California Online First Report of Injury

www.lwpclaims.com

Welcome to ClaimsLink

LWP's online loss reporting tool for our California Clients

This document is a guide for users. It is intended to offer a step-by-step guide to completing and submitting an Employer's First Report of Injury (Form 5020) using LWP's secure loss reporting portal.

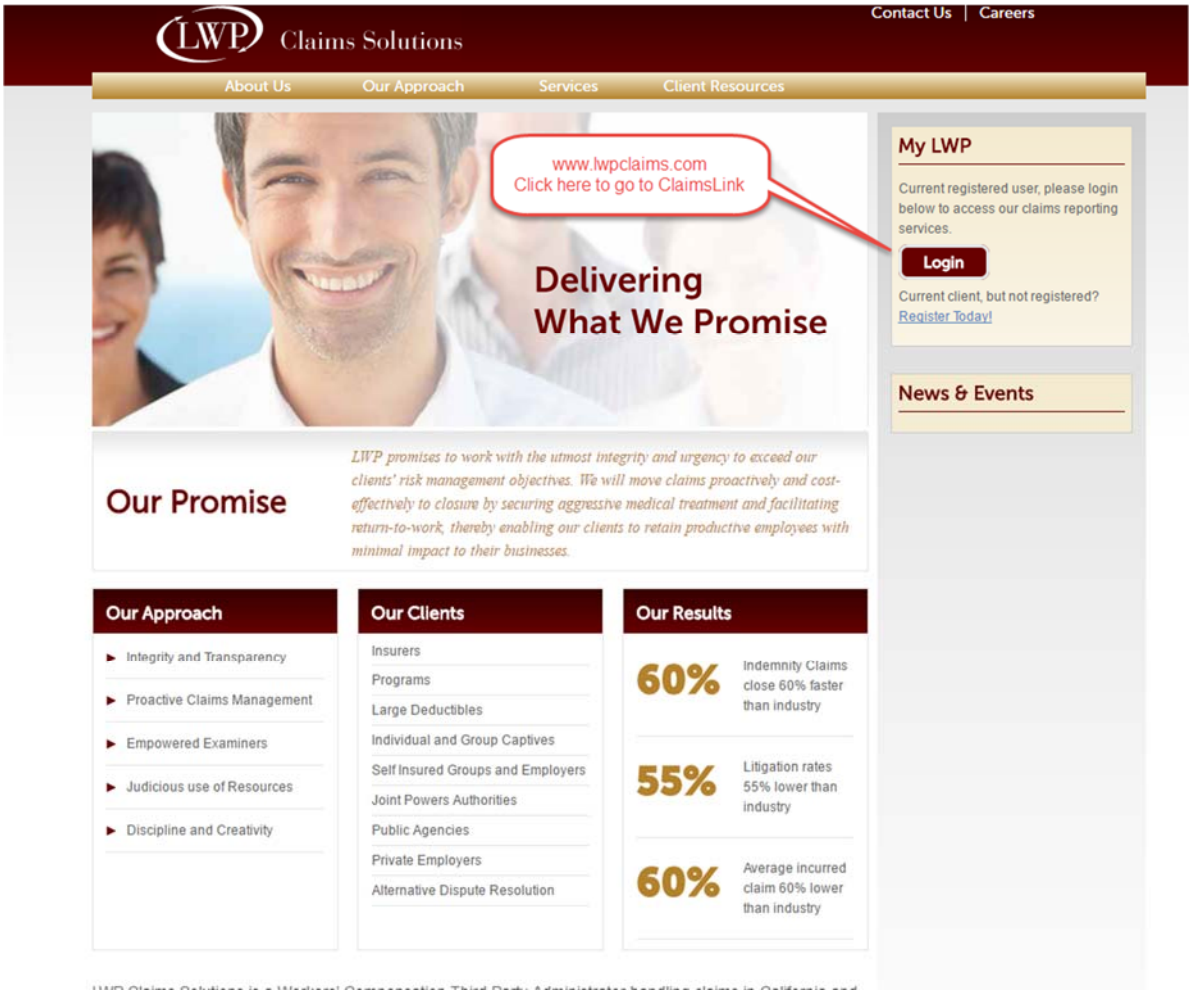
LWP will be happy to offer further assistance (including telephonic training) at any time. For training, please contact the Claims Supervisor or Manager with whom you work.

For any problems using the site, please contact LWP at lwphelpdesk@lwpclaims.com. Please describe the issue as completely as possible, so that we are prepared to assist you with a solution as quickly as possible.

