PAN-AMERICAN LIFE INSURANCE COMPANY EMPLOYER ADMINISTRATIVE GUIDE FOR YOUR GROUP OCCUPATIONAL ACCIDENT PLAN

GreenWood International Insurance Services, Inc.
P.O. Box 1055
Marshfield, MA 02050
Toll Free: Phone: 855-837-1091 / Fax: 855-837-0380
Email: texasns@gwigroup.com

This Administrative Guide has been provided to help you in the administration of your Group Occupational Accident Plan. It will provide you with general information, instructions and procedures to follow. For matters relating to insurance coverage and benefits, please refer to your Group Policy. All rights, benefits and conditions are determined by the Group Policy.

Effective Date of Coverage

All full-time and part-time employees are eligible for coverage on the date of their employment or the effective date of the Participating Employer, whichever is later, provided they meet the Eligibility Provisions stated in the Group Policy. Please note, proof of employee eligibility may be requested by Greenwood International Insurance Services (in the form of payroll records, TWC reports, etc.).

Termination of Coverage

An employee's insurance terminates on the earlier of the following:

1. The date of termination of employment; or
2. The date of termination of the Group Policy or the Participating Employer.

However, see the provision entitled "Extension of Benefits" in the Group Policy for information concerning employees in a benefit period when termination occurs. Please note, proof of employee termination may be requested by Greenwood International Insurance Services (in the form of payroll records, TWC, reports, etc.).

Premiums

Premiums are due on the due date. Instructions for calculating your premium payment have been provided and will also be included with your second month's premium statement. There is a 31-day premium payment grace period. If premiums due are not paid prior to the expiration of the 31-day grace period, coverage will terminate for non-payment of premium.

Please note, all employees, including part-time employees, must be covered under this plan. If applicable, when completing the premium statement, be sure to include all the prior monthøs gross payroll (excluding bonus). Owners and officers may waive coverage; if the owners and/or officers have waived coverage do not include their payroll when calculating the premium due. The maximum payroll reported for any one employee should not exceed $5,000 per month.

***Premium payments should be made payable to*:**
Pan-American Life Insurance Company

Premium Payments should be sent to:
Pan-American Life Insurance Company
Department 701
P.O. Box 4110
Woburn, MA 01888-4110

Premiums (continued)

Note: the payroll figures and adjustments you submit in calculating your premium payment should reflect the employees' actual wage from the most recent prior period, excluding bonuses.

State Unemployment Tax Reports

Texas Workforce Commission Employer's Quarterly Reports are required at case submission and quarterly as needed. This report will be used to verify that an employee eligibility, payroll and to check plan participation. Please note, proof of employee eligibility and payroll may also be requested by Greenwood International Insurance Services in the form of payroll records.

Beneficiary Designations

A Beneficiary form should be completed by each employee and kept on file with your Company. Failure of an employee to designate a Beneficiary will result in benefits being paid to the employee's estate, which requires an administrator to be appointed by a court. When a change in Beneficiary is requested, have the employee complete a new Beneficiary Form. Staple the new Beneficiary form on top of the old Beneficiary form.

Claims Submission

With respect to other claims for occupational accident benefits, the following forms should be submitted to Greenwood International Insurance Services:

1. Reporting Claims Form ó Via Fax or Email (pg 6)
2. Occupational Accident Claim Form ó Employerøs First Report of Injury, Form GWI-OAC-01 (pg7)
3. Occupational Accident Claim Form ó Employeeøs Statement. Form, GWI-OAC-02 (pg 8)
4. Employee Instructions and Acknowledgement (pg 9)
5. Occupational Accident Claim Form ó Supervisorøs Investigation Report, Form GWI-OAC-03 (pg 10)
6. Authorization to Release Medical Information (pg 11)
7. Attending Physician Report (pg 12)
8. Employerøs Report of Disability ó Request for Wage Benefit Reimbursement, Form GWI-DWR-01 (pg 13)
9. Statement of Claim ó Accidental Dismemberment or Loss of Sight Benefits. Form GWI-ADB-01 (pg 14)

In the event of the death of an Insured employee, Greenwood International Insurance Services should be notified immediately. Notification should include the following information:

1. A certified copy of the Death Certificate.
2. Typical Beneficiary Designations (pg 15)
3. A copy of the employee's most recent Beneficiary Designation form, along with the address of the beneficiary (beneficiaries). Form GWI-BDF-01 (pg 16)
4. A copy of the employee's payroll records for the 90 day period immediately preceding the accident date.

All claims should be submitted promptly. Medical bills which pertain to the claim being filed should be attached to the claim form.

Mail, fax or email completed claim forms, together with related statements and bills to:

Greenwood International Insurance Services
P.O. Box 1055
Marshfield, MA 02050

Toll Free Fax: 855-837-0380
Email: texasns@gwigroup.com

Questions

Any questions that are not answered to your satisfaction by reference to these Guidelines, or to the Group Policy, should be referred to your agent or Greenwood International Insurance Services.

For questions regarding premium remittance, please contact the accounting department: **800-272-7488.**

For questions regarding claims, please contact the claims department: **855-837-1091.**

WHEN AN EMPLOYEE IS INJURED

Immediately refer the employee to a nearby physician's office, clinic, ambulatory surgical center or hospital. Ask a co-worker (from management, if possible) to accompany the injured employee. Regardless of the place of service, make sure the provider is a doctor of medicine or a doctor of osteopathy.

If the injury is not a severe one and hospital admission is not required, and if there are no unusual circumstances pertaining to the accident, there is no need to notify Greenwood International Insurance Services of the injury, apart from actually filing the claim. However, there are four situations with respect to which we request immediate notification:

Certified Hospital Admissions - Preadmission Review - Your plan includes preadmission review. Hospital preadmission review is a means for helping assure that expensive hospital inpatient facilities are used only when medically necessary. Under this program, all hospital confinements, including length of stay, must be certified before full benefits under your group health insurance plan are payable. This review and certification is provided by a company which specializes in medical review services and cost control (professional review organization).

This procedure also applies to emergency admissions (nonscheduled) even though the Admission cannot be certified in advance. For each emergency hospital admission, the professional review organization should be called within 48 hours following the admission.

Failure to follow the required procedures for hospital admission review, and/or length of stay, or if the admission cannot be certified, will result in lesser benefits being paid, as described below:

1. After the Deductible Amount Per Insured Per Accident is applied, the benefits otherwise payable for hospital charges for that confinement will be reduced by $500.
2. If additional days of confinement are not certified, no benefits are payable for charges incurred during all such additional days.

Catastrophic Case - If the injury is severe, we would like to have immediate notification, so we can involve our medical professionals. Their objective is to make sure catastrophic cases are handled in the manner most beneficial to all involved. With severe injury or prolonged treatment, all health care providers are often not well-coordinated. As a guideline, please immediately notify us of the following injuries:

brain injury
spinal injury resulting in real or suspected paralysis of a limb
serious burns (10%+ of the body with third degree or 30%+ with second degree burns)
multiple or serious fractures
crushing of massive internal injuries

Subrogation - If the injury is due to the negligence of a third party, please notify Greenwood International Insurance Services as quickly as possible. We will want to initiate an investigation of the circumstances and file a lien. There are two important points to remember in this regard:

(1)We will not delay the processing of any claims. We will reimburse the providers quickly and file liens with the third party carriers.

(2) We will not pursue subrogation against the employer/policyholder.

Investigations - We would like to know of an injury as early as possible. If there is something extraordinary, unusual, or suspicious about the circumstances of the accident, private investigators are hired as necessary to review such accidents, therefore it is best to get the investigator involved as soon as possible.

REPORTING CLAIMS TO GREENWOOD INTERNATIONAL INSURANCE SERVICES

Claims may be submitted by fax or email:
Toll Free Fax: 855-837-0380
Email: texasns@gwigroup.com

Transmittal Cover Sheet

Transmittal Date: ____________________________ # of Pages Faxed ____

Employer Name: ____________________________

Injured Employee: ___________________________

Policy Number: _____________________________

===

Contact Name: ____________________________

Contact Phone #: __________________________

Contact Fax: ______________________________

===

Forms to fax or email for reporting a new claim:

Employer's First Report of Injury
Employee's Statement (completed and signed by the employee)
Employee Instructions and Acknowledgement
Authorization to Release Medical Information (signed by the employee)
Attending Physician Form
Supervisor's Investigative Report
Authorization to Release Medical Information (signed by the employee)

If the injured employee is losing time off of work or is expected to lose time after the elimination period, please fax or email the following:

Employer's Report of Disability
Disability Claim Form

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

OCCUPATIONAL ACCIDENT CLAIM FORM
EMPLOYER'S FIRST REPORT OF INJURY
(Form GWI-OAC-01)

Name of Employer ________________________________ Policy Number___________________

Address____ Phone Number ___________________
____ Fax Number ____________________

Employer Contact ___________________________________ Contact Email_____________________

Employee's Name_________________________________ Social Security #___________________

Employee's Address ____

Date of Hire _______________ Date of Birth ______________ Sex: Male___ Female___

Does employee speak English? YES NO If no, specify language ____________________

Occupation of Injured Employee____

Body part injured _____________ Type of Injury (cut, sprain, bruise, etc) ______________________

Was employee paid from the company at the time of injury? YES ____ NO____

Who did the employee report the accident to? _________________________ Title ______________

Date and time of injury ___________________ Date injury reported by Employee _____________

Date work resumed _________ Or expected return date _________ Last full day worked ________

Average #of hours worked per week _________ Rate of Pay$ ______________ Hourly___ Weekly___

Name, address & phone # of medical facility employee received treatment

____

____

Print Name ____________________________________ Title ____________________

Signature ______________________________________ Date ______________________

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OCCUPATIONAL ACCIDENT CLAIM FORM
EMPLOYEE'S STATEMENT
(Form GWI-OAC-02)

Name of Employer__________________________ Policy Number________________________
Employee Name____________________________ Social Security Number ________________

Address ______________________________ Sex: Male ____ Female ____
______________________________ Date of Birth ______________________________
______________________________ Home Phone ______________________________

Date and Time of Accident ___________________ Name of Supervisor _____________________
Nature of Injury or Illness (cut, bruise, sprain, etc.) ____

____
Body Part(s) Affected ____

Address Where Accident Occurred ____

Who did you report injury to? _________________________ Date Injury Reported ____________

How many days did you miss from work? __________ Date Last Worked ____________

Witness(es) ____

In your own words, describe the accident including substances, materials, or vehicles involved:

____

____

____

Have you ever had a similar injury in the past? Yes No If yes, explain ______________________
____
____

Was medical attention sought for this accident? Yes____ No____

Name & Address of Physician Consulted ____
____

Name & Address of Your Primary Care Physician____
____

_____________________________________ _______________
Employee's Signature Date

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EMPLOYEE INSTRUCTIONS AND ACKNOWLEDGEMENT

This information will explain your responsibilities under your employer's On-The-Job Injury Benefit Plan (hereafter Plan). You must comply with all of the guidelines contained in your employer's Plan. Failure to act in accordance with the guidelines of the Plan and not following the instructions contained in this document will result in delay, denial, or indefinite interruption of payment of medical bills and/or disability benefit payments that may be provided to you under your employer's Plan.

1. Your employer is a Non-Subscriber to the Texas Workers' Compensation Act. Your employer does not carry workers' compensation insurance on employees who work in Texas.

2. Any injury sustained while directly performing your job duties must be reported to your supervisor or manager immediately. Do not wait until the end of your shift or end of the day. Failure to report the injury immediately may result in a denial of your benefits.

