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)
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
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: 4170022 Company Name: THE POST BREWING CO

Address or Location (if different than mailing address): 105 WEST EMMA STREET, LAFAYETTE CO 80026

Prepared by: _____ (Please Print) Title: _____

E-mail: _____ Fax: (_____) _____-_____

Phone: (303) 593 - 2066 Date Completed: _____ /_____ /_____

INJURED WORKER INFORMATION

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

First Name: _____ M.I. ____ Last Name: _____

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

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: _____ (Attach Additional Information if Necessary)

Specific Activity the Employee Was Engaged In: _____ What Equipment Was Being Used: _____

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

BIGREDF RESTAURANT GROUP

Date

Injured Worker Name
Address
City, State ZIP

Dear [Injured Worker Name],

We are 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:

Boulder Occupational Health Services
1000 W South Boulder Road, SUITE 214
Lafayette, CO 80026
(303) 604-4660

OR

Exempla Family & Occupational Medicine
16570 Washington Street
Thornton, CO 80023
(303) 689-6600

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 19

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

Pinnacol Assurance
WC Policy # 4170022
(303) 361-4000

Sincerely,

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

BIGREDF RESTAURANT GROUP

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

Boulder Occupational Health Services
1000 W South Boulder Road, SUITE 214
Lafayette, CO 80026
(303) 604-4660
HOURS: M-F 8AM- 5PM
Directions: Right on S. Public Road
Right on W. South Boulder Road
Left on Angevine Way; Destination on the left

OR

Exempla Family & Occupational Medicine
16570 Washington Street
Thornton, CO 80023
(303) 689-6600
HOURS: M-F 8AM- 5PM; SAT 8AM-12:30PM
Directions: Left on S. Public Road; Right on E. Baseline; Right on Huron Street; 1st left on W 160th; Left on Washington; Destination on right

EMERGENCY

For emergency medical needs OR outside designated provider business hours

Exempla Good Samaritan Medical Center
200 Exempla Circle, Lafayette, CO 80026
(303) 689-5000
Directions: Right on S. Public; Left on S. 112th; Continue on straight on 112th through the traffic circle; Right on Exempla Circle; Destination on the left

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BigRedF Workers' Compensation Insurance Provider
Pinnacol Assurance
7501 E. Lowry Blvd, Denver, CO 80230
(303) 361-4000
POST BREWING CO Policy #4170022

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

BIGREDF RESTAURANT GROUP

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: #4170022

Thank You,

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