



CITY OF AUSTIN

Rolling Owner Controlled Insurance Program VI

[Project Name]

LOCATION CODE: [60xx]

AUSTIN, TEXAS

**ROCIP VI
CLAIMS KIT**

Presented By:





IX. ACCIDENT REPORTING AND CLAIMS PROCEDURES

A. GENERAL PROCEDURES:

This section describes basic procedures for reporting various types of Claims:

- **Workers’ Compensation** (Worker/Employee Injury)
- **General Liability** (Third Party Bodily Injury or Property Damage)
- **Automobile** (notice only) and **Pollution** (notice only).

The immediate reporting of all accidents or circumstances which might lead to or involve a Claim is required. Report all injuries, occupational-related illnesses, third party bodily injury or property damage to the *General Contractor Claim Contact* immediately. All Parties will instruct employees and other personnel to report, in writing, within 24 hours all Accidents and Occurrences of any type to the *General Contractor Claim Contact*.

Overview of Claims Reporting Process

| Action Required: | Responsible | Form: |
|---|---------------------|---------------------------|
| 1. Accident/Injury occurs | | |
| 2. On-Site Supervisor is notified | Parties involved | |
| 3. Claim form is completed | On-Site Supervisor | GL or WC Claim Report |
| 4. If injury, worker is sent for medical treatment with authorization form | On-Site Supervisor, | Authorization for Medical |
| 5. Claim form is provided to GC Claim Contact within 24 hours | On-Site Supervisor | GL or WC Claim Report |
| 6. GC Claim Contact reports claim to insurance carrier immediately by phone to: Liberty Mutual 1-800-362-0000 Account Number for ROCIP VI: 42404 | GC Claim Contact | GL or WC Claim Report |
| 7. Completed form faxed to: Anthony Pleasant, ROCIP Safety @ 512-974-3411 Melodie Langford, ROCIP Claim Advocate @ 248-701-4168 | GC Claim Contact | GL or WC Claim Report |

Please refer to section B. Workers’ Compensation and C. General Liability for step-by-step procedures on the following pages.

The *General Contractor Claim Contact* will immediately contact the **ROCIP VI Safety Representative, Anthony Pleasant and , Melody Langford, ROCIP Claim Advocate** in the event of any of the following “serious accidents”, incidents and injuries:

Any injury for which an ambulance is called

- **Injury to head or neck**
- **Possible injury to back or spinal cord**
- **Unconscious employee**
- **Possible blindness**
- **Amputation of limbs**
- **Fatality**
- **Heart attack or stroke**
- **Hospitalization**
- **Property damage estimated over \$1,000**



Investigation Assistance:

All Parties will assist in the investigation of any accident or occurrence involving injury to persons or property. All Enrolled Parties will cooperate with the companies involved in adjusting any claim by securing and giving evidence and obtaining the participation and attendance of witnesses required for the investigation and defense of any claim or suit.

When in doubt, refer all questions regarding the reporting of a claim to the *General Contractor Claims Contact* and/or *ROCIP VI Claim Advocate*

**[General Contractor
Claim Contact Info]**

Melodie Langford

Marsh USA, Inc.

500 Dallas Street

Houston, TX 78002

Phone: 248-701-4168

Melodie.s.Langford@marsh.com

**B. WORKERS' COMPENSATION CLAIMS REPORTING PROCEDURES:**

These procedures apply to ALL employees covered by ROCIP VI for this project.

Immediately notify the ROCIP VI Safety Representative in the event of a serious injury or accident.

Contractors' on-site personnel will follow these procedures if any employee is involved in an accident or occurrence resulting in bodily injury:

1. **Contact the Injured Worker's On-Site Project Supervisor immediately and transport the injured worker to the on-site first aid or medical facility, as necessary. An *Authorization for Medical Treatment Form* is to be sent with the Injured Worker prior to the first medical treatment, which includes the request for mandatory post accident drug testing.**
2. **Report all injuries or occupational-related illnesses to the *General Contractor Claim Contact* immediately.**
3. **Project Supervisor must complete a *WC Claim Report Form* and return to the *General Contractor Claim Contact* within 24 hours of employee's notice of injury/claim. The *General Contractor Claim Contact* will call the injury/claim into the Insurance Carrier immediately.**
4. **The *General Contractor Claim Contact* will fax a copy of the *WC Claim Report Form* to Anthony Pleasant, ROCIP VI Safety Representative at 512-974-3411 and Melody Langford ROCIP Claim Advocate at 212-948-5020**
5. **An accident investigation is to be completed as soon as possible by all contractors involved in the accident. An *Incident Investigation Report* must be completed by the General Contractor Supervisor and provided to Anthony Pleasant and Melody Langford, ROCIP Claim Advocate at 212-948-5020.**
6. **All "serious accidents", incidents and injuries will be reported immediately by phone to Anthony Pleasant at 512-632-3333 and Melody Langford, ROCIP Claim Advocate at 248-701-4168.**
7. **If possible, Contractor and its lower-tier Subcontractor(s) may provide for Modified Alternate Duty based upon the work abilities given to the Injured Party from the treating physician.**
8. **Immediately send all subsequent return to work notes, inquiries or correspondence about an Injured Party to the *General Contractor Claim Contact*.**
9. **No Injured Party will be allowed on a job site unless they have provided the *General Contractor Claim Contact* with the proper return to work note, either full duty or modified duty, as well as verification that post accident drug testing was completed.**