3. After verbally reporting injury to your supervisor, you must complete a written report on the "EMPLOYEE'S FIRST REPORT OF INJURY" form and submit into your supervisor within 48 hours following the injury occurrence. Failure to complete report as indication may result in denial of benefits.

4. You and your supervisor will make a determination regarding when and if medical attention is necessary. If the incident seems to be minor, you have fulfilled your reporting duty under the Plan. Initial soreness following a minor injury may resolve without further problems. However, what initially seems to be a minor injury could progress into a condition needing medical attention.

5. For injuries requiring prompt medical attention, you will be taken to a medical clinic or hospital for treatment. If this initial visit is to a medical provider other than the normal company approved physician, you must seek follow up or subsequent care from an approved physician for your injury. The approved physician will assume control of your medical care and may refer you to specialists as necessary. Medical care and treatment by physicians not approved is only acceptable under your employer's Plan immediately following an injury to provide immediate emergency care.

6. You must remain cooperative in investigating and documenting the injury incident. Unless the injury causes serious physical disability that prohibits your involvement, you shall assist your supervisor in completing required reports. The "EMPLOYEE'S FIRST REPORT of INJURY" requires certain personal information from you and allows you to provide details and circumstances of the injury incident. You must also complete an õAUTHORIZATION FOR RELEASE OF MEDICAL RECORDS" form. Your supervisor will be completing other required reports and documents as soon after the injury as possible. In the event you are unable to physically return to your supervisor to complete the necessary reports, your supervisor may come to you at the earliest opportunity to fulfill the reporting obligations.

7. You must follow the doctor's orders and instructions regarding medical care, treatment plans and return-to-work. You are also responsible for attending all scheduled medical appointments.

8. It is your responsibility to stay in frequent communication with your supervisor regarding doctor appointments, medical status updates, and return-to-work (and off-duty orders) directions. Prior to and following each doctor's visit you shall call your supervisor or manager to advise them of the appointment and to inform them of the doctor's findings and results of any examination. You must deliver to your supervisor each written statement from the doctor regarding your medical situation and work status. The doctor's written statement will be placed in your injury incident file as a part of your records. Acceptance of the benefits under your employer's On-The-Job Injury Benefit Plan constitutes acceptance of all terms and conditions of the Plan.

Employee Name:______________________________ Date:__________

Employee Signature:__________________________

Signature of Translator (if required):____________________________________

Fax or Email Report To:
GreenWood International Insurance Services
Toll Free Fax: 855-837-0380
Email: texasns@gwigroup.com

OCCUPATIONAL ACCIDENT CLAIM FORM
SUPERVISOR'S INVESTIGATION REPORT
(Form GWI-OAC-03)

Employee Name ____________________________ Social Security Number ___________________
Department ________________________________ Job Title _______________________________
Supervisor ________________________________
Date of Injury ______________________________ Time of Injury _________________________
Location Where Accident Occurred ____
Day of Week _______________________________ Date & Time Reported ___________________
Nature of Injury ____________________________ Medical Treatment _____________________
Number of Days Lost From Work ______________ Expected Return to Work Date ____________

Witnesses to the incident

1. Name _________________________________ Telephone ______________________________
Address ____
If the witness's description of the incident is different than the employee's, please describe:
____
____

2. Name _________________________________ Telephone ______________________________
Address ____
If the witness's description of the incident is different than the employee's, please describe:
____
____

Description of Accident ____
____
____
____

Cause of the Accident ____
____
____
____

Action Taken to Prevent a Similar Accident ____
____
____
____

Additional Comments ____
____
____

Supervisor Signature ____ Date _____________

Reviewed by (Name and Title) _________________________________ Date _____________

Signature ____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

EMPLOYEE NAME: ____

POLICY #: _______________________________

EMPLOYER NAME:____

EMPLOYER ADDRESS:____
____
____

CLAIM #: _________________________________

TO: ______________________________________ DATE: _____________
(provider)

and any other physicians, hospitals, clinic or medical care provider, presently unknown to me, who may have or subsequently acquire information concerning my physical condition.

You are hereby authorized to give GREENWOOD INTERNATIONAL INSURANCE SERVICES or any of its representatives, all information, facts and particulars, including reports, records, results from diagnostic tests, x-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment rendered, prognosis, estimates of disability, or recommendations for further treatment and to furnish them copies of such reports. You are further authorized to allow any physician appointed by them to review all such reports, records and x-rays in your possession.

I am willing that a copy of this authorization be accepted with the same authority as the original.

This information is to be used for purposes of evaluating and handling my occupational accident injury, and for no other purpose, now or in the future.

THIS AUTHORIZATION EXPIRES ON CONCLUSION OF CLAIM.

SIGNATURE: ______________________________________

ATTENDING PHYSICIAN REPORT

1.Name of patient:____

2.Date of Birth: :____

(a) Date first consulted on account of the injury described: ______________

(b) Date of last treatment: _____________________

3.Describe the exact nature, location, and extent of all injuries sustained:

____

____

____

4. If the accident caused the loss of hand or foot, indicate the date of amputation:

____

5. If the injury resulted in total and irrecoverable lost of sight, date on which such loss occurred:

____

If the injury necessitated removal of the eye, date of removal: __________________

(a)What was the vision in each eye prior to the accident? _______________

(b) What percentage of vision, if any, now remains in the injured eye? ________

(c) Was the injury described solely responsible for the loss? ________________

(d) If not, give the particulars of any contributing cause or causes:

____

____

Attending Physician Signature: ____

Address: ____

____

Date: _____________

EMPLOYER'S REPORT OF DISABILITY
REQUEST FOR WAGE BENEFIT REIMBURSEMENT
(Form GWI-DWR-01)

EMPLOYEE INFORMATION

Name of Injured Employee:________________________________ Date of Injury:______________________

Social Security #:____ Date Lost Time Began:________________

Home Phone:____ ☐ Male ☐ Female

Claim #:____

EMPLOYER INFORMATION

Employer Name:____ Policy #:_________________________

City, State, Zip:____ Phone Number: ____________________

REPORTING PERIOD

This request covers lost time period

Date From:__________________ Date To:___________________ Has Employee returned to work? ☐ Yes ☐ No

If not, estimated return to work date:_________________________

WAGE HISTORY

For the year preceding the injury beginning with the last full week worked what was the employee's annual wage? ___________

Copies of employee payroll checks for the prior 4 pay periods must accompany this request along with written documentation from medical provider verifying "off work" status.

Additional Comments (if any)____

____

____
Signature and title of person completing request

____
Print Name

____
Date

Fax or Email Report To:
GreenWood International Insurance Services
Toll Free Fax: 855-837-0380
Email: texasns@gwigroup.com

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STATEMENT OF CLAIM

For Accidental Dismemberment Benefits or Loss of Sight Benefits

(Form GWI-ADB-01)

TO BE COMPLETED BY THE EMPLOYEE

1. Employee's full(Print)____Date of birth _____________ MALE ___FEMALE___
2. Present address: ____
   (Number) (Street) (City) (State) (Zipcode)
3. Telephone number: _________________________
4. When did the accident happen? Month________Day_________Year________ At_________am/pm
5. Give brief description of the accident:____

____

Date ______________________________ Signature ____
(Insured Employee)

TO BE COMPLETED BY THE EMPLOYER

1. Employee's name:______________________________Social Security No:._________________Account No.:___________
2. Average number of hours worked per week:__________________☐ Full-time ☐ Part-time
3. Hire Date: _______________Termination Date:_____________Wage/Salary $____________ Per ☐Hour ☐Week ☐Month
4. If this coverage has been canceled, give the date and reason:___________________________________

____

5. Date last worked: _____________________________________
6. Date returned to work: __________________________________
7. Employee's occupation and duties:____
8. Have you any information which may assist the Company in the consideration of this claim?

____

Complete this part only if claim is not due to an Occupational Accident

1. Has this claim been considered in connection with Workmen's Compensation coverage? Yes______ No _______

   If yes, what is present status of compensation claim? ______________________________________

2. Amount of Accidental Dismemberment Benefit: _____________________________ Date effective: __________________

Employer: ____

Branch:____

Date:____________ By:____
(Title)

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TYPICAL BENEFICIARY DESIGNATIONS

NOTE: WHEN A BENEFICIARY IS A MARRIED WOMAN, HER FULL NAME SHOULD BE SHOWN RATHER THAN HER HUSBAND'S FIRST NAME OR INITIALS

One Beneficiary - Mary A. Doe, Wife

Two Beneficiaries - The Insured's parents, Mary A. and John J. Doe, in equal shares, or to the survivor.

Three or More Beneficiaries - The Insured's children, John J., Joseph P. and Richard M. Doe, in equal shares, or to the survivors or survivor.

Fractional Amount - When fractional distribution is requested, fractions must be used instead of an amount, for example: One half to the Insured's wife, Mary A. Doe, and on fourth each to the Insured's son and daughter, John J. and Helen C. Doe. Should any of the aforesaid beneficiaries predecease the Insured, the respective share which would have been payable to such beneficiary, if living, shall be paid in equal shares, to the survivors or survivor.

Successive or Contingent - The Insured's wife, Jane A. Doe, if living; if not living, to the Insured's children, John J., Jerry A. and Joseph P. Doe, in equal shares to the survivors or survivor.

Estate - The executors or administrators of the Insured's Estate.

Minor Beneficiary - The naming of a minor without designating a trustee should be avoided since application to a court for appointment of a guardian or administrator results in delay and involves expense to the beneficiary that could be avoided. Add the following wording when children are designated during their minority, making sure to include the relationship of the trustee to the Insured and the trustee's address if different from the Insured's: Any amount becoming due to a child named above, payable during his or her minority, shall be paid to [name, relationship to Insured, address], as trustee for such minor child. It is understood and agreed that Greenwood International Insurance Services, Inc. shall not be responsible for any failure of a trustee to perform the duties of trustee or the application or disposition of any money paid to a trustee and such payment shall fully discharge the Insurance Company and Greenwood International Insurance Services, Inc. for the amounts so paid.

BENEFICIARY DESIGNATION/CHANGE FORM

(Form GWI-BDF-01)

THIS FORM FOR USE TO DESIGNATE BENEFICIARY AND/OR TO RECORD ANY SUBSEQUENT CHANGE OF BENEFICIARY BY THE INSURED EMPLOYEE

Employer:_______________________________ Account Number:________________________

Employee:_______________________________ Social Security:__________________________

(Please print name)

In accordance with the conditions of the above Group Policy, I hereby designate as beneficiary, in the event of my death:

Primary Beneficiary: Relationship Date of Birth

Name(s)_____________________________ _____________ _______________

_____________________________ _____________ _______________

Contingent Beneficiary Relationship Date of Birth

Name(s)_____________________________ _____________ _______________

This beneficiary designation revokes any previous beneficiary designation for this coverage. I reserve the right to change this designation. Such a change will take effect on the date signed, but without prejudice to Greenwood International Insurance Services, Inc. for any payment made prior to this receipt.

Signed at:____

This____________________day of________________Year

Signature of Employee:_________________________________

Signature of Witness:__________________________________

Signature of Spouse **(if required, as explained below)** ____

If the state in which the insured Employee resides is a community property state, then the signature of the spouse of the Employee is required if someone other than the spouse of the Employee is named as primary beneficiary.

The original copy of this form is to be maintained in the office of the Employer. In the event that a benefit becomes payable to the named beneficiary (beneficiaries), the original, signed copy of this form should be sent, along with the address of the beneficiary (beneficiaries), and all required proof of death forms to:

Greenwood International Insurance Services, Inc.
P.O. Box 1055
Marshfield, MA 02050

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