COVENTRY
Workers' Comp Services

APPROVED MEDICAL CARE PLAN
EMPLOYER APPLICATION FORM

Employer Name: _____
(Please Print)

Employer Representative: _____ **Telephone:** _____
(Please Print)

Business Location(s): _____

(Include number of employees per _____

site, if more than one location) _____

_____

DBAs & Subsidiaries: _____

_____

Total No. of Employees: _____ **Type Of Business:** _____

Average Number Of Work-Related Injuries Per Year: _____

INSURANCE INFORMATION

Please Check One: ☐ Workers' Compensation Carrier ☐ Third Party Administrator (If self-insured)

Name: _____

Address: _____

_____

_____

Insurance Representative: _____ **Phone:** _____

Policy Number: _____ **Policy Term:** _____

AGENT INFORMATION (If Applicable)

Agency: _____ **Agency Address:** _____

_____

_____

Agent Representative: _____ **Telephone:** _____

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ALTERNATE/MODIFIED DUTY INFORMATION

Indicate the type of Return-to-Work Program currently in place *(choose from the following):* _____ Temporary modified duty program (attach description)

_____ Case by case modified duty plan

COLLECTIVE BARGAINING INFORMATION

Are any employees covered by a collective bargaining agreement? Yes _____ No _____

Are you subject to any collective bargaining agreement which prevents your participation in an Approved Medical Care Plan? Yes _____ No _____

Note: The collective bargaining agreement must be provided to the Commissioner upon request.

PLAN PARTICIPATION

Has the employer agreed to the performance of all obligations as outlined in the original Coventry Plan application? Yes _____ No _____

If no, please attach a detailed description of any employer responsibilities, which have been amended by a new client-sponsor contract.

If different from the original network filing, attach a copy of the plain-language explanation to be distributed to employees.

We, _____ consent to participate in and adopt the Medical
(Company Name)
Care Plan filed as noted herein.

Employer Representative Signature: _____

Printed Name: _____

Title: _____

Date: _____

Return this application to:

Michael Read
Regulatory Analyst
Coventry Workers Comp Services
4630 Woodland Corp Blvd. 3rd Floor
Tampa, Fl, 33614
(813) 806-2151 Phone
(813) 806-2220 Fax

TRANSITIONAL WORK PROGRAM

As your employer we are committed to the success of our Transitional Work Program. Regarding this program, we will review each claimant's restrictions, on a case-by-case basis, to determine the injured employee's ability to safely return to work in a modified duty position. Assignments will be made in accordance with the medical restrictions and shall be within the same union, and to the extent possible, shall be within the same department and related to the type of work normally performed by the employee. If a transitional work duty position is unavailable, the employee can qualify for continued benefits under section 31-308 (a).

In the event that an employee receives work restrictions from his or her treating physician and is therefore unable to return to his or her regular job, the following alternate duty work positions are examples of those which would be made available, consistent with the employee's medical restrictions:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

_____

EMPLOYER REPRESENTATIVE NAME: _____
(Please print)

EMPLOYER REPRESENTATIVE SIGNATURE: _____

TITLE: _____

PHONE: _____

SAFETY COMMITTEE INFORMATION

Employer Name _____

Address _____

Telephone _____ **Date** _____

SAFETY COMMITTEE MEMBERS

Representation must consist of an equal ratio of employees and employers or in favor of employees.

MANAGEMENT

NAME	WORK-SITE ADDRESS	WORK-SITE TELEPHONE #

Non-Management

NAME	WORK-SITE ADDRESS	WORK-SITE TELEPHONE #

THE ROLE OF THE EMPLOYER

- Educate employees, including all new hires, of how and where services are available and that treatment received outside of the network may result in suspension of benefits.
- Provide Access to Provider Network, upon request and for review by employees.
- Post the work site posting in a prominent place where covered workers are employed.
- Develop safety committees in accordance with C.G.S. Section 31-40v-1 through 31-40v-11.
- Ensure that insurance carrier is advised of injury.
- Employer provides temporary modified duty & provides job descriptions to medical providers.

EMPLOYEE RESPONSIBILITY

- Report injury to supervisor immediately.
- Seek treatment at Urgent Care Center listed in provider network.
- Stay in touch with supervisor -- advise of medical progress and issues regarding return to work
- Cooperate and communicate with insurance claims staff and case management specialists