



## 2017 WORKER'S COMPENSATION PACKET

SADLY, ONE OF YOUR EMPLOYEE'S WAS INJURED ON YOUR WATCH, NOW WHAT?

1. PLEASE REFERENCE THE INJURED EMPLOYEE HID (available on [learn.bigredf.com](http://learn.bigredf.com))
2. PRINT THIS PACKET OUT
3. GIVE THE INJURED EMPLOYEE PAGES 3, 4 & 5
4. *VERY IMPORTANT*: BE SURE THE EMPLOYEE GIVES THE MEDICAL PROVIDER THE MEDICAL PROVIDER LETTER AT THE TIME OF SERVICES. THIS WILL ENSURE THAT PINNACOL IS BILLED FOR MEDICAL SERVICES AND YOUR EMPLOYEE IS **NOT**
5. ONLY COMPLETE THE FROI FORM (PG 2) IF YOU ARE FAXING OR CALLING IN YOUR CLAIM
6. CLAIMS MUST BE FILED WITHIN 24 HOURS OF TIME OF INJURY OR WHEN THE EMPLOYEE INFORMS YOU OF THEIR INJURY

# PINNACOL ASSURANCE

## FIRST REPORT OF INJURY

To report a claim:  
Call 303-361-4000 or 1-800-873-7242  
Or Fax to 303-361-5000 or 1-888-329-2251  
Or, go to [www.pinnacol.com](http://www.pinnacol.com)  
PLEASE PRINT CLEARLY

### Early reporting can save you money. Report all injuries immediately!

The information below allows Pinnacol Assurance's customer service representatives to quickly and accurately process your claim. Use the completed form as a guide when reporting by phone or online to save you time. Don't wait to report if you don't have all the answers.

### POLICY INFORMATION

Policy Number: 4166213 Company Name: JAX FISH HOUSE FORT COLLINS

Address or Location (if different than mailing address): 123 N COLLEGE, FORT COLLINS, CO 80524

Prepared by: \_\_\_\_\_ Title: \_\_\_\_\_  
Please Print

E-mail: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Phone: ( 970 ) 682 - 2275 Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

### INJURED WORKER INFORMATION

Injured Worker's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

First Name: \_\_\_\_\_ M.I. \_\_\_\_ Last Name: \_\_\_\_\_

Home/Mailing Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
City State Zip Code

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female Martial Status: \_\_\_\_\_

Language:  English  Spanish  Other: \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date Hired: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Status:  Full-time  Part-time  Seasonal  Volunteer  Independent Contractor

Days Worked per Week: \_\_\_\_\_ Hours Worked per Day: \_\_\_\_\_

Pay Rate: \_\_\_\_\_  Hourly  Weekly  Monthly  Annually  Other: \_\_\_\_\_

### ACCIDENT / INJURY INFORMATION

Fatal Injury:  Yes  No If Fatal Injury: Date of Death \_\_\_\_/\_\_\_\_/\_\_\_\_

Time of Injury: \_\_\_\_\_  am  pm Time Work Began: \_\_\_\_\_ Last Day Worked: \_\_\_\_/\_\_\_\_/\_\_\_\_

Full Pay on Date of Injury:  Yes  No

Accident Occurred on Employers Premises:  Yes  No If Applicable: Location Code: \_\_\_\_\_ Dept Code: \_\_\_\_\_

Accident Location: \_\_\_\_\_  
City State Zip Code

Name of Employer Representative Notified: \_\_\_\_\_ Date Notified: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witnesses: \_\_\_\_\_  
Name(s) and Phone Number(s)

How Did the Injury Occur: \_\_\_\_\_

Specific Activity the Employee Was Engaged In: \_\_\_\_\_ What Equipment Was Being Used: \_\_\_\_\_  
Attach Additional Information if Necessary

Body Part(s) Injured: \_\_\_\_\_  Right  Left  Not Applicable

Type of Injury Sustained: \_\_\_\_\_

Safety Equipment Provided  Safety Equipment Used  Possible Drug/Alcohol Involved  Employer Questioning Liability

### RETURN TO WORK INFORMATION

Has the Injured Worker Returned to Work?  Yes  No

Date Returned to Work: \_\_\_\_/\_\_\_\_/\_\_\_\_ Estimated Return to Work Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this a lost time Claim?  Yes  No (Claim is lost time if there is a loss of more than three scheduled work days due to the injury).