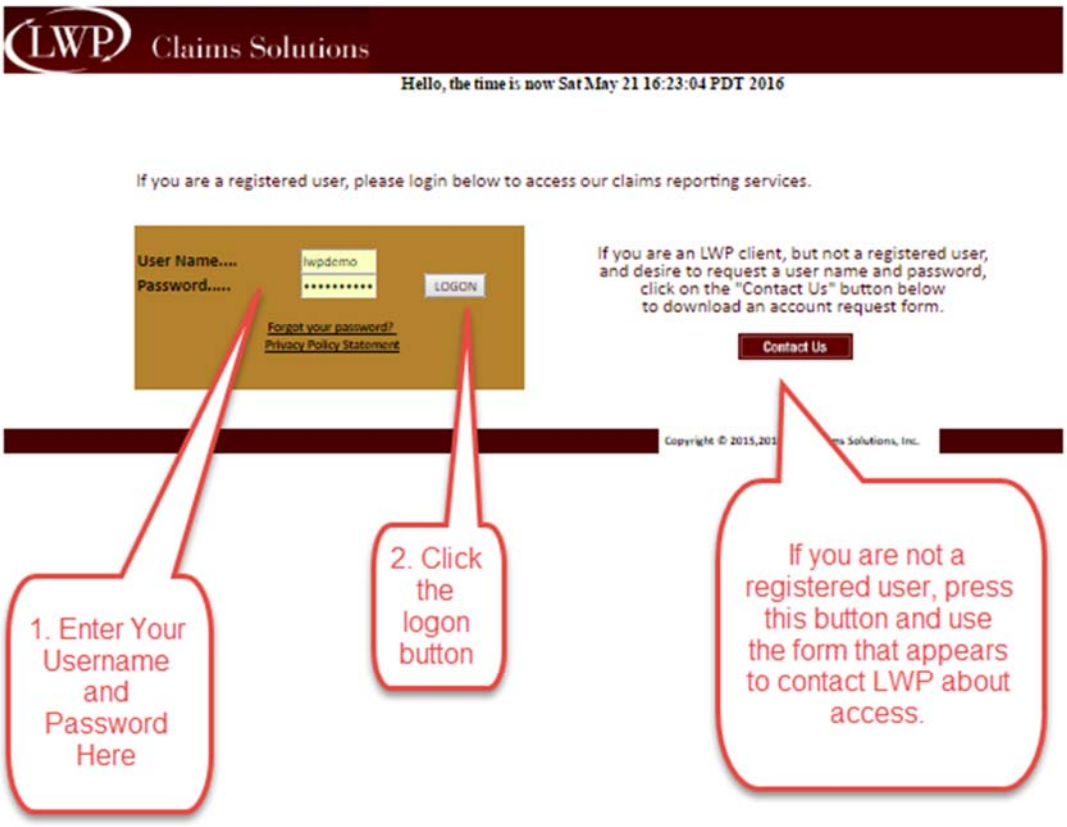
Thank you,

The LWP Team

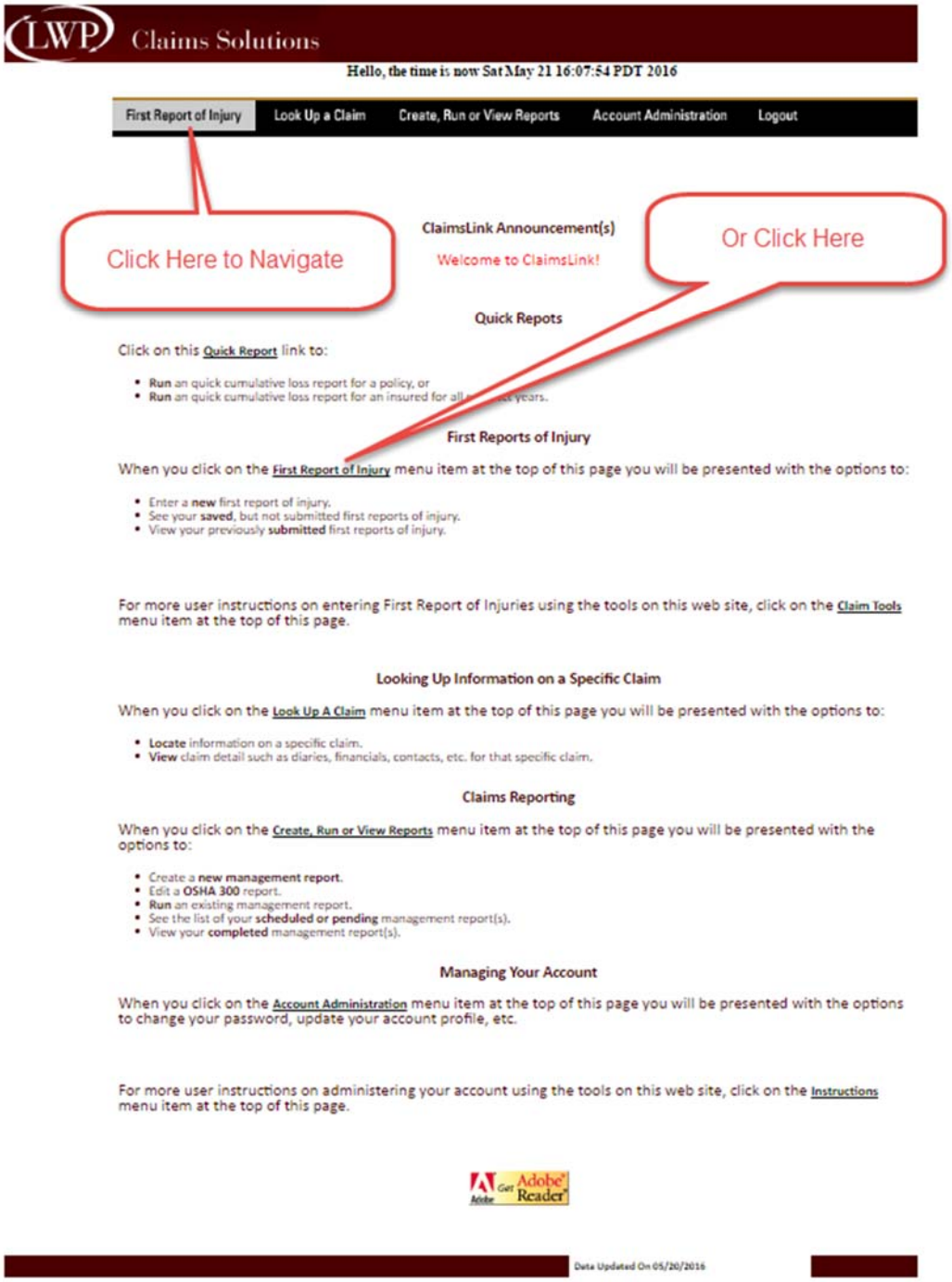
To access ClaimsLink, open the browser of your choice and navigate to www.lwpclaims.com. You should see the web page below. Click on “Login” in the “My LWP” section of the webpage.



You will be taken to the page below. If you are not a registered user, use 'Contact Us' to open an account request form that you should complete and return to us. Otherwise, please enter your username and password to Logon.



To access the Employer's First Report of Injury section of the website, click on the **First Report of Injury** link in the title bar or on the first section on the screen.

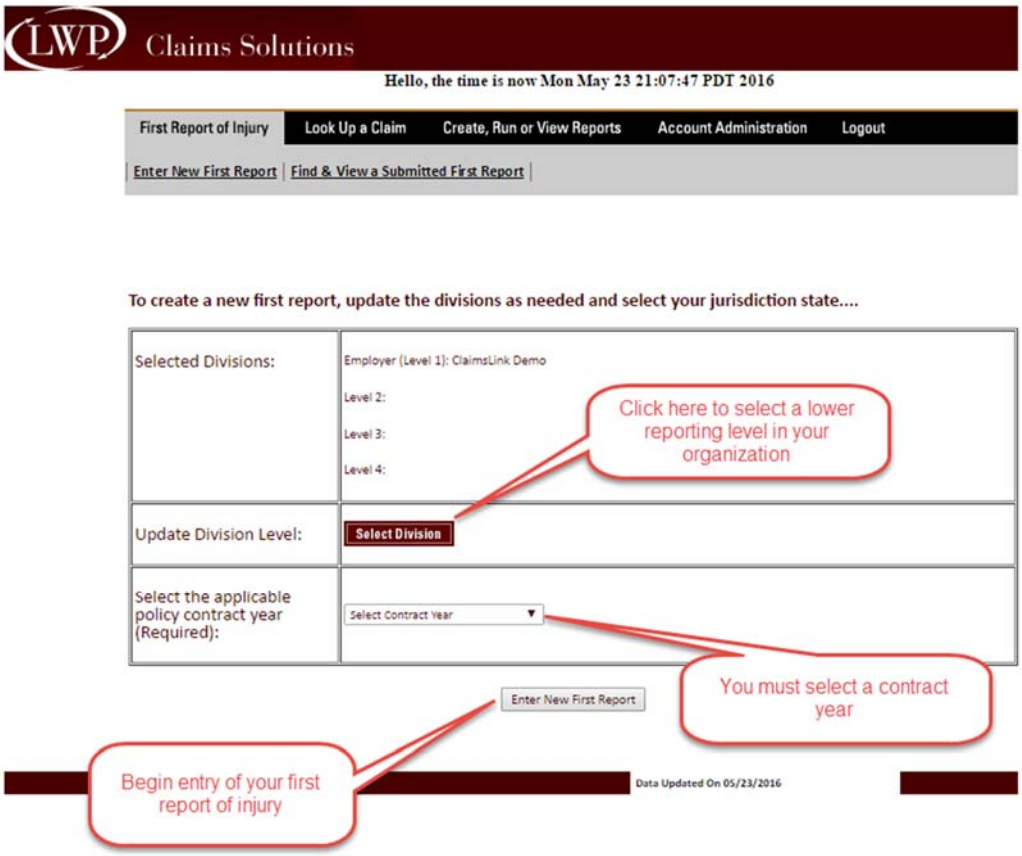


The First Report submission system is a secure way to complete and submit the First Report form. From this screen you can enter a new injury or retrieve a first report of injury that was previously submitted.