**C. GENERAL LIABILITY & PROPERTY DAMAGE CLAIM REPORTING PROCEDURES:**

Contractors must immediately report all Accidents at the Project Site involving death, injury, or damage to property of non-employee personnel (the public, tenants, and visitors) to the **General Contractor Claim Contact**. As soon as the onsite personnel become aware of the accident or occurrence, they must:

1. **Take appropriate emergency measures to prevent additional injury or damage, including contacting police and fire authorities as required by law.**
2. **Complete and submit a *GL Claim Report Form* to the General Contractor Claim Contact within 24 hours of the incident. The General Contractor Claim Contact will call the claim into the Insurance Carrier immediately.**
3. **The General Contractor Claim Contact will fax a copy of the *GL Claim Report Form* to Anthony Pleasant, ROCIP VI Safety Representative at 512-974-3411 and Melody Langford, ROCIP Claim Advocate at 212-948-5020.**
4. **An accident investigation is to be completed as soon as possible by all contractors involved in the accident. An *Incident Investigation Report* must be completed by the General Contractor Supervisor and provided to Anthony Pleasant and Melody Langford, ROCIP Claim Advocate at 212-948-5020.**
5. **All Serious accidents, incidents and injuries will be reported immediately by phone to the City of Austin ROCIP V Safety Representative, Anthony Pleasant, at 512-632-3333 and Melody Langford, ROCIP Claim Advocate at 248-701-4168.**
6. **Immediately send all subsequent inquires or correspondence about an insured loss or claim, including a summons or other legal documents, to the General Contractor Claim Contact immediately.**

The first five thousand dollars (\$5,000) of any insurable general liability property damage loss will be the responsibility of and paid by the Contractor and deducted from the contract amount.

D. AUTOMOBILE LIABILITY CLAIMS PROCEDURES:

No coverage is provided for automobile accidents under the ROCIP VI. It is the sole responsibility of each Party to report accidents/claims involving their automobiles to their own insurers.

However, all accidents occurring in or around the Project site must be reported to the **General Contractor Claim Contact**. Accident investigations will occur and focus on liability arising out of the Project construction activities that could result in future claims (i.e. due to the conditions of the roads, etc.). Each Party shall cooperate in the investigation of all automobile accidents.

**E. POLLUTION CLAIMS PROCEDURES:**

No coverage is provided for pollution incidents under the ROCIP VI. It is the sole responsibility of each Party to report accidents/claims involving pollution coverage to their own insurers. However, all accidents occurring in or around the Project site must be reported to the ***General Contractor Claim Contact***. Accident investigations will occur and focus on liability arising out of the Project construction activities that could result in future claims involving Bodily Injury or Property Damage not deemed to have been caused by a pollution event. Each Party shall cooperate in the investigation of all pollution incidents.

F. LOSS RUNS:

An enrolled contractor may obtain loss runs for their own on-site experience by requesting, in writing on their company letterhead, directed to the ROCIP VI Administrator. Please note that the loss information is also available from the ROCIP VI Insurance Carrier.

G. ALCOHOL & DRUG TESTING:

Please refer to the City of Austin Capital Improvements Program ROCIP Project Safety Manual for the Controlled Substances Safety Policy & Procedures.

INJURY INFORMATION

Injury Description:

Date of Death (if applicable):

Is Employee Hospitalized? Yes No

Lost Time? Yes No

If Yes, What was First Full Day Out:

Date Last Day Worked:

Date Disability Began:

Date Returned to Work:

OR Estimated Return to Work Date:

Time Workday Began:

Which Part of the Body was Injured? (e.g. Head, Neck, Arm, Leg)?

Nature of Injury: (e.g. Laceration, Bruise, Fracture)

Part of Body Location: (e.g. Left, Right, Upper, Lower?)

Source of Injury:

MEDICAL INFORMATION

Safeguards Provided? Yes No

Safeguards Utilized? Yes No

Initial Medical Treatment: (Select One) ER Treated and Released Hospitalized Physician/Clinic Minor/Onsite No Medical Treatment

Hospital - Name, Address, Phone:

Clinic/Doctor - Name, Address, Phone:

WITNESS INFORMATION

Were there any Witnesses? Yes No

If Yes, List Names and How to Contact Them:

ADDITIONAL COMMENTS & INFORMATION

REPORT PREPARED BY

Name:

Title:

Signature:

Phone:

**CITY OF AUSTIN
ROCIP VI
AUTHORIZATION FOR MEDICAL TREATMENT**

**SEND WITH INJURED WORKER OR FAX TO MEDICAL PROVIDER PRIOR TO THE FIRST
MEDICAL TREATMENT**

FACSIMILE TRANSMITTAL SHEET

TO: _____ **FAX NUMBER:** _____
Medical Provider

FROM: _____ **PHONE:** _____

TOTAL NO. OF PAGES INCLUDING COVER: _____ **DATE:** _____

RE: _____
Injured Worker

CITY OF AUSTIN ROCIP V

Project Name & Site Code: _____

Enrolled Contractor Name & Address: _____

_____ **Contractor** **WC** **Policy** **Number:** _____

Contractor Main Contact Person: _____ **Phone:** _____

Employee Name/Injured Worker: _____ **DOB:** _____

Date of Incident: _____ **Description of Incident:** _____

Which of the following test(s) will be administered to the injured worker?

Drug Screen **Breath Alcohol** **Drug Screen & Breath Alcohol** **Urine Collection Only**

ALL DRUG SCREEN/BREATH ALCOHOL TEST RESULTS & BILLS WILL BE SENT TO:

Contractor Name

ATTN:

Address

City, State and Zip

TO MEDICAL PROVIDER:

Send Medical Bills only and Reports to ROCIP VI Insurance Carrier:

Liberty Mutual Group

Central billing Unit

P.O. Box 7203

London, KY 40742

Phone: 1-800-300-0110 for inquiries or pre-authorization

ROCIP VI Account Number: 42404

City of Austin ROCIP VI Incident Investigation Report

This form must be completed within 24 hours after the incident

| | | |
|--|---|--------------------------------------|
| 1. Company: | 2. Project Name: CLMC128 S. I35, Segment 2/5, I35 Slaughter & Onion Crossings, 36-inch WM | 3. Project Site Code: 0009-01 |
| 4. Company Contact: | 5. Phone Number: | |
| 6. Exact Location of Incident: | 7. Date of Incident: | |
| | 8. Time: | |
| | 9. Date Reported: | |
| City/State: | 10. Job-Site Phone Number: | |
| 11. Type of Loss: <input type="checkbox"/> WC <input type="checkbox"/> Environmental <input type="checkbox"/> Liability <input type="checkbox"/> Property <input type="checkbox"/> Fire <input type="checkbox"/> Crime <input type="checkbox"/> CIP <input type="checkbox"/> Other | | |
| Injury or Illness | Property Damage (Vehicle, Building, Equipment) | Other Incidents |
| 12. Name of Injured | | |
| 13. Company | | |
| 14. Age and Years Experience | | |
| 15. Part of Body Affected | | |
| 16. Nature of Injury/Illness | | |
| 17. Object/Equip/Substance Inflicting Injury | | |
| 18. Person with Most Control | | |
| 19a. OSHA Recordable <input type="checkbox"/> Yes <input type="checkbox"/> No | 19b. Lost Time <input type="checkbox"/> Yes <input type="checkbox"/> No | 19c. Days Lost |
| 20. Person Injured: | | |
| Date of Birth: _____ Social Security #: _____ Marital _____ Status: _____ | | |
| Date of Hire: _____ Job _____ Title: _____ | | |
| _____ Address: _____ | | |
| _____ | | |
| Telephone No: _____ Return _____ to _____ Work _____ Date: _____ | | |
| Name _____ of _____ Medical _____ Provider: _____ | | |

21. Describe clearly how the incident/accident occurred

22. Identify improper acts and/or condition that were the primary causes:

23. Why did the unsafe acts or conditions in 22 above occur?:

| | |
|--|---|
| Evaluation: Check the Severity and Recurrence Potential for a similar incident/accident. | |
| 24. Severity Potential <input type="checkbox"/> Major <input type="checkbox"/> Serious <input type="checkbox"/> Minor | 25. Recurrence Potential <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Rare |
| 26. Have similar incidents occurred previously? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 27. Comments on reason for occurrences: | |
| 28. Steps to prevent recurrence List those steps that have or must be taken to prevent a recurrence: | Follow-up Action |
| | Intermediate Action Taken-Date: Completion Date: |
| 29. Did this involve a defective machine, tool, vehicle or product? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | |
|--------------|-------------------|
| 30. Witness: | Name: |
| | Address: |
| | City, State, Zip: |

Attach Witness Statement

| | |
|----------|-------------------|
| Witness: | Name: |
| | Address: |
| | City, State, Zip: |

Attach Witness Statement

| | |
|----------|-------------------|
| Witness: | Name: |
| | Address: |
| | City, State, Zip: |

Attach Witness Statement

| | |
|-----------------------------------|----------------|
| 31. Police Dept. Responding Name: | |
| Precinct: | Shield Number: |

| | | | |
|----------------------|-------|--------------|-------|
| 32. Investigated by: | Date: | Reviewed by: | Date: |
|----------------------|-------|--------------|-------|

| | |
|--------------------------|--------|
| 33. Report Completed By: | Title: |
|--------------------------|--------|