### MEDICAL PROVIDER INFORMATION: Where Was Your Employee Treated?

No Medical Treatment  Treated by Employer  911 Called  Walk-In Clinic

Emergency Room  Hospitalized > 24 hrs/Overnight  Possible Surgery

Medical Provider Name \_\_\_\_\_ Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_



RE: LETTER TO INJURED EMPLOYEE

Dear BigRedFer,

We are so sorry to learn that you have been injured. To ensure that you receive the care you need, we are filing a claim with our workers' compensation insurance carrier, Pinnacol Assurance. A Pinnacol Representative will contact you with your claim number and additional information very soon. In the meantime, you should see one of the medical providers we have selected to treat our injured employees. These medical providers specialize in on-the-job injuries and I want you to have the best care.

Our Designated Providers are:

Concentra Medical Center  
620 S Lemay Ave  
Fort Collins, CO 80524  
(970) 482-6620

OR Poudre Valley Hospital, Medical Group-Occupational Health  
4674 Snow Mesa Drive, Ste 200  
Fort Collins, CO 80528  
(970) 495-8450

Please contact one of them to be seen as soon as possible. After your first appointment, please follow up, so that we can review your medical status and work capabilities together. If you have any questions, please feel free to call or email. Our goal is to ensure that you receive the care you need to recover quickly and return to work as soon as possible.

Name and contact information for BigRedF's authorized representative:

Iva Townsend  
iva.townsend@bigredf.com  
303-448-9182 ext 119

Pinnacol Assurance is our workers' compensation insurance company. Please see the contact information below:

Pinnacol Assurance  
7501 E Lowry Blvd  
Denver, CO 80230-7006  
(303) 361-4000

Worker's Compensation Insurance Policy # 4166213

Sincerely,

BigRedF's 'People Division' [aka Human Resources]



Your health and safety is of utmost importance to us. To ensure that you receive the proper care, we will file a claim with our workers compensation provider, Pinnacol Assurance. Please proceed to one of the designated providers listed below for your medical needs. These providers specialize in on-the- job injuries and will provide the best care. After your appointment, please follow up with your manager to discuss your medical status and work capabilities.

### **DESIGNATED PROVIDERS**

Employees should use the designated provider if the injury occurs within business hours of the provider and is non-life threatening. ALL follow up care should occur at the designated provider

#### **Concentra Medical Center**

620 S Lemay Ave  
Fort Collins, CO 80524  
(970) 482-6620

**HOURS: M-F 7AM-7PM; S/S 10AM-2PM**

*Directions:* South on N. College towards W. Mountain; Left on E. Mulberry Street; Slight right on Riverside Ave; Left on S. Lemay; Destination on right

#### **Poudre Valley Hospital**

Medical Group-Occupational Health  
4674 Snow Mesa Drive, Ste 200  
Fort Collins, CO 80528  
(970) 495-8450

**HOURS: M-F 8AM-5PM**

*Directions:* South on N. College Ave; Left E. Harmony Rd; Right on Corbett Dr. Right on Timberwood Dr; Right on Snow Mesa

### **EMERGENCY**

For emergency medical needs OR outside designated provider business hours

#### **Poudre Valley Hospital**

1024 S Lemay Ave, Fort Collins, CO  
(800) 252-5784

*Directions:* South on N. College towards W. Mountain; Left on E. Mulberry Street; Slight right on Riverside Ave; Right on S. Lemay; Destination on right

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BigRedF Workers' Compensation Insurance Provider  
Pinnacol Assurance  
7501 E. Lowry Blvd, Denver, CO 80230  
(303) 361-4000  
Jax Holdings Policy #4166213

BRF Representative – Iva Townsend  
iva.townsend@bigredf.com  
(303) 448-9182 ext 119



RE: Worker's Compensation Medical Provider Letter

Dear Medical Provider,

This letter has been provided to our employee as proof that this injury is work related and occurred during on the job. All billing matters should be directed to our workers compensation carrier:

Pinnacol Assurance.  
7501 E. Lowry Blvd. Denver. Co.  
80230-7006  
1 (800) 873-7242 OR (303) 361-4000

**Policy Number: #4166213**

Thank You,

Big Red F Restaurant Group / Big Red F Management Co  
5440 Conestoga Court  
Boulder, Co 80301  
303-448-9182