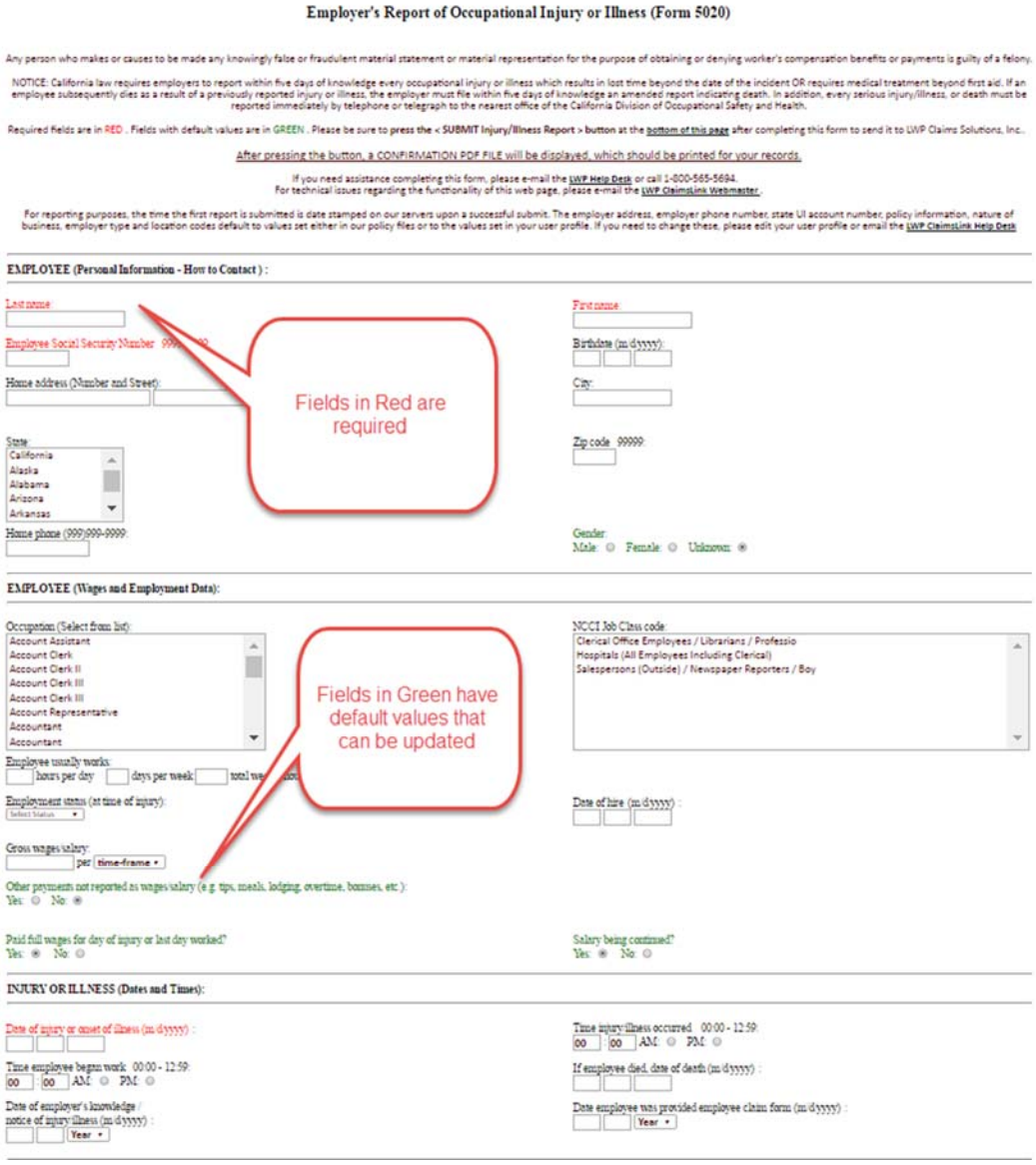
Once a first report of injury has been submitted you cannot make changes to the form. If you receive additional or corrected information please contact your Claims Examiner.

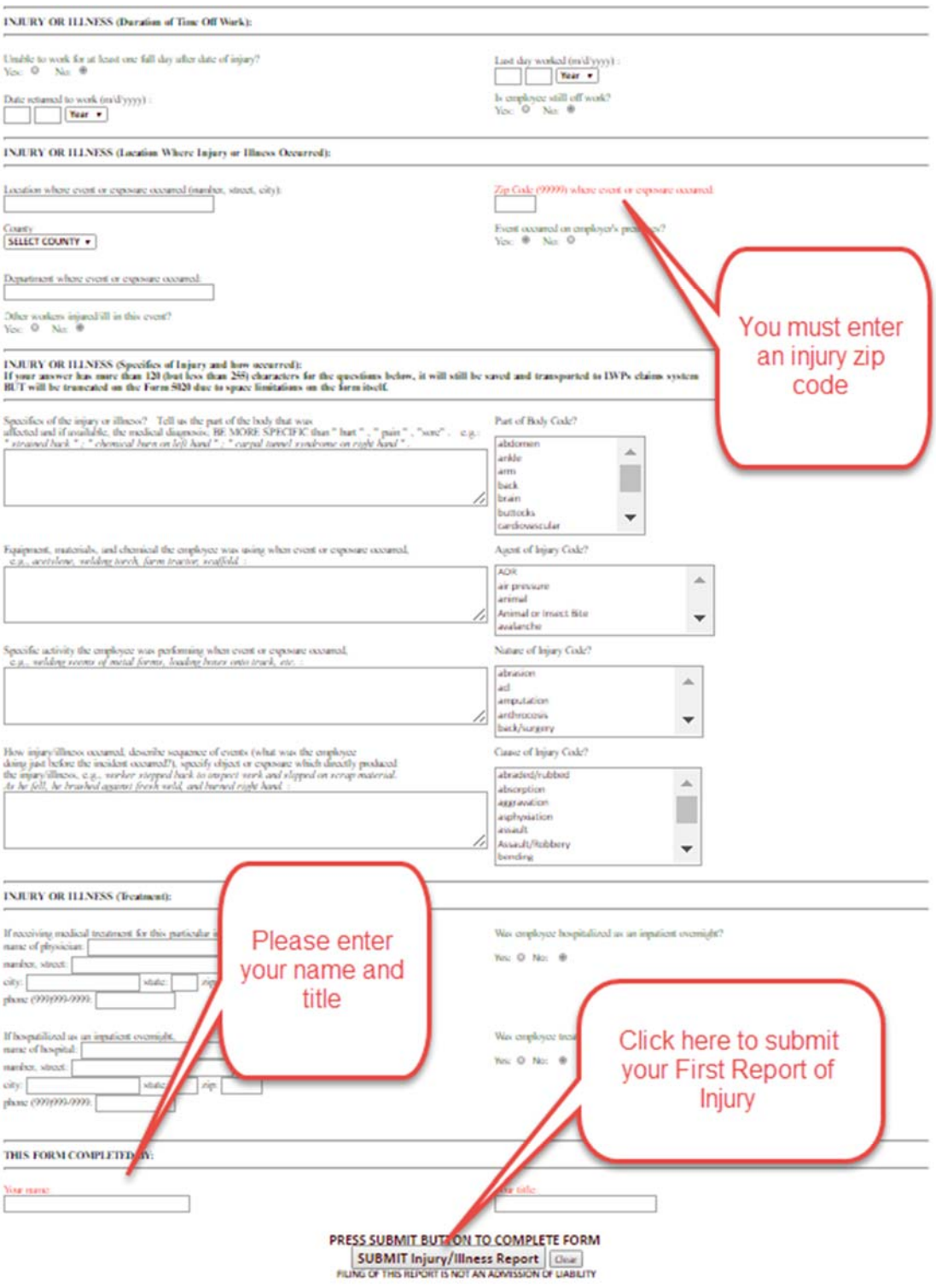
In order to begin please do the following:

1) To enter a new first report of injury, select the appropriate division level by clicking on the **Select Division** button. After you have completed the selection of the division level, click on the **Select Contract Year** and make a selection from the drop down list. Then click on the **Enter New First Report** button.
2) Select a contract year (the date of injury must be contained within the contract year)
3) Click on the 'Enter New First Report' button.



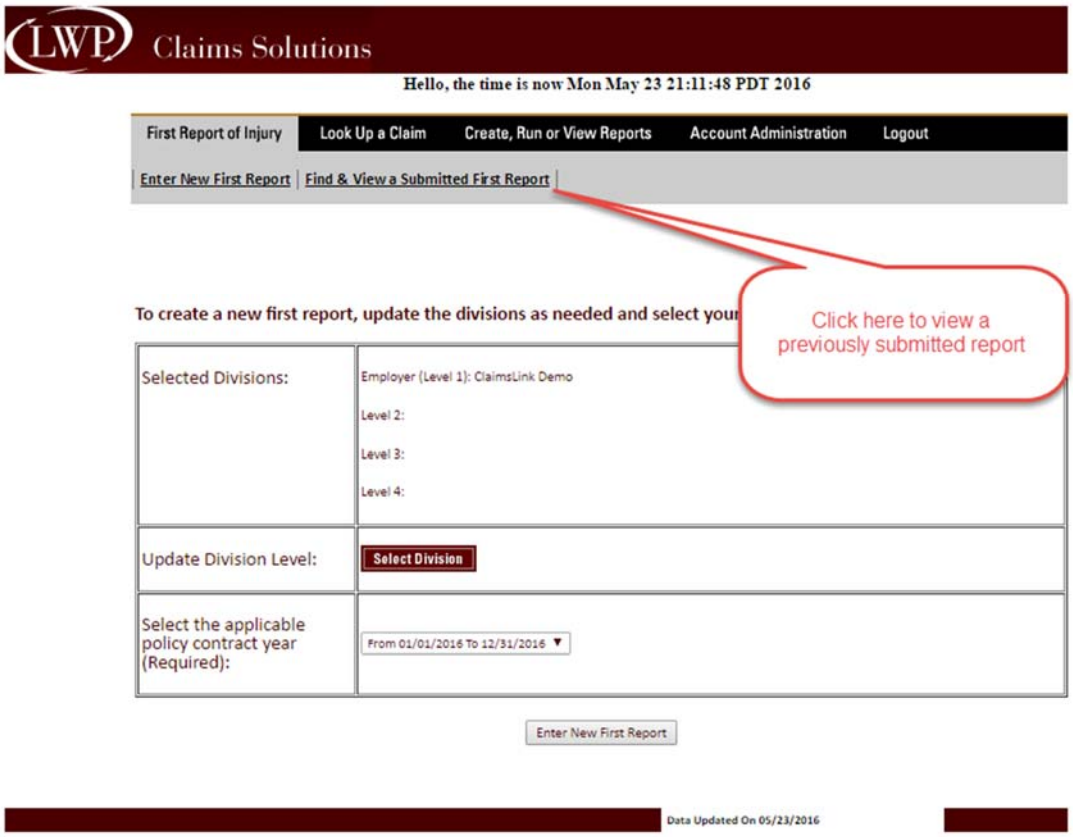
Using your tab key, fill in the information – you must, at a minimum, fill in the red highlighted boxes. Should you miss a required field, you will receive a validation edit, advising you an error. If this happens, click on the **OK** box and make the corrections. Click on the **Submit** button and the form is submitted to LWP's claims system.



