IMPORTANT BILLING INFORMATION

Thank you for choosing Sheffield as your Workers' Compensation provider. If you have chosen to pay your premium on a monthly basis, you will receive a Monthly Payment Invoice. The invoice will be mailed to you around the 25th day of each month and will include a section at the bottom entitled "Monthly Payroll Worksheet". If the completed Monthly Payroll Worksheet is timely received by Sheffield, the payroll figures reported therein will be used to calculate the amount of premium due on the next Monthly Payment Invoice. If not timely received, the next Monthly Payment Invoice will reflect approximately 1/12 of your estimated annual premium and the estimated amount must be paid regardless of the actual payroll figures for the applicable month. Credit for any overpayment will be given when the annual payroll audit is conducted.

IF YOU HAVE A QUESTION ABOUT YOUR INVOICE OR ANY PROCEDURAL ISSUE, PLEASE CONTACT OUR CUSTOMER SERVICE DEPARTMENT ON OUR TOLL FREE CUSTOMER SERVICE LINE.

1-866-839-4381

Our mailing address is:

THE SHEFFIELD GROUP, INC.
1800 Corporate Drive
BIRMINGHAM, ALABAMA 35242

THE SHEFFIELD GROUP

MONTHLY BILLING SCHEDULE AND PROCEDURES

PLEASE REVIEW CLOSELY. The following guidelines and procedures are followed for all Accounts billed on a Monthly basis.

1. All Monthly Payment Invoices are mailed approximately the 25th day of the month. On New Business, the first Premium Payment due is based on 1/12th of your Estimated Yearly Premium. On the same Invoice, middle of statement, is a **MONTHLY PAYROLL WORKSHEET** requesting **GROSS PAYROLLS** to be reported for applicable month in questions. If payrolls are reported as requested and received in a timely manner, your next month's Premium will be computed by multiplying payrolls reported by rates and discounts on your Account. If we do not have your payrolls as requested, your next months Invoice will be 1/12th of your Estimated Yearly Premium. All accounts are subject to yearend audits.

2. Payments on Monthly Invoices are **due** by the 10th day of the Month. If payment is not received by the 15th day of the Month, the Account is considered past due. Once this has occurred, **a 15 day Notice of Intent to Cancel** is issued with an additional **$35.00** late fee assessed against any outstanding balance due. A copy is also mailed and faxed to your Agent notifying them that your Account is Past Due.

3. If Payment on the past due balance is not received by the termination date shown on the **Notice of Intent to Cancel,** a **Confirmation of Termination** will be issued. A copy of the Termination Notice is also sent to your Agent notifying them that any Certificates of Coverage on Workers Compensation should be revoked.

4. Once an Account has been issued a **Termination Notice for Non-payment,** at the sole discretion of The Sheffield Group it may be reinstated within 5 days. Once the 5 days have past, the appropriate state department will be notified that coverage has lapsed for **Non-payment.**

If we can be of any assistance in regard to the information above or anything else on your Account, please do not hesitate to give us a call at 1-866-839-4381.

Sincerely,

The Sheffield Group

SHEFFIELD

WELCOME TO THE SHEFFIELD FUND!

We are pleased that you have chosen to join thousands of other Alabama employers in pooling your workers' compensation liabilities and we intend to work hard to provide you with prompt, courteous and efficient service.

As you browse through this Information Kit, you will notice it has been divided into two sections: Billing and Claims. In each section, we have tried to provide you with all forms, telephone numbers, addresses and procedures needed to utilize your Fund. However, if you are a new member please feel free to contact our Customer Service Department at (205) 437-2344 or (866) 839-4381.

The Sheffield Fund workers' compensation program is sponsored by the Sheffield Association of Federated Employers (SAFE). We know that safety in your operations is of primary importance in your efforts to operate your organization safely, efficiently, and profitable. The enclosed SAFE publication "A Workplace Safety Handbook" is provided to assist you in developing and managing your safety program activities and controlling on the job injuries and illnesses to your workers. A Loss Control representative may visit your operations in the next few months. The representative will obtain information about your organization's operations and may make suggestions to help you improve workplace safety and, in turn, keep your workers compensation cost as low as possible. If you would like a visit by a loss control representative, would like free use of the safety videos available to you, or would like other safety program assistance or material, please call our Loss Control Manager at 205-991-9603.

We at The Sheffield Fund are constantly striving to improve every aspect of member service. It is our goal that as your awareness of our program grows, you will share our belief that The Sheffield Fund is the premier provider of workers' compensation coverage for Alabama businesses.

Sincerely,
The Sheffield Fund

THE SHEFFIELD FUND

The Sheffield Building, Meadowbrook Corporate Park
1800 Corporate Drive
BIRMINGHAM, ALABAMA 35242
Telephone (205) 991-9603 • Fax (205) 991-7921

Safety Services for Fund Members

Safety Services are available to the Fund Members
through Sheffield Risk Management Services, LLC
1800 Corporate Drive • Birmingham, AL 35242
Telephone (205) 991-9603
Fax (205) 991-7921

The Safety Services available to Fund members include:

- On site and other Consultation for your safety program needs and accident prevention,
- Management and supervisory safety training assistance,
- Safety Training video library available for free loan to members,
- The Workplace Safety Handbook to assist you in your safety program efforts,
- Assistance with other safety problems including ergonomic evaluations, lifting and material handling problems, industrial hygiene, and occupational disease exposures.

If you would like to use any of the Safety Services available to the Fund Members, please contact the Loss Control Manager at (205) 991-9603

Sheffield Risk Management Services, LLC

IMPORTANT **CLAIMS** INFORMATION . . . .

IF YOU HAVE A QUESTION ABOUT A CLAIM,
PLEASE CONTACT OUR CLAIMS SERVICE COMPANY

SHEFFIELD RISK MANAGEMENT SERVICES, LLC

Our mailing address is:

Sheffield Risk Management Services, LLC
1800 Corporate Dive
Birmingham, AL 35242

Our Telephone number is:
(205) 991-7552

Our fax number is:
(205) 991-7978

PLEASE REMEMBER TO REPORT ALL CLAIMS PROMPTLY

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

WCC Form 2
Rev. 1985
Rev. 1993
Rev. 2005

FAX #205-991-7978

STATE OF ALABAMA

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Ombudsman 1-800-528-5166

CLAIM REFERENCE

1. Insured Policy Number
2. Claims Administrator Claim Nbr N/A
3. OSHA Log Case Number N/A

EMPLOYER

4. Employer Business Name
5. Physical Address 1
6. Physical Address 2
7. City 8. State 9. Zip

ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS
