of Illinois Early Intervention Program via the toll-free 24-hour number **1-833-891-1372.** **Identity yourself as a State of Illinois employee and use this GB ID: 040035** They should provide you with a claim number. Write this down and keep it with your records.	Gallagher Bassett has the responsibility for determining the compensability of Workers' Compensation claims and authorizing the payment of benefits.
Injured employee	Report injury or illness to your supervisor **within 48 hours** or as soon as it is realized that an injury or illness has occurred.	This report can be given orally or in writing, but by law, it must include all the following: date, time, and location. It is also recommended that your notice include a brief description of the accident and the injury sustained.	Your supervisor has the responsibility to ensure the incident is reported to the university and must complete their portion of the worker's compensation packet as soon as possible.
Injured Employee	Report your injury to the NIU Worker's Compensation Coordinator (WCC) **within 48 hours** by completing the Worker' Compensation packet.	**Bridgett Davis** workerscomp@niu.edu or by phone at 815-753-6318	The WCC will coordinate the reports and work with Gallagher Bassett to ensure your information is dealt with in a timely manner.

Giving immediate notice of an injury or illness allows for an investigation of the claim to begin and a timely determination to be made concerning compensability, causation, and prevention. Notice to a fellow worker who is not a supervisor or otherwise a part of management is not considered notice to the employer.

The benefits may include payment of bills for necessary medical treatment, rehabilitation services, temporary disability income payments, and in some cases a settlement to compensate for permanent impairment that the employee may have as a result of the injury or disease.

Fraud Warning

According to the Workers' Compensation Act of Illinois, Section 25.5, it is unlawful for any person to present or cause to be presented any false or fraudulent claim for payment of any workers' compensation benefit. Section 25.5 (a) (2) of the Act states it is unlawful to intentionally make a false or fraudulent material statement or material representations for the purpose of obtaining a workers' compensation benefit.

Northern Illinois University
Human Resource Services

Print and complete all forms listed below (page number refers to document number in this packet –the first six (6) informational pages of this packet are kept by the employee for their records and not returned to the WCC):

Document in this packet	Page Number in this packet	Who Completes	Responsibility to complete and submit
Worker's Compensation Employee's Notice of Injury	1 & 2	Employee	Complete and return to WCC in HR
Supervisor's Report of Injury or Illness	3	Supervisor	Provide document to Supervisor after notification of injury/illness and request they complete and return it to WCC in HR
Worker's Compensation Witness Report (multiple copies may be made if more than one witness exists)	4	Witness(es)	Provide document to any witness(es) of the injury/illness and request they complete and return it to WCC in HR
Initial WC Medical Letter and Report	5 & 6	Treating Physician	Physician completes and Employee returns to WCC in HR
Authorization to Disclose Medical Information	7	Employee	Complete and return to WCC in HR
Notice of Benefit Option	8	Employee	Complete and return to WCC in HR

Return all signed and completed forms to your Worker's Compensation Coordinator (WCC) by fax, email, drop off or mail to:

Human Resources – Attn: Workers' Compensation
1515 W. Lincoln Highway
Dekalb, IL 60115
Fax 815-753-2335
Phone:815-753-6000
Email: workerscomp@niu.edu

Please be aware that **your Worker's Compensation claim is still pending until Gallagher Bassett approves** the incident and determines compensability as a covered Worker's Compensation event. All claim forms should be completed in a timely manner. Without the completed packet, Gallagher Bassett cannot determine compensability of the claim, which can pay you for any time lost, or consider any medical bills for payment.

Seeking Medical Attention

- If you need to seek medical attention, it is recommended that you visit a network provider within your group health insurance carrier when receiving treatment. ***If Gallagher Bassett determines that your claim is not compensable, you can then submit the medical bills to your health insurance.***

- It is the employee's responsibility to notify the medical care provider that you are seeking treatment for a potential work-related injury. Please provide the claim number to the medical provider, so they may submit all medical bills directly to Gallagher Bassett:

Gallagher Bassett
P.O. Box 2934
Clinton, IA 52733-2803
Fax: 847-621-7101

Northern Illinois University
Human Resource Services

Subject to compensability determination by Gallagher Bassett, you are entitled to receive all necessary medical, surgical and hospital services reasonably required to cure or relieve the effects of this injury/illness. Where necessary, you are also entitled to receive appropriate physical, mental or vocational rehabilitation. If the treatment is reasonably required to cure or relieve the effects of the injury/illness and the provider of the services has given the employer the information required by law, the employer is required to pay all reasonable charges. It is your responsibility to provide the contact information of all medical facilities that have rendered service to you for this injury/illness to the WCC. It is also imperative that you provide information on any treatment plan(s) including follow-up medical care. If prompt medical attention is deemed reasonably necessary by Gallagher Bassett, the employer will be responsible for payment of those medical costs. The employer is also responsible for costs of first aid and/or emergency medical treatment if necessary for treatment of a compensable accident/injury or illness. It is again recommended that employee remain within the parameters of their personal insurance network, as applicable, to avoid paying medical costs if the claim in denied.

Failure to provide medical documentation may result in a delay of benefits. Failure to inform the medical provider that the injury/illness is work-related will result in the employee being billed directly for the services or having the claim submitted to their health insurance plan. Please give the provider your Workers' Compensation claim number when seeking services.

- **If your medical provider places you out of work**, or on any form of restricted duty, you MUST provide a written work status note to the Workers' Compensation Coordinator (WCC) as soon as possible so that appropriate benefits can be applied to absence from work.

- The employee is responsible for notifying the WCC of any days that they are absent from work due to a work-related injury/illness and providing a physician's statement verifying the inability to work. The required Gallagher Bassett Medical Report to be completed by the physician is in the worker's compensation packet (pages 11 & 12).

- **Before returning to work** from a Worker's Compensation Leave of Absence, the employee must present to the Workers' Compensation Coordinator a physician's release to return to work signed by the physician with the date of return. The employee may not return to the workplace until the WCC has received such notification and authorized the employee's return to work. Other departmental fitness for duty requirements may be applicable. At all times, the employee is responsible for adhering to departmental policies regarding the report of absence(s).

- **Return to Work with Restrictions:** in the event the physician determines an employee may return to work with restriction(s), the physician's written notification must be received by the WCC before the employee may return to the workplace. The WCC will promptly contact the employing department to determine whether suitably restricted duty is available. If restricted duty or other reasonable accommodations are unavailable, the employee will be required to remain off work. Once the WCC has received proper medical documentation for the employee to return to work without restriction(s), the employee may return to the workplace as directed. An employee's refusal to accept suitably restricted duty may result in a forfeiture of any rights to workers' compensation benefits.

It is the employee's responsibility to keep the Workers' Compensation Coordinator and their supervisor informed of their status and progress.

Northern Illinois University
Human Resource Services

Compensability

Subject to compensability determination by Gallagher Bassett, you have the option of using your accrued paid benefits or Worker's Compensation Total Temporary Disability (TTD) while absent from work to recover from a work-related injury or illness.

- Read and complete the Notice of Benefit Option, page 14 of this packet.
- TTD is 66-2/3 of the average weekly wages one year prior to the date of injury/illness.
- The State of Illinois Workers' Compensation Commission established the amount of this benefit, subject to certain legal maximums and minimums (**http://www.iwcc.il.gov/benefits.htm**).
- TTD payment is based on a 7-day workweek, regardless of the number of days per week you are normally scheduled to work. This means the daily payment is one-seventh of the weekly payment.
- TTD is paid by Gallagher Bassett and not administered by NIU Payroll.
- TTD payments are not subject to federal or state taxes.
- TTD is not paid for the first three days off work (waiting period) unless the time lost exceeds 14 or more calendar days, then the first three full work days will be compensated under TTD retroactively.
- An employee may use accrued paid benefits to supplement the waiting period.
- While on TTD, you are responsible to pay all deductions directly to the state and all other supplemental vendors normally withheld from your university paycheck.

Permanent Impairment

Once the employee has reached maximum medical improvement from their injury/illness, the employee's physician will provide the written medical findings of whether a permanent impairment exists. If permanent impairment is determined, the employee may be entitled to additional compensation. Compensation amounts vary and are based on the extent of loss to various part(s) of the body. For further clarification, please refer to the Handbook on Workers' Compensation and Occupational Diseases at http://www.iwcc.il.gov/handbook.htm. Claims for additional compensation must be filed within three (3) years of the date of the incident, or within two (2) years of the last compensation payment or medical bill, whichever is later.

Death Benefits

If the death of an employee is due to a work-related injury/illness, the employee's family may be entitled to weekly compensation.

NIU Policies and Procedures

All periods of disability leave are subject to Northern Illinois University's policies and procedures.

Disclaimer: Northern Illinois University, Human Resource Services, provides this information as guidance for employees. All procedures, terms, and conditions of the Illinois Workers' Compensation program are as provided by Gallagher Bassett and the State of Illinois. While every effort has been made to ensure the accuracy and completeness of information, it is recommended employees directly access the information provided by the designated agencies responsible for administration.

WORKERS' COMPENSATION

is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work.

Benefits are paid regardless of fault.

IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

1. GET MEDICAL ASSISTANCE. By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocationalrehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation, the PPP counts asone of your two choices of providers.
2. NOTIFY YOUR EMPLOYER. You must notify your employer of the accidental injury or illness within 45 days,either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.
3. LEARN YOUR RIGHTS. Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

   If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

   It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.
4. KEEP WITHIN THE TIME LIMITS. Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

   Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033	Chicago:	312/814-6611	Peoria:	309/671-3019	Springfield: 217/785-7087
Web site: www.iwcc.il.gov	Collinsville:	618/346-3450	Rockford:	815/987-7292	TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.			
Party handling workers' compensation claims	Gallagher Bassett		
Business address	P.O. Box 2803, Clinton, IA 52733-2934		
Business phone	1-833-891-1372		
Effective date	02/01/2023	Termination date	01/31/2024
Policy number	Self-insured	Employer's FEIN	205743877

ICPN 10/11 Printed by the authority of the State of Illinois.

The employee will keep the first six (6) informational pages of this packet. The remaining pages are to be completed and returned to the WCC as soon as possible.

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

WORKERS' COMPENSATION EMPLOYEE'S NOTICE OF INJURY (COMPLETE ALL ITEMS)

EMPLOYEE'S NAME: (last) (first)		
EMPLOYEE'S ADDRESS: (no.) (street)		
(city) (state) (zip)		TELEPHONE: Home: _____ Work: _____
SOCIAL SECURITY NO.	DATE OF BIRTH (mo) (day) (year)	SEX: ☐ Female ☐ Male
MARITAL STATUS: ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced		NUMBER OF DEPENDENT CHILDREN UNDER 18 AT DATE OF INJURY _____
DATE OF INJURY OR ILLNESS (mo) (day) (year)	TIME: ☐ AM ☐ PM	LAST DAY WORKED:
NAME OF AGENCY	ADDRESS OF AGENCY	WORK COUNTY
REPORTED TO SUPERVISOR ☐ Yes ☐ No	NAME OF SUPERVISOR	DATE & TIME _____ _____ REPORTED (am) (pm) (mo) (day) (year)
IF NOT REPORTED ON DATE OF INCIDENT, EXPLAIN:		
HAVE YOU SOUGHTMEDICAL ATTENTION? ☐ Yes ☐ No	NAME, ADDRESS AND PHONE NO. OF DOCTOR:	
ANY SICK, VACATION OR PERSONALDAYS USED FOR THIS INJURY? ☐ Yes ☐ No	NUMBER AND TYPE	
HAS ANY INSURANCE COMPANY PAID FOR TREATMENT AS A RESULT OF THIS INJURY? ☐ Yes ☐ No	NAME AND POLICY NO.	
WHAT DUTY WERE YOU PERFORMING AT TIME OF INJURY? (BE SPECIFIC)		
PLACE WHERE INJURY OCCURRED (BE SPECIFIC)		
DETAIL HOW INJURY OCCURRED (USE REVERSE SIDE IF NECESSARY)		
DID A THIRD PARTY CAUSE OR CONTRIBUTE TO ACCIDENT? ☐ Yes ☐ No		
IF YES, EXPLAIN AND PROVIDE ADDRESS AND PHONE # OF NEGLIGENT PARTY (USE REVERSE SIDE IF NECESSARY):		
DESCRIBE INJURY (INDICATE PART(S) OF BODY AFFECTED)		
ANY WITNESS(ES) TO INJURY ☐ Yes ☐ No	IF YES, NAME(S):	
HAVE YOU SUBMITTED ANY PREVIOUS CLAIMS FOR INJURY/ILLNESS? ☐ Yes ☐ No (IF YES, IDENTIFY EACH ON REVERSE SIDE.)		
DATE THIS FORM COMPLETED _____ (mo) (day) (year)	SIGNATURE OF INJURED EMPLOYEE	
IF INJURED EMPLOYEE UNABLE TO SIGN ABOVE, SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM		

PO Box 2934 • Clinton, IA 52733-2934 • Fax 847-621-7101

Reverse side must be completed if applicable before submission to Gallagher Bassett

ADDITIONAL DETAILS HOW INJURY OCCURRED:

PREVIOUS INJURIES OR ILLNESSES

DATE(S) OF INJURY/ILLNESS	DESCRIBE INJURY/ILLNESS	WAS THIS WORKERS' COMPENSATION (YES OR NO)	NAME AND ADDRESS OF DOCTOR	IF YES, AMOUNT OF SETTLEMENT

ADDITIONAL DETAILS CONCERNING THIRD PARTY NEGLIGENCE

This is a written request for workers' compensation benefits as a result of the incident described therein.

Please fill out the form truthfully and accurately. Under Section 25.5 of the Illinois Workers' Compensation Act, it is unlawful for any person to intentionally make or cause to be made any false or fraudulent material statement or material representation for the purpose of obtaining any workers' compensation benefit. I have reviewed, understand and acknowledge the above statement.

Employee signature (if available to sign) _____ Date _____

Employer Signature _____ Date _____

PO Box 2934 • Clinton, IA 52733-2934 • Fax 847-621-7101

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

SUPERVISOR'S REPORT OF INJURY OR ILLNESS

Claim Number _____

This form must be completed thoroughly by employee's supervisor within 24 hours after an accident

PART I – GENERAL INFORMATION

Employee Name	Title		Social Security No.
Address	City/State	Zip	Home Phone
Agency	Location		Work Phone

Job Description and/or Assigned Duties of Employee (be specific):

Number of Years in current job title: _____

Previous job title: _____ Number of years previous title: _____

Activity at time of accident/incident: _____

Date of Accident/Incident	Hour: ◯ AM ◯ PM	Exact Location		
Did you witness? ■ Yes ☐ No	How was notice received? ☐ Written ☐ Oral	Date Received	Time Received	From Whom Notice Received

PART II – DETAILS OF ACCIDENT

Description of Accident/Incident:

Did a third party cause or contribute to the accident? ◯ Yes ◯ No

If yes, explain and provide name, address and phone number of negligent party (use reverse side if necessary):

Description of Injury – Part(s) of Body Injured:

Name(s) of Witness(es) (if none, so state):