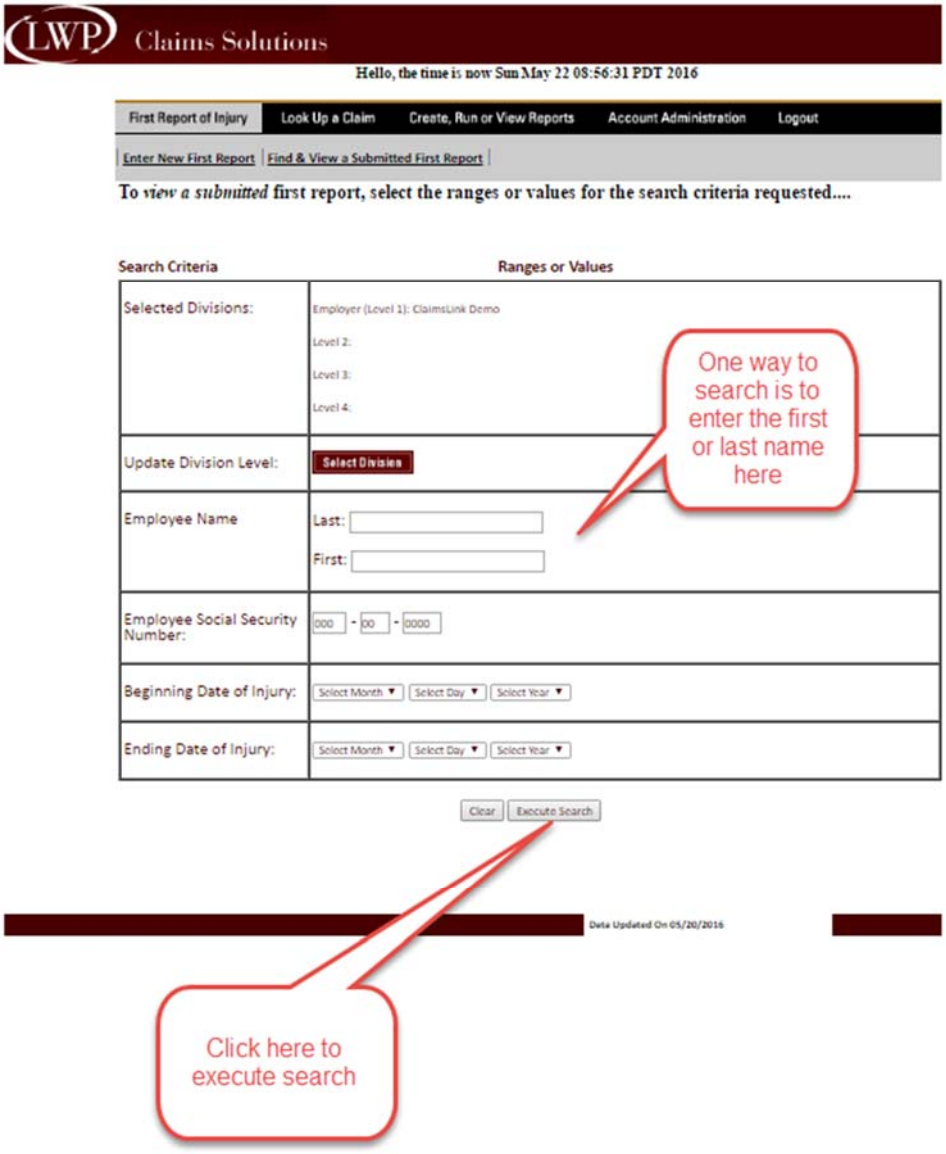

INJURY OR ILLNESS (Duration of Time Off Work):
Unable to work for at least one full day after date of injury?
Yes: No:
Last day worked (m/d/yyyy):
Year
Date returned to work (m/d/yyyy):
Year
Is employee still off work?
Yes: No:
INJURY OR ILLNESS (Location Where Injury or Illness Occurred):
Location where event or exposure occurred (number, street, city):
Zip Code (99999) where event or exposure occurred:
County:
SELECT COUNTY
Event occurred on employer's premises?
Yes: No:
Department where event or exposure occurred:
Other workers injured/ill in this event?
Yes: No:
You must enter an injury zip code
INJURY OR ILLNESS (Specifics of Injury and how occurred):
If your answer has more than 120 (but less than 255) characters for the questions below, it will still be saved and transported to LWPs claims system BUT will be truncated on the Form 5020 due to space limitations on the form itself.
Specifics of the injury or illness? Tell us the part of the body that was affected and if available, the medical diagnosis. BE MORE SPECIFIC than " hurt " , " pain " , "sore" . e.g.: " strained back " ; " chemical burn on left hand " ; " carpal tunnel syndrome on right hand ".
Part of Body Code?
abdomen
ankle
arm
back
brain
buttocks
cardiovascular
Equipment, materials, and chemical the employee was using when event or exposure occurred, e.g., acetylene, welding torch, farm tractor, scaffold.
Agent of Injury Code?
AOR
air pressure
animal
Animal or insect bite
avalanche
Specific activity the employee was performing when event or exposure occurred, e.g., welding seams of metal forms, loading hoses onto truck, etc.
Nature of Injury Code?
abrasion
aid
amputation
arthrocosis
back/surgery
How injury/illness occurred; describe sequence of events (what was the employee doing just before the incident occurred?); specify object or exposure which directly produced the injury/illness, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand.
Cause of Injury Code?
abraded/rubbed
absorption
aggravation
asphyxiation
assault
Assault/Robbery
bending
INJURY OR ILLNESS (Treatment):
If receiving medical treatment for this particular i
name of physician:
number, street:
city:
state:
zip:
phone (999)999-9999:
Was employee hospitalized as an inpatient overnight?
Yes: No:
Please enter your name and title
If hospitalized as an inpatient overnight,
name of hospital:
number, street:
city:
state:
zip:
phone (999)999-9999:
Was employee trea
Yes: No:
Click here to submit your First Report of Injury
THIS FORM COMPLETED BY:
Your name:
title:
PRESS SUBMIT BUTTON TO COMPLETE FORM
SUBMIT Injury/Illness Report
Clear
FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY
Please be sure to press the < SUBMIT Injury/Illness Report > button after completing this form to send it to LWP Claims Solutions, Inc..
After pressing the button, a CONFIRMATION PDF FILE will be displayed, which should be printed for your records.
If you need assistance completing this form, please e-mail LWP Help Desk or call 1-800-565-5604.
For technical issues regarding the functionality of this web page, please e-mail the LWP ClaimsLink Webmaster.

Once the “submit” button is clicked, the system will take you to a web page and ask you if would like to view the submitted first report. This page will also offer you the option to save a copy of the report.

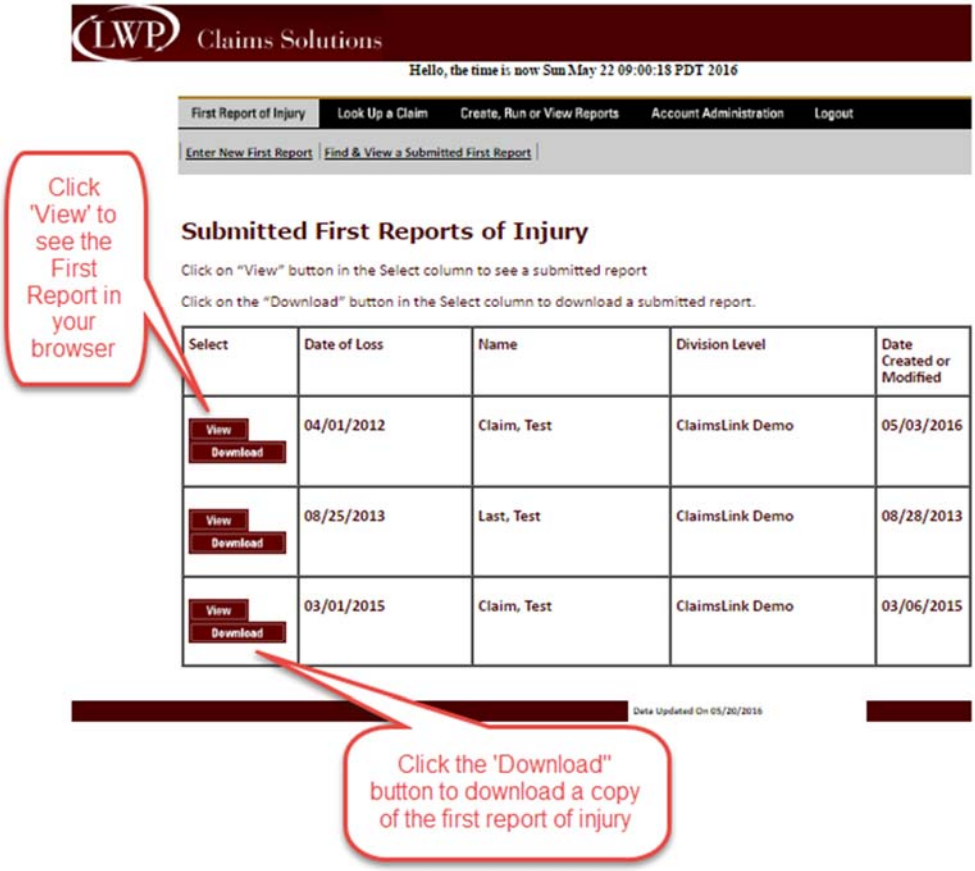
To look up a previously submitted report click on **Find & View a Submitted First Report**.



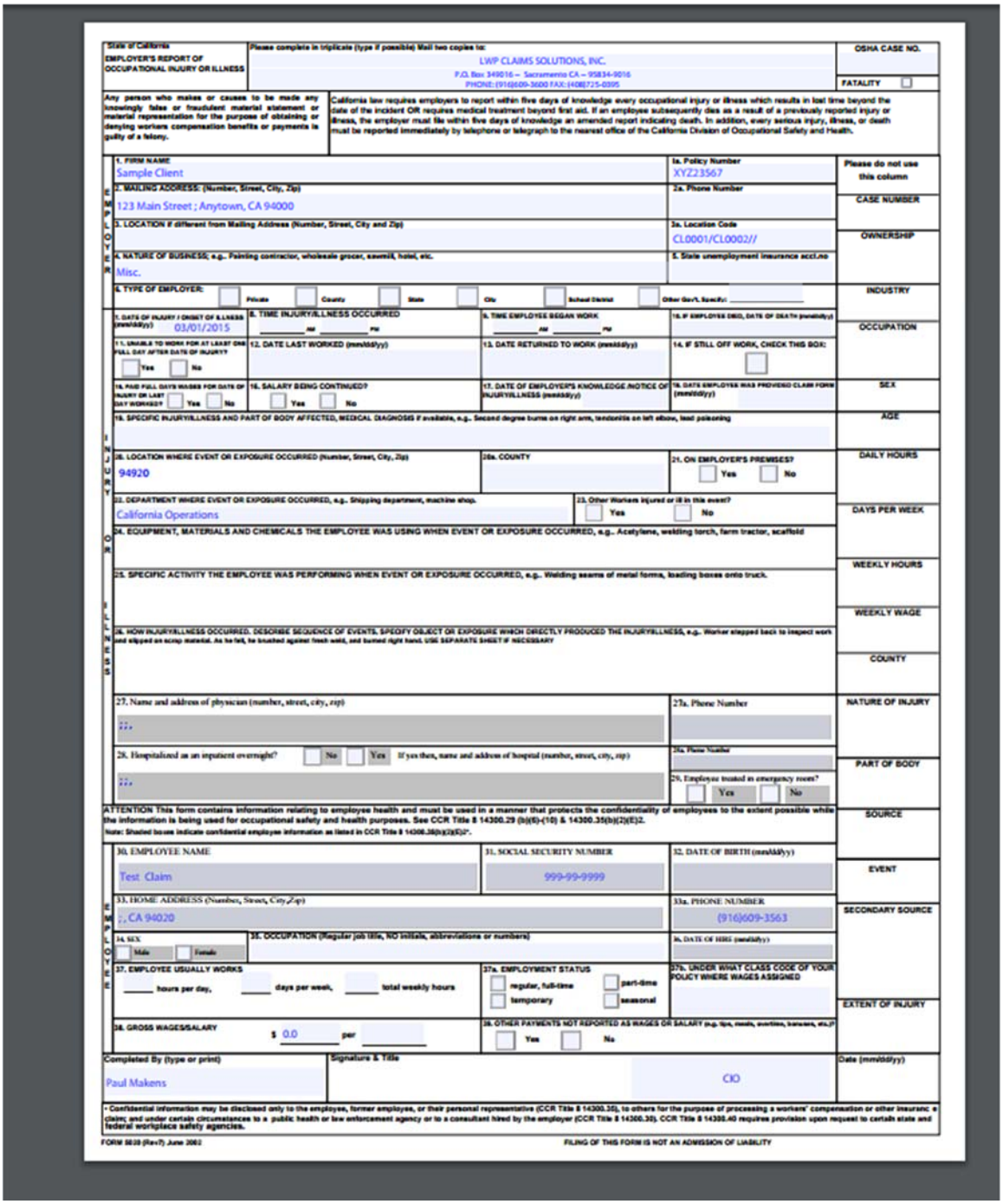
There are a number of search criteria that can be used to find the First Report that you are looking for. On this screen, you can search by name (first or last), by Social Security Number or by a range of injury dates. It is not necessary to enter the information for all fields. For example, if you only know the claimant's social security number, enter it and click "ExecuteSearch".



A list of claims that match the criteria you searched for will come up. Click “View” or “Download” to see the details of the report in PDF format.



Below is a view of a completed 5020 Form.



State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:
LWP CLAIMS SOLUTIONS, INC.
P.O. Box 349016 – Sacramento CA – 95834-9016
PHONE: (916)609-3600 FAX: (408)725-0395

OSHA CASE NO.

FATALITY ☐

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.

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: Sample Client
1a. Policy Number: XYZ23567
2. MAILING ADDRESS: (Number, Street, City, Zip): 123 Main Street ; Anytown, CA 94000
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code: CL0001/CL0002//
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.: Misc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ County ☐ State ☐ City ☐ School District ☐ Other Gov't. Specify: _____

INJURY

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 03/01/2015
8. TIME INJURY/ILLNESS OCCURRED: ____ AM ____ PM
9. TIME EMPLOYEE BEGAN WORK: ____ AM ____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYER WAS PROVIDED CLAIM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): 94920
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.: California Operations
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip): ,,,
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip): ,,,
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME: Test Claim
31. SOCIAL SECURITY NUMBER: 999-99-9999
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip): , CA 94020
33a. PHONE NUMBER: (916)609-3563
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS ____ hours per day, ____ days per week, ____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ 0.0 per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES OR SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

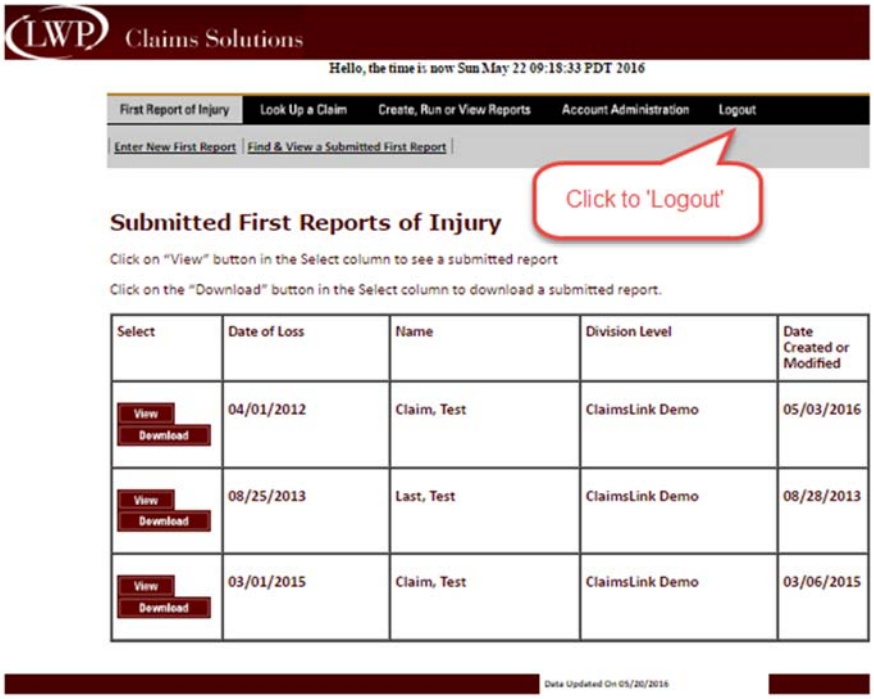
Completed By (type or print): Paul Makens
Signature & Title: CIO
Date (mm/dd/yy)

* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.35). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FORM 5020 (Rev7) June 2002
FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

If you want to download the report, click 'Download'. Depending on the browser you use, you may be prompted for a save location (and possibly name) or the browser may store the report in the default download location for your MAC or PC.

To return to search, navigate back to the list of reports of injury using your browsers 'back" button or arrow. You will see the list of submitted reports again.



When you are finished working in the website click 'Logout' from the black title bar. You will be returned to the initial log in screen.