CONSTRUCTION CLAIMS MANAGEMENT, INC.
WWW.AHBFUND.COM
P.O. Box 244202 • Montgomery, AL 36124-4202 • Phone: (334) 834-0283 or 1-800-372-1801 • Fax: (334) 834-9293

When an employee reports an on-the-job injury, you need to file a workers' compensation claim. Emergency Injuries - Dial 911. After hours assistance - Dial 334-834-0283 or 1-800-372-1801 and follow the directions from the voice system for assistance.

1. **Assist your employee in obtaining prompt medical care**
    - ***In an emergency***, the employee should seek immediate medical care at the nearest emergency room or urgent care clinic and notify you as soon as possible thereafter.
    - ***In all other instances***, the employee should inform you of the injury before seeking medical care. You should provide first aid on site, if necessary. Then refer the employee to an approved medical provider.
    - ***Immediately request a drug screen from the medical provider***

2. **File a claim with Construction Claims Management (CCM), Alabama Home Builders Self Insurers Fund's claims service provider, immediately after a work-related injury occurs (within 24 hours of occurrence.)**
    - ***Complete the First Report of Injury form with your worker, if possible***. No decision can be made on a claim until all required information is received. Explain workers' compensation procedures to the worker and assist in relieving any anxieties he or she may have relating to the injury. A First Report of Injury form is also available at www.ahbsif.com.
    - ***Fax*** the First Report of Injury form to (334) 834-9293
    - ***Or E-mail*** the First Report of Injury to firstreport@hbaa.org

3. **Conduct and investigation immediately while the information is fresh in people's minds** – then take the necessary corrective action to prevent the injury from occurring again. The AHBSIF has loss control representatives that can assist you in this investigation. Call for the person in your area. Your written accident investigation report should include:
    - Inspection of the accident site
    - A determination of the reasons why the accident happened
    - The circumstances involving the accident
    - Evidence and photographs
    - Interviews of all witnesses and others in the accident area, asking them to write down their statements. Interviews should be conducted in a sensitive manner.
    - Determine the necessary corrective action to be taken to prevent the injury from happening again.

If the investigation suggests that your employee's injury is not work related or seems questionable in nature, be sure to provide your comments and attach it to the First Report of Injury form. If you have already submitted the First Report of Injury form, please write or call CCM with your concerns at (334) 834-0283.

4. **Complete all the required paperwork in a timely manner and fax to CCM at (334) 834-9293 or e-mail to ccmmedrecords@hbaa.org**. Including: Wage Statement, Consent Form, and the Employee's Report of Injury form.
5. **Promptly send in any medical documentation and/or bills to CCM for processing**
6. **Refer all medical providers to CCM for any treatment approval**
7. **Immediately forward any documentation, lawsuit, etc. to CCM**

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NATURE OF INJURY

01. No Physical Injury
02. Amputation
03. Angina Pectoris
04. Burn
07. Concussion
10. Contusion
13. Crushing
16. Dislocation
19. Electric Shock
22. Enucleation
25. Foreign Body
28. Fracture
30. Freezing
31. Hearing Loss or Impairment
32. Heat Prostration
34. Hernia
36. Infection
37. Inflammation
40. Laceration
41. Myocardial Infarction
42. Poisoning - General
43. Puncture
46. Rupture
47. Severance
49. Sprain or Tear
52. Strain or Tear
53. Syncope
54. Asphyxiation
55. Vascular
58. Vision Loss
59. All Other Specific Injuries, NOC
60. Dust Disease, NOC
61. Asbestosis
62. Black Lung
63. Byssinosis
64. Silicosis
65. Respiratory Disorders
66. Poisoning - Chemical, (Other Than Metals)
67. Poisoning - Metal
68. Dermatitis
69. Mental Disorder
70. Radiation
71. All Other Occupational Disease Injury, NOC
72. Loss of Hearing
73. Contagious Disease
74. Cancer
75. AIDS
76. VDT - Related Diseases
77. Mental Stress
78. Carpal Tunnel Syndrome
79. Hepatitis C
80. All Other Cumulative Injury, NOC
90. Multiple Physical Injuries Only
91. Multiple Injuries Including Both Physical & Psychological

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PART OF BODY

10. Multiple Head Injury
11. Skull
12. Brain
13. Ear(s)
14. Eye(s)
15. Nose
16. Teeth
17. Mouth
18. Soft Tissue
19. Facial Bones
20. Multiple Neck Injury
21. Vertebrae
22. Disc
23. Spinal Cord
24. Larynx
25. Soft Tissue
26. Trachea
30. Multiple Upper Extremities
31. Upper Arm
32. Elbow
33. Lower Arm
34. Wrist
35. Hand
36. Finger(s)
38. Shoulder(s)
39. Wrist (s) & Hand(s)
40. Multiple Trunk
41. Upper Back Area
42. Lower Back Area
43. Disc
44. Chest
45. Sacrum and Coccyx
46. Pelvis
47. Spinal Cord
48. Internal Organs
49. Heart
50. Multiple Lower Extremities
51. Hip
52. Upper Leg
53. Knee
54. Lower Leg
55. Ankle
56. Foot
57. Toes
58. Big Toes
60. Lungs
61. Abdomen Including Groin
62. Buttocks
63. Lumbar & or Sacral Vertebrae
64. Artificial Appliance
65. Insufficient Info to Properly Identify
66. No Physical Injury
90. Multiple Body Parts
91. Body Systems and Multiple Body
99. Whole Body

#66

CAUSE OF INJURY

01. Chemicals
02. Hot Objects or Substances
03. Temperature Extremes
04. Fire or Flame
05. Steam or Hot Fluids
06. Dust, Gases, Fumes or Vapors
07. Welding Operation
08. Radiation
09. Contact With, NOC.
10. Machine or Machinery
11. Cold Objects or Substances
12. Object Handled
13. Caught In, Under or Between, NOC.
14. Abnormal Air Pressure
15. Broken Glass
16. Hand Tool, Utensil; Not Powered
17. Object Being Lifted or Handled
18. Powered Hand Tool, Appliance
19. Caught, Puncture, Scrape, NOC.
20. Collapsing Materials (Slides of Earth) Either Man Made or Natural
25. From Different Level (Elevation) Off Wall, Catwalk, Bridge, Etc.
26. From Ladder or Scaffolding
27. From Liquid or Grease Spills
28. Into Openings Shafts, Excavations, Floor Openings, Etc.
29. On Same Level
30. Slipped, Do Not Fall
31. Fall, Slip or Trip, NOC.
32. On Ice or Snow
33. On Stairs
40. Crash of Water Vehicle
41. Crash of Rail Vehicle
45. Collision or Sideswipe With Another Vehicle
46. Collision with a Fixed Object Standing Vehicle or Stationary Object
47. Crash of Airplane
48. Vehicle Upset Overturned or Jackknifed
50. Motor Vehicle, NOC.
52. Continual Noise
53. Twisting
54. Jumping
55. Holding or Carrying
56. Lifting
57. Pushing or Pulling
58. Reaching
59. Using Tool or Machinery
60. Strain or Injury By, NOC.
61. Wielding or Throwing
65. Moving Part of Machine
66. Object Being Lifted or Handled
67. Sanding, Scraping, Cleaning Operation
68. Stationary Object
69. Stepping on Sharp Object
70. Striking Against or Stepping On, NOC.
74. Fellow Worker; Patient
75. Falling or Flying Object
76. Hand Tool or Machine in Use
77. Motor Vehicle
78. Moving Parts of Machine
79. Object Being Lifted or Handled
80. Object Handled By Others
81. Struck or Injured, NOC.
82. Absorption, Ingestion or Inhalation, NOC
84. Electrical Current
85. Animal or Insect
86. Explosion or Flare Back
87. Foreign Matter (Body) in Eye(s)
88. Natural Disasters
89. Person in Act of a Crime
90. Other Than Physical Cause of Injury
91. Mold
94. Repetitive Motion Callous, Blister, Etc.
95. Rubbed or Abraded, NOC.
96. Terrorism
97. Repetitive Motion Carpel Tunnel Syndrome
98. Cumulative, NOC
99. Other - Miscellaneous, NOC

INSTRUCTIONS FOR FILING WC FIRST REPORT OF INJURY

Employers should send a completed legible form to the insurance carrier or, if self-insured, to the designated office handling their workers' compensation claims. The insurance carrier or designated office should forward this First Report on to the Workers' Compensation Division, Department of Labor, Montgomery, Alabama 36131 within fifteen (15) days from the date of injury or date of notification to the employer for all injuries for which compensation is claimed or paid. This includes deaths, permanent disabilities or temporary disabilities exceeding three (3) days).

Block 1. A number assigned by the insured to identify a specific claim
Block 2. An identifier for a specific claim within a claim administrator's claims processing system.
Block 3. Case number from log maintained for OSHA
Block 4 - Block 14. Self Explanatory
Block 15. Employer Federal ID number
Block 16. Employer Unemployment Compensation Account Number
Block 17. NAICS Industry Codes http://dir.alabama.gov/docs/forms/wc_naics.pdf
Block 18. Carrier's name
Block 19. Carrier's FEIN
Block 20. A code representing the kind of entity providing financial responsibility for the claim, exp: (I) Insurance Carrier (S) Self Insurer (G) Guarantee Fund/Group
Block 21 through Block 63. Self Explanatory
Block 64. Nature of Injury Codes http://dir.alabama.gov/docs/forms/wcio_nature_table.pdf
Block 65. Part of Body Codes http://dir.alabama.gov/docs/forms/wcio_part_table.pdf
Block 66. Cause of Injury Codes http://dir.alabama.gov/docs/forms/wcio_cause_table.pdf
Block 67 through Block 81. Self Explanatory

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2
Rev. 10/2012

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE

1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS
5. Physical Address 1	10. Mailing Address 1
6. Physical Address 2	11. Mailing Address 2
7. City 8. State 9. Zip	12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number	17. NAICS

INSURER / FILING OFFICE

18. Insurer Name Alabama Home Builders S.I.F.	21. Filing Office Name Construction Claims Management
	22. Mailing Address 1 P.O. Box 244202
19. Insurer Federal ID Number 63-0887677	23. Mailing Address 2 or Telephone Number 334-834-0283 / 800-372-1801
	24. City Montgomery 25. State AL 26. Zip 36124
20. Type Insurer Ins Co ☐ Self-Insurer ☐ Group Fund ☒	27. Filing Office Federal ID Number 63-1103048

EMPLOYEE / WAGES

28. First Name 29. Middle Name 30. Last Name 31 Last Name Suffix (ie. Jr., Sr., III)	32. Employee ID Number 33. Type Employee ID Number SSN ☐ Passport Number ☐ Green Card ☐ Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1 35. Mailing Address 2 36. City 37. State 38. Zip 39. Phone	40. Gender Male ☐ Female ☐	41. Date of Birth 42.Nbr of Dependents

43. Marital Status Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐	44. Date Hired
45. Occupation Description	46. Number of Days Worked Per Week

47. Wages $ 48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐	49. Received Full Pay For Day of Injury? Yes ☐ No ☐ 50. Did Salary Continue? Yes ☐ No ☐

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE 56. Site Address 57. City 58. State 59. Zip 60. County	61. Injury Occurred on Employer's Premises? Yes ☐ No ☐ 62. Date Employer Notified

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

67. Initial Treatment First Aid By Employer ☐ Emergency Room ☐ Hospitalized > 24 Hours ☐	No Medical Treatment ☐ Minor Clinic / Hospital ☐ Hospitalized Overnight ☐ Outpatient Treatment ☐	68. Name of Treatment Facility 69. Address 70. City 71. State 72. Zip

73. Name of Physician or Other Health Care Professional	74. Has Injured Returned to Work Yes ☐ No ☐	If so, 75. Date 76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name 79. Last Name 80. Title	81. Preparer's Telephone Number