PART III – CAUSE OF ACCIDENT

Describe any unsafe acts or conditions which contribute to the accident/incident:

PART IV – CORRECTIVE ACTION TAKEN

Was the condition above corrected (how)?	Reported to higher authority (Name & Title)?
Name and Title of Supervisor	Did the incident result in any disciplinary action? ◯ Yes ◯ No

_____ Signature of Supervisor/Phone Number

_____ Report Date

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

Claim Number _____

WORKERS' COMPENSATION WITNESS REPORT

Injured Employee Name	Work Location	
Your Name	Do you work for the State of Illinois? ☐ Yes ☐ No	Work Phone
Home Address (Street)	(City/State/Zip)	Home Phone

Did you see the accident? ☐ Yes ☐ No	Date you witnessed? Time ☐ AM ☐ PM	Did you know employee before the accident? ☐ Yes ☐ No

What did you see or hear? – Be specific (use back side if necessary)

Exact location of what you saw or heard

Name(s) and Address(es) of any other witness(es)

I CERTIFY THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

_____ Date Completed

_____ Signature of Witness

Name and Title of Individual Making Report (print)

_____ Print Name

The employee must also call Gallagher Bassett at 1-833-891-1372 to report the injury.

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

Dear Medical Provider:

The Illinois Worker's Compensation and Occupational Diseases Act provides that the employer is obligated to pay all medical, hospital and surgical charges incurred in connection with an accidental injury and/or disease which arises out of and in the course of employment. This obligation is "limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury or disease."

The Act further provides that "Every hospital, physician, surgeon or other person rendering treatment or services in accordance with the provisions of this Section shall upon written request furnish full and complete reports thereof to, and permit their records to be copied by, the employer***."

The Act also provides that "in the event the (Illinois Workers' Compensation) Commission shall find that a doctor selected by the employee is rendering improper or inadequate care, the Commission may order the employee to select another doctor certified or qualified in the medical field for which treatment is required. If the employee refuses to make such change the Commission may relieve the employer of his obligation to pay the doctor's charges from the date of refusal to the date of compliance."

In accordance with the above provisions, you are requested to complete the attached medical report. Your timely furnishing of this report will work to the benefit of the injured employee in that it will enable Gallagher Bassett to make prompt decisions regarding the compensability of the injury and issuance of appropriate disability payments to the employee. Your detailed completion of this report is also necessary for us to process your itemized bill for payment.

Should any clarification of this report or copies of other medical records be required, we will specifically request same. Thank you in advance for your cooperation.

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND

Mail To: PO Box 2934
Clinton, IA 52733-2934
Fax: 847-621-7101
ATTN: State of Illinois

INITIAL WORKERS' COMPENSATION MEDICAL REPORT Claim No. _____

The Illinois Workers' Compensation and Occupational Diseases Act provides that the employer is obligated to pay all first aid, medical and surgical services reasonably necessary to cure or relieve from the effects of occupationally-related injury or disease. Every hospital and doctor shall, upon written request, furnish complete records and permit their records to be copied by the employer and/or the employee.

Your detailed completion of this report is also necessary to enable our office to process your itemized bill for payment.

A. Employee's Name _____ Date of Report _____

Agency/Facility _____

Date of Accident _____ Date Examined _____ Height _____ Weight _____

☐ Family Doctor ☐ Specialist ☐ Chiropractor ☐ Other Number of years of Relationship _____

B. History (Description of Accident) _____

_____

History of previous injuries and illnesses _____

_____

Name(s) of other physician(s) who served on case _____

C. Diagnosis (ICD-9-CM Code(s)) _____

Describe nature and extent of injuries _____

_____

D. Treatment (Proposed or completed, surgical, dressing(s), etc.) _____

_____

Medications _____ (Given/Prescribed) _____

X-Ray Results (Attach copy of report) _____

E. Prognosis _____

_____

Estimated date or return to work with restrictions _____ Identify Restrictions _____

Estimated date of return to work without restrictions _____

F. Final Report (Complete the following if treatment is no longer being rendered to this employee by the undersigned physician)

Date patient discharged from treatment _____ Case transferred to _____

Name of Doctor (please print or type) _____

Address _____

_____

Phone _____

DOCTOR'S SIGNATURE _____ Date _____

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

AUTHORIZATION TO USE OR DISCLOSE INFORMATION

Employer: State of Illinois **Agency/Facility:** _____
Patient Name: _____ **Claim Number:** _____

Patient Address/Telephone: _____

Patient Social Security No. _____ **Patient Date of Birth:** _____

I, _____, understand that this authorization is voluntary, and that I may refuse to sign this authorization, and that I may revoke this authorization at any time by sending my written revocation to the entity providing the information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall remain in effect until the workers' compensation claim is fully resolved unless a different date is specified here _____ (Date).

☐ Medical Information ☐ Mental Health / Psychiatric Information

I hereby authorize any physician, psychologist, psychiatrist, dentist, hospital or other medical provider to furnish all records, reports, histories, diagnostic tests and evaluation, physician and nurses' notes and therapy notes to Gallagher Bassett/Employing State Agency and its legal representative, for purposes of processing and administration of the workers' compensation claim identified herein.

I understand that the recipient may not lawfully further use or disclose the information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If an authorization is requested by a person / organization listed above for the use or disclosure of protected health information, the person / organization listed above must provide me with a copy of the signed authorization. I understand I have a right to receive a copy of this authorization.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

A carbon, photo static, or thermo fax copy of this true release shall be as valid as the original.

_____ _____
Signature of Patient, Parent or Legal Guardian *Date*

_____ _____
If signed by other than patient, indicate relationship *Witness to Signature*

Northern Illinois University

NOTICE OF BENEFIT OPTION

Employee Name _____ Date of Incident _____

Claim Number _____ Supervisor's Name _____

If you are absent from work due to a work-related injury, you must choose to receive either Temporary Total Disability benefits (TTD) from Workers' Compensation according to the rules and regulations of the Illinois Workers' Compensation Act or be paid using personal accumulative sick and/or vacation leave benefits. Workers' compensation benefits are not taxed by Federal or State governments.

If your on-the-job injury will result in you missing three (3) or fewer consecutive scheduled work days, you are not eligible to receive Temporary Total Disability (TTD) benefits (i.e. wage replacement). In addition, if your case is deemed to be compensable and the period of disability does not exceed thirteen (13) days, you will not be paid Workers' Compensation TTD benefits for the first three (3) workdays of the disability period. Accrued sick leave and vacation are available for these first three days.

Please choose one option below, then sign and date:
I am aware that if I choose to apply for Workers' Compensation Temporary Total Disability (TTD) Benefit payments, payment is not guaranteed. The compensability of my claim is determined by the State of Illinois, Department of Central Management Services, Risk Management Division.

Option 1:

___I choose to receive Workers' Compensation Temporary Total Disability (TTD) Benefits. I understand that while I receive TTD benefits, I will be on a leave of absence without pay status with the university. I will not accrue sick or vacation time and I will not be paid for holidays during this period of leave of absence without pay. I also understand that while I am on a Workers' Compensation Leave of Absence using Temporary Total Disability (TTD) Benefits, I will be responsible for paying any payroll deductions normally deducted from a university paycheck.

Option 2:

___ I choose to use my university paid accumulative sick leave and/or vacation benefits for this on-the-job accident. I understand I will not be permitted to receive both paid personal leave benefits and TTD simultaneously. I reserve the right to discontinue use of sick and/or vacation benefits and utilize TTD benefits with at least an eight (8) day notice before the end of the pay period or understand that this change will take place in the pay period following my request. I must submit a corrected *Notice of Benefit Option* form, choosing Option 1 above if I decide to make this change.

Signature_____ Date_____