RIVERSIDE COMMUNITY COLLEGE DISTRICT

CLAIMS REPORTING MANUAL

Risk Management

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AUTOMOBILE CLAIM PROCEDURES

After an auto accident/incident the following procedures must be followed:

- District police or local police (depending on where the accident occurs) must be notified so a Police Report can be generated.
- The RCCD driver must obtain a report number from the responding officer so it can be inserted into the accident report.
- When at the scene, the RCCD driver should exchange information with the other driver (if applicable). It is important that the following information is obtained:

  - ☐ Other Driver Name
  - ☐ Other Driver Address
  - ☐ Other Driver Telephone Number
  - ☐ Other Driver Driver's License Number
  - ☐ Other Vehicle License Plate Number
  - ☐ Other Vehicle Year, Make, Model, and Color
  - ☐ Other Driver Automobile Insurance Carrier Name
  - ☐ Other Driver Automobile Insurance Carrier Policy Number
  - ☐ Pictures of the Other Vehicle Damage (if possible)

- All of the information taken at the scene should be included on a **VEHICLE COLISION REPORT FORM** (see Exhibit 1 on page 5) and returned to the Risk Management Department attention Bj.cain@rccd.edu.
- On the Vehicle Collision Report, the RCCD driver must provide a complete description of the RCCD vehicle, year, make, model, color, area of damage, and current location of the vehicle for inspection.
- The incident should be reported to any involved employee's supervisor.
- Any district employee involved in the accident must call Medcor at **(800) 775-5866** to report the incident and report any injuries.
- Two estimates for repairs should be turned into the Risk Management Department attention Bj.Cain@rccd.edu. Risk Management will forward the information to the District's auto insurance carrier.

  - The auto insurance carrier can assign an estimator if necessary.

- Once the estimates are received, and a vendor is chosen for the repairs, the driver's department will be responsible for creating a requisition and going through the usual purchasing process to complete the repairs. A copy of the requisition should be sent via email to Bj.cain@rccd.edu.

- The department is to use their budget for the repairs. The insurance company will send reimbursement to Risk Management for the repairs less any deductible.

- Once Risk Management receives the reimbursement check, the check will be sent to accounts receivable to ensure the funds are returned to the department's budget. A copy of the check will be sent to the driver's department notifying the department head that the reimbursement is in route.

- Please note that no repairs can be completed until a PO is generated by the driver's department.

- Please note that anyone driving on school or district business must be first cleared to drive. Contact Sylvia Valentines at extension 3547 or by e-mail at Sylvia.valentines@rccd.edu to verify if individuals are cleared.

Preferred Auto Providers

Moreno Valley Campus:

- Buds Tire Pros | 22510 Alessandro Blvd., Moreno Valley CA 92553 | (951) 653-0707 | Galaxy #39393
- Solutions RV | 25620 Sierra Cadiz Ct., Moreno Valley CA 92551 | (951) 490-8041 | Galaxy #103212

Norco Campus:

- Hemborg Ford | 1900 Hamner Ave., Norco CA 92860 | 951-737-6151 | Galaxy #44333

Riverside Campus:

- Fritts Ford | 8000 Auto Dr., Riverside CA 92504 | 951-687-2121 | Galaxy #16830

Exhibit 1 – Vehicle Collision Report Form

VEHICLE COLLISION REPORT

School District:_____ Address:
Phone: _____

Date of Collision: _____ Time: _____ Location of Collision: _____ Police Report #:
Violations/Citations: _____

What to do in Case of Vehicle Collision

1. Warn other motorist. Use flashlight, flares or car lights
2. Call police. If someone is injured, summon ambulance.
3. Write down facts. Get as much information as possible.
4. Obtain names, addresses and telephone numbers of all witnesses. This is very important.
5. DON'T ADMIT LIABILITY, but give other party your name and address. Advise other party to call 951-222-8127 for insurance information.
6. Notify your supervisor of the collision immediately.
7. Complete vehicle collision report form immediately.

College / Personal Vehicle

VEHICLE # _____ YEAR _____ MAKE _____ MODEL _____
DRIVER _____ OWNER _____ DRIVER'S LICENSE _____
SUPERVISOR _____ WORK PHONE _____
DAMAGES _____

Other Vehicle Or Property

VEHICLE # _____ YEAR _____ MAKE _____ MODEL _____
DRIVER _____ OWNER _____ DRIVER'S LICENSE _____
ADDRESS _____ PHONE # _____
INSURANCE CO./POLICY _____ AGENT'S PHONE # _____
DAMAGES _____

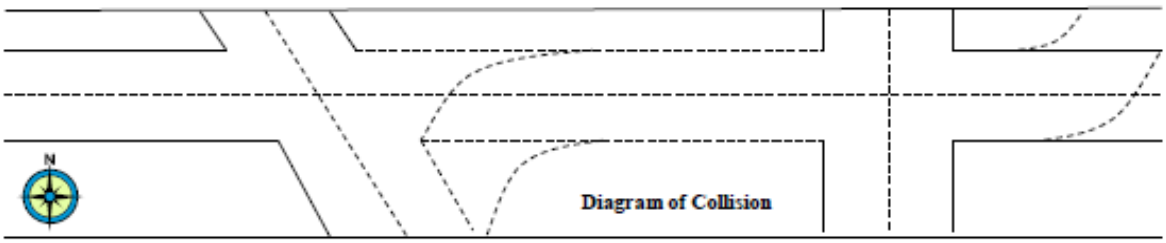
Injuries

NAME	DOB	ADDRESS	PHONE #	DIST. AUTO	OTHER AUTO	PED

Witnesses

NAME	DOB	ADDRESS	PHONE #

USE SYMBOL & NUMBER YOUR CAR #1, OTHER CAR #2. MAKE STOP SIGNS AND STOP LIGHTS. GIVE STREET NAMES OR NUMBERS OF HIGHWAYS. SHOW POSITION OF CAR BEFORE, AT, AND AFTER IMPACT. DESIGNATE THE NUMBER OF TRAFFIC LANES FOR EACH DIRECTION.



EXPLAIN FULLY MANNER IN WHICH COLLISION OCCURRED: _____

DRIVER SIGNATURE _____ SUPERVISOR SIGNATURE _____
DATE _____ DATE _____

Distribution: Original – Carl Warren, Copy – SCSRM, Copy – Originator SCSRM-130(11/2010)

PROPERTY LOSS CLAIM PROCEDURES (RCCD OWNED PROPERTY)

After a property loss or incident, the following procedures must be followed:

- The incident must be reported to Risk Management using the reporting procedure as follows:
    - Complete the **CALIFORNIA SCHOOLS RISK MANAGEMENT LOSS OR DAMAGE REPORT** (Exhibit 2 on page 8) and submit to Risk Management via email at Bj.cain@rccd.edu .
- Risk Management will notify the claims administrator (Carl Warren Adjusters) via e-mail within 24 hours.
    - Auto Liability Adjuster | Jeff Peters | (657) 622-4235 | jpeters@carlwarren.com
    - Property Adjuster | Neil Butterbaugh | (949) 235-8642 | neil@crstpa.com
- A complete inventory of all damages must be submitted to Risk Management by the department.
    - Copies of assets sheets or purchase order invoices will be sent to Carl Warren.
    - A copy of the original PO/invoice for all items that have been, or will be replaced, must be submitted to support a replacement cost value payment.
    - For Theft or Vandalism a police report must be obtained and submitted.
- A Loss or Damage Report must be completed by the department and submitted to Risk Management.
    - The department will be responsible for going through the usual purchasing process, including processing the requisition and getting multiple quotes if required per Board Policy AP5340 “Bids & Contracts”. Contact the District Purchasing Department for public works estimate over $25,000 for further instructions.
    - Once the estimates are received, the department will work with the adjustor to choose a vendor.
    - Please note, California Schools Risk Management JPA maintains a panel of three (3) preferred vendor partners specializing in property damage claims. These vendors offer RCCD a 10% professional discount because of the District’s CSRM membership. These vendors are listed on page 7.
    - The department is to use their budget for the repairs.
    - A copy of the requisition, PO, quotes, pictures of the damage and final invoices must be sent to Risk Management.
    - Risk Management will seek reimbursement from the insurance company once the repairs total more than the $50,000 deductible.
    - Please note that no repairs should be started or completed until a PO is generated.

Preferred Property Loss Providers

- Belfor | Inland Empire | (877) 543-8239 | Galaxy #104606
    - Mitch Lavine | mitch.lavine@us.belfor.com
- All County Environmental Restoration | (866) 839-8049 | Galaxy #104633
    - Don Moser | dmoser@allcountyenvironmental.com
- Padgett's | (800) 273-1194 | Galaxy #41822
    - Mary Padgett Mary@trustpadgetts.com | Tim Padgett Tim@trustpadgetts.com

LAPTOP LOSS CLAIM PROCEDURES (RCCD OWNED PROPERTY)

- The incident must be reported to Risk Management using the reporting procedure as follows:
    - Complete the **CALIFORNIA SCHOOLS RISK MANAGEMENT LOSS OR DAMAGE REPORT** (Exhibit 2 on page 8) and submit to Risk Management via email at Bj.cain@rccd.edu .
- Risk Management will notify the claims administrator (Carl Warren Adjusters) via e-mail within 24 hours.
- A complete inventory of all damages must be submitted to Risk Management by the department.
    - A copy of the original PO/invoice for all items that have been, or will be replaced, must be submitted to support a replacement cost value payment.
    - For Theft or Vandalism a police report must be obtained and submitted.
- The department will be responsible for creating a requisition and going through the usual purchasing process to purchase a replacement item. A copy of the requisition should be sent via email to Bj.cain@rccd.edu.
    - The department is to use their budget for the repairs. The insurance company will send reimbursement to Risk Management for the repairs less any deductible.
    - Once Risk Management receives the reimbursement check, the check will be sent to accounts receivable to ensure the funds are returned to the department's budget. A copy of the check will be sent to the department notifying the department head that the reimbursement is in route.

Exhibit 2 – California Schools Risk Management Loss or Damage Report Form

California Schools JPA
RISK MANAGEMENT | EMPLOYEE BENEFITS

CSRM

CALIFORNIA SCHOOLS RISK MANAGEMENT
LOSS OR DAMAGE REPORT

District Owned or Leased Property
Lost, Stolen, or Damaged by Fired, Illegal Entry, Etc.
(Instructions for Completing This Report On Reverse)

Status Code

D – Damaged
S – Stolen
L – Lost

I. EQUIPMENT (If leased, insert asterisk after description & enter lessor's identity in remarks)

Item Description (Include Make & Model)	Asset Inventory	Mfg. Serial No.	Approximate Value	Status

Date of Loss	School/College District	Loss Discovered By	Date Reported to Police	Police Report #	Badge #

Campus	Building	Room No.

Steps Taken to Recover/Remarks:

II. BUILDING OR PROPERTY DAMAGE/LOSS:

Date of Break-In or Damage	Time	Discovered By	Campus	Building No.	Room No.

Type of Entry (Forced, Key, etc.) – Describe

Cause of Damage or Loss (Fire, Wind, Vandalism, Rain, Theft, Etc.)

Full Description of Damage

Reported By _____ Date _____

Approved By _____ Date _____

REVISED 4/23/19

STUDENT ACCIDENT INSURANCE CLAIMS PROCEDURE

Student (Accident) Insurance covers all registered students. This plan serves as a secondary accident medical coverage policy when students are already covered under a medical insurance policy of their own. However, if the student does not have their own medical insurance policy, this plan becomes the primary payer in the event of an accident on campus. All student accident insurance claims must be reported as follows to be eligible for coverage:

- Immediately report all accidents to College authority (instructor, coach, trainer or health center) (see Exhibit 3 on page 10 for instructions).

- Complete and send both the **STUDENT ACCIDENT INSURANCE ClAIM FORM** (see Exhibit 4) and the **ACCIDENT REPORT FORM** (see Exhibit 5) to the Plan Administrator within 120 days of the accidental injury.

- Forms should be submitted via:

    - Email: claims@myers-stevens.com CC: bj.cain@rccd.edu
    - Fax: (949) 348-2630
    - Mail: Myers-Stevens & Toohey | 26101 Marguerite Pkwy, Mission Viejo CA 92692
    - Questions: (800) 827-4695, bilingual support (800) 827-4695

- At the same time, the injured student must file a claim with any other available health and/or accident carrier plans. This can include employee plans, union plans, CHAMPUS (military plans), service contracts, self-insured benefit plans, or health maintenance plans (HMO's). The Student Insurance carrier will require this report if other insurance plans are available.

- Attach all itemized bills to the claim form and mail within 90 days of the first date of treatment.

Exhibit 3 – Student Accident Insurance Claim Instructions

myers | stevens | toohey

Student Accident Insurance
COLLEGE CLAIM FILING INSTRUCTIONS

FOR CLAIMANTS OF LEGAL AGE, PARENTS AND LEGAL GUARDIANS

Coverage terms and conditions

Prior to an injury or sickness occurring or as soon as possible thereafter, please familiarize yourself with the terms and conditions of coverage including: what activities are covered; benefits; exclusions; requirements and limitations; important deadlines, etc. These may be found in policies on file with school authorities, printed brochures used to secure coverage, online or by contacting us directly at (800) 827-4695.

Obtaining a claim form

If not included with these instructions or unavailable through your school, you may obtain a claim form directly by calling (800) 827-4695, by email at claims@myers-stevens.com or by faxing (949) 348-2630.

Instructions for completing the claim form as a result of an injury during:

REGULAR SCHOOL SESSIONS / INTERCOLLEGIATE ATHLETICS

- Report school-related injuries immediately to school officials, providing as much detail as possible.
- Request a College Insurance claim form from the school and ask an authorized school official to **completely and legibly** fill out Part A of the form. Only one claim form is required per injury or condition.
- **Completely and legibly** fill out Part B (missing fields will cause delays) provide signatures where requested, date and return to our office along with your itemized bills and Explanations of Benefits (EOBs) from any other applicable insurance or health plan.

OR

COVID-MANDATED SCHOOL CLOSURES / DISTANCE LEARNING

- Immediately report school-related injuries or other covered losses to the school using the remote contact instructions provided by your school if applicable. Complete Part A as fully as possible, providing all the same information given to the school including the name and title of the official the injury/loss was reported to.
- Complete the rest of the form, sign and return per instructions on the form. In addition to helping us verify circumstances surrounding a reported loss, please know that we rely on the school to confirm that the claimant is an enrolled student. Our Claims staff will follow up through our established school contacts to verify information provided.

IMPORTANT – All fields must be clearly completed and signatures provided where requested or processing will be delayed!

Finding a health provider

Students are free to go to any properly licensed health provider but out-of-pocket costs may be reduced if you seek care from providers who are contracted under the *First Health Network* or *First Choice Health Network* (WA only). Contracted providers may be found at www.firsthealth.com (800) 226-5116 or www.fchn.com (800) 231-6935. If students also have coverage through an HMO, please know that benefits under many of our school-paid blanket plans may be reduced should they seek out-of-network services that are not preauthorized by their HMO. This potential benefit limitation does not apply to emergency care.

When treatment is sought

- Provide the billing/admissions person your primary insurance/health plan information (if applicable).
- Let the billing person know that the insured is covered under a blanket plan that is paid for by the school, identify the school system involved and the specific school. In either case, explain that this is medical expense insurance that provides benefits on an excess or secondary basis and that it is not what is sometimes referred to as "third party" insurance. The student is the insured.
- Request the billing department to add Myers-Stevens & Toohey into their system as a payor and to either send us the itemized bills described above directly (preferred!) or to send you those same bills to be forwarded to us. Letting the provider know that you are assigning benefits to them may help smooth the process. If you have difficulty, please contact us and we'll be happy to help.

If the student has other insurance or health coverage

File a claim with that primary plan (except Medicaid) and send us copies of their "Explanation of Benefits" or "EOBs" once processed.

What we need from the providers who see the student*

In order to evaluate your claim and provide benefits, we will need fully itemized bills from any providers seen. These are known as HCFA 1500 or CMS 1500 forms from providers such as doctors and as a UB04 form from facilities such as hospitals and surgery centers. They contain the following required information:

- Date(s) of Service
- Billed Charges
- Diagnostic Codes - these tell us what is wrong with your child
- Procedural or Revenue Codes - these tell us what was done to evaluate/treat the problem
- Provider Tax ID Number – needed to issue W-9s when benefits are assigned to providers
- National Provider Identifier (NPI) – needed to comply with Federal regulations

NOTE– we are not able to use "statements" from providers, primary health plan EOBs or a receipt of payment in lieu of the required itemized billings as described above.

**If you have Kaiser, request "courtesy statements" from Kaiser Member Services that include the information listed above. Please make sure the documentation submitted indicates what portion of the charges, if any, you are obligated to pay out of your own pocket.*

Final Steps

Send: 1) Completed claim form; 2) Itemized bills; 3) Other insurance/health plan EOBs (when applicable) to:

Myers-Stevens & Toohey & Co., Inc.
Attn: Claims Department
26101 Marguerite Parkway
Mission Viejo, CA. 92692

OR **Fax: (949) 348-9350** *OR* **Email: claimsinfo@myers-stevens.com**

Need more help? Call us at (800) 827-4695

Exhibit 4 – Student Accident Insurance Claim Form

myers | stevens | toohey

STUDENT ACCIDENT INSURANCE COLLEGE CLAIM FORM

PART A SCHOOL STATEMENT (Claimant of legal age, parent or legal guardian or may complete Part A if injury is sustained during COVID-related distance learning at home)

NAME OF CLAIMANT FIRST MI LAST | AGE | GRADE | ☐ FEMALE ☐ MALE | DATE OF BIRTH MO / DAY / YR

ADDRESS OF CLAIMANT CITY STATE ZIP CODE

IS THE CLAIMANT A: ☐ STUDENT ☐ STAFF ☐ VISITOR ☐ OTHER _____ | ID # FROM ID CARD (If applicable)

NAME OF SCHOOL | NAME OF COLLEGE SCHOOL SYSTEM

SCHOOL MAILING ADDRESS CITY STATE ZIP CODE

DURING WHAT ACTIVITY DID THE INJURY OCCUR? ☐ INTERCOLLEGIATE PRACTICE ☐ INTERCOLLEGIATE GAME ☐ CLASSROOM ☐ TRAVEL ☐ AT HOME ☐ OTHER _____

WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL-SPONSORED AND SUPERVISED? ☐ YES ☐ NO IF YES, LIST NAME OF SPORTS ORGANIZATION: | TYPE OF SPORT: | DOES THE SCHOOL HAVE RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? ☐ YES ☐ NO If YES, name of plan:

DATE OF INJURY/SICKNESS MO / DAY / YR | TIME OF INJURY : ○○ (CIRCLE ONE) | WHAT SIDE OF THE BODY WAS INJURED? ☐ LEFT ☐ RIGHT | HAS THE CLAIMANT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

PROVIDE DETAILS ON HOW AND WHERE THE INJURY OR ILLNESS OCCURRED. PLEASE BE SPECIFIC

NAME AND TITLE OF SUPERVISING OFFICIAL AT TIME OF INJURY | WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO | DATE SCHOOL WAS NOTIFIED / /

NAME AND TITLE OF SCHOOL OFFICIAL INJURY WAS REPORTED TO | SIGNATURE X | DATE SIGNED | SCHOOL TELEPHONE NUMBER ( )

PART B CLAIMANT, PARENT OR LEGAL GUARDIAN INFORMATION

NAME OF CLAIMANT'S PRIMARY PHYSICIAN | ADDRESS | PHONE NUMBER ( )

IS THE CLAIMANT COVERED, DIRECTLY AND/OR AS A DEPENDENT UNDER ANY OTHER INSURANCE OR HEALTH PLAN(S)? ☐ YES ☐ NO IF YES, NAME OF PLAN(S) | POLICY NUMBER(S)

NAME OF CLAIMANT'S EMPLOYER (If applicable) | ADDRESS | PHONE NUMBER ( )

NAME OF FATHER OR LEGAL MALE GUARDIAN (If claimant is under legal age) | MOBILE TELEPHONE NO. ( ) | HOME TELEPHONE NO. ( )

ADDRESS CITY STATE ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE ( )

ADDRESS OF EMPLOYER CITY STATE ZIP CODE

NAME OF MOTHER OR LEGAL FEMALE GUARDIAN (If claimant is under legal age) | MOBILE TELEPHONE NO. ( ) | HOME TELEPHONE NO. ( )

ADDRESS CITY STATE ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE ( )

ADDRESS OF EMPLOYER CITY STATE ZIP CODE

AUTHORIZATION: I hereby authorize any School, Participating Organization, Policyholder, trust, employer, insurance company, health plan, medical/dental provider or other person or entity to release any information/documentation needed to process this claim to Myers-Stevens & Toohey Co., Inc. (MST) or its insuring company when requested by them to do so. This may include but is not limited to: details of the reported loss; identification of witnesses and supervisors; verification of other insurance or health coverage; coverage terms; explanations of benefits; complete health records including those involving mental/emotional disorders and substance abuse; prescription drug history and fully itemized bills in the form of CMS/HCFA 1500s and UB04s. If the claim is reported by the result of participating in a School, Participating Organization or Policyholder activity, I authorize MST to share information concerning this claim as necessary with representatives of the School, Participating Organization or Policyholder as applicable. I understand that the authorization to release claim-related information/documentation to MST will terminate two years from the date of signature unless terminated in writing on an earlier date by me. A photo static/digital copy of this authorization shall be considered as valid and effective as the original.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

ASSIGNMENT OF BENEFITS: I authorize the payment of benefits directly to the provider(s) of services and/or supplies associated with this claim.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and/or civil penalties.
I have read and acknowledge the General Fraud Warning above and the specific version for my state on the reverse side.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

Exhibit 5 – Accident Report Form

RCCD | RIVERSIDE COMMUNITY COLLEGE DISTRICT
RISK MANAGEMENT, SAFETY & POLICE
MORENO VALLEY COLLEGE | NORCO COLLEGE | RIVERSIDE CITY COLLEGE

Injured person is a: ☐ Student ☐ Employee ☐ Visitor ☐ Student doing clinical hours | Date of report:

Injured person's name: | Date of birth: Age: | Gender ☐ M ☐ F | Telephone:

Injured person's address: | City: | State: | Zip Code:

Date of injury: | Time of Injury: | Campus: ☐ Riverside ☐ Norco ☐ Moreno Valley | Location: ☐ District Office ☐ Coil ☐ Ben Clark Training Center ☐ Culinary Academy ☐ March ☐ Other

Student Information:
Provide instructor's name:
Provide class name:
Student ID Number:
Email Address:

Employee Information:
Provide supervisor's name and telephone number
Work Schedule:
Department: Time work shift began on day of accident ☐ a.m. ☐ p.m.
Date of hire: Job Title: Time injury reported to supervisor:

Visitor Information:
Which site(s) were you on
Which buidling/room were you in

Was the incident an exposure? ☐ yes ☐ no If yes, what type of exposure?
Last date on site Sites you were at that day

Exact place accident occurred (*provide location name and complete address*):

Specific activity the employee was doing when the event occurred:

Describe how accident occurred:

Specific Body part injured: | First aid given: ☐ Yes ☐ No If yes by whom:

Name: | Signature: | Date:

Witnesses

Witness name:	Telephone:	Email Address:

Instructions

1. If the injured person is an employee, complete the *Worker's Compensation Claim Form (DWC1)* in addition to the Accident Report, and forward all originals to the Risk Management Office **within 24 hours of the accident**.
2. All employees injured on the job **MUST call Medcor** at 800-775-5866. In cases of serious or life threatening emergencies, the employee should call 911. Please call (951) 222-8127 or (951) 222-8128 for further information in regards to industrial injuries.

Date received by the Risk Management Office	Received by (*printed name*)	Signature

WORKERS' COMPENSATION CLAIMS PROCEDURE

After a Workers Compensation injury the following procedures must be followed:

- The injured employee and/or their supervisor must call the triage nurse service (Medcor) at (800) 775-5866 to report the incident and any injuries immediately.
    - Please note that Medcor must be called even if the employee does not desire medical treatment.
    - Employees include full and part-time employees, student workers, and students performing their volunteer hours at the time of the injury.
- Medcor will direct the injured worker to the nearest medical facility if medical treatment is needed.
    - Injured workers should proceed to the medical facility immediately.
    - Medcor will fax authorization for treatment to the facility. No paperwork or appointment is needed to be seen for the first time.
- Risk Management will send the necessary paperwork to the injured worker and their supervisor via email. (See exhibits 6, 7 & 8).
- After employees are seen at the clinic, Risk Management will send an email to the supervisor informing them of any restrictions (if applicable) and when the employee will be seen again.
    - Risk Management encourages all supervisors to accommodate modified duty.
- Absence affidavits should be filled out for any absences and turned into payroll.
    - Please mark "other" on the form and write in "workers' compensation."
    - Please note that payroll will request confirmation from Risk Management on a monthly basis to confirm that the absences were due to the workers compensation claim.
    - Payroll tracks the time an employee is off work for the first 60 days of Education Code benefits. After the 60 days of Education Code benefits expire, the injured worker will start using a small portion of their comp time, sick time, or vacation, and 100 days of half pay (in that order) during the time they are off work. This process will continue until all benefits have been exhausted or the employee returns to work.

Workers Compensation Claims Contacts

RCCD has a self-insured workers' compensation program through the State of California, Department of Industrial Relations under a "*Certificate of Consent to Self-Insure*" number 7582. RCCD's claims are administered by a Third Party Administrator (TPA), Sedgwick.

- Sedgwick's mailing address is:
  Sedgwick | P.O. Box 14153, Lexington KY, 40512

- The assigned adjuster is Tammy Lancaster. Ms. Lancaster can be reached at (909) 942-4801 or by e-mail at tammy.lancaster@sedgwick.com

- The assigned adjuster is Anna Romero. Ms. Romero can be reached at (909) 942-5449 or by e-mail at anna.romero@sedgwick.com

- Risk Management Claims Contact is Bj Cain. She can be reached at (951) 222-8127 or by email at Bj.Cain@rccd.edu
  For after hours the Risk Management Claims contact is Beiwei Tu. She can be reached at (951) 222-8128 or by email at Beiwei.Tu@rccd.edu

- The Workers Compensation Appeals Board (WCAB) for Riverside is located at:
  3737 Main St., Room 300, Riverside CA 92501 | (800) 736-7401

  - The Information and Assistance (IA) officer is also located at this location and can be reached at (951) 782-4347.

  - The Riverside WCAB also holds free monthly one-hour workshops for injured workers the first Tuesday of the month at 1:30pm.

- The Family and Medical Leave Act (FMLA) process is managed by HRER:

- RCC & District -Danielle Sanders (951) 222-8591 Danielle.Sanders@rccd.edu

- Norco College-Graciela Caringella (951) 222-8356 & (951) 739-7801 Graciela.Caringella@rccd.edu

- Moreno Valley College-Silvester Julienne (951) 222-8593 Silvester.Julienne@rccd.edu

- The Accommodations process is managed by Lorraine Jones and Georgina Villasenor-Lee in Human Resources and Employee Relations.
  Lorraine Jones (951) 328-3874 or (951) 222-8595 lorraine.jones@rccd.edu
  Georgina Villasenor-Lee (951) 328-3725 georgina.villasenor-lee@rccd.edu

Exhibit 6 – California DWC-1 Form

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____
   You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* Riverside Community College District
11. Address. *Dirección.* Attn Risk Management 3801 Market St., Riverside, CA 92501
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* _____
    York Insurance Services Group, Inc., a Sedgwick Company P.O. Box 619079, Roseville, CA 95661
16. Insurance Policy Number. *El número de la póliza de Seguro.* Self-Insured: Certificate #7582
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* Casualty Claims Coordinator 19. Telephone. *Teléfono.* (951) 222-8127

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/*Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

Exhibit 7 – Employee Accident Report Form

RCCD | RIVERSIDE COMMUNITY COLLEGE DISTRICT
RISK MANAGEMENT, SAFETY & POLICE
MORENO VALLEY COLLEGE | NORCO COLLEGE | RIVERSIDE CITY COLLEGE

Injured person is a: ☐ Student ☐ Employee ☐ Visitor ☐ Student doing clinical hours | Date of report:

Injured person's name: | Date of birth: _____ Age: _____ | Gender ☐ M ☐ F | Telephone:

Injured person's address: | City: | State: | Zip Code:

Date of injury: _____ Time of Injury: _____

Campus: ☐ Riverside ☐ Norco ☐ Moreno Valley

Location: ☐ District Office ☐ Coil ☐ Ben Clark Training Center ☐ Culinary Academy ☐ March ☐ Other _____

Student Information:
Provide instructor's name: _____
Provide class name: _____
Student ID Number: _____
Email Address: _____

Employee Information:
Provide supervisor's name and telephone number _____
Work Schedule: _____
Department: _____ Time work shift began on day of accident _____ ☐ a.m. ☐ p.m.
Date of hire: _____ Job Title: _____ Time injury reported to supervisor: _____

Visitor Information:
Which site(s) were you on _____
Which buidling/room were you in _____

Was the incident an exposure? ☐ yes ☐ no If yes, what type of exposure? _____
Last date on site _____ Sites you were at that day _____

Exact place accident occurred (*provide location name and complete address*):

Specific activity the employee was doing when the event occurred:

Describe how accident occurred:

Specific Body part injured: _____
First aid given: ☐ Yes ☐ No
If yes by whom: _____

Name: | Signature: | Date:

Witnesses

Witness name:	Telephone:	Email Address:

Instructions

1. If the injured person is an employee, complete the *Worker's Compensation Claim Form (DWC1)* in addition to the Accident Report, and forward all originals to the Risk Management Office **within 24 hours of the accident**.
2. All employees injured on the job **MUST call Medcor** at 800-775-6866. In cases of serious or life threatening emergencies, the employee should call 911. Please call (951) 222-8127 or (951) 222-8128 for further information in regards to industrial injuries.

Date received by the Risk Management Office	Received by (*printed name*)	Signature

Exhibit 8 – Supervisor's Accident Investigation Report

RCCD | RIVERSIDE COMMUNITY COLLEGE DISTRICT
RISK MANAGEMENT, SAFETY & POLICE
MORENO VALLEY COLLEGE | NORCO COLLEGE | RIVERSIDE CITY COLLEGE

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

COMPLETE ALL SECTIONS – ATTACH ADDITIONAL SHEETS IF NECESSARY
REPORT MUST BE COMPLETED FOR ALL INCIDENTS AND SENT TO RISK MANAGEMENT DEPARTMENT VIA EMAIL TO MONICA.ESQUEDA@RCCD.EDU
WITHIN 24 HOURS OF THE INCIDENT / ACCIDENT

College / District Location	College Safety Coordinator Name	Supervisor/ Person Completing Report
Location Address	Location Phone Number	Location Fax Number
Employee / Injured Party Name		Injured Party Phone
Job Title / Student / Other		Full Time ☐ Part-Time ☐ Student Employee ☐ Other ☐
Date of Accident	Time of Accident ☐ AM ☐ PM	Date Reported / Late Report? ☐ YES ☐ NO
Specific Location of Accident/Near Miss		Injured Body Part (i.e. leg, arm, back, left or right)
Injury Type (i.e. cut, pain, skin rash)		Visual Description of Injury (i.e. bleeding, bump, redness, bruise)
Witness Name	Witness Address	Witness Phone
Was First Aid Given at the College/District Site? ☐ YES ☐ NO	If yes, by whom?	Type of Treatment Given (splint, bandage, etc.)
Treated at Medical Clinic? ☐ YES ☐ NO	Clinic Name	Clinic Phone
Equipment, materials, and/or chemicals the employee was using when injury happened?		
How did the injury / near miss occur? *(use extra sheets of paper if necessary)*	Describe sequence of events. Get all the facts by studying the job and situation involved. Question WHO, WHAT, WHY, WHERE, WHEN, and HOW	

IMMEDIATE ACCIDENT / INCIDENT CAUSE(S)

Section A - UNSAFE ACT

- ☐ Bypassing Safety Devices
- ☐ Distraction / Inattention
- ☐ Failure to Use Proper Equipment (PPE)
- ☐ Employee Performing Tasks Outside of Job Description
- ☐ Horseplay
- ☐ Improper Attire
- ☐ Improper Use of Body
- ☐ Improper Use of Equipment
- ☐ Incorrect Lift / Carry
- ☐ Unsafe Speed of Task
- ☐ Failure to Report Maintenance Issue
- ☐ Intentional Act
- ☐ Other

Section B - UNSAFE CONDITION

- ☐ Arrangement
- ☐ Congestion
- ☐ Design / Construction
- ☐ Guarding
- ☐ Tools/Utensils
- ☐ Traffic (Foot or Vehicle)
- ☐ Ventilation
- ☐ Failure to Report/Fix Unsafe Condition
- ☐ Maintenance Failure
- ☐ Other

What is the College / District Plan to Prevent Recurrence (Summarize). Examine causes and determine how this type of accident can be prevented in the future WHO will initiate plan, WHEN and HOW. This may include counseling the injured on proper future safety precautions.

Reporting Manager or Supervisor Signature	Today's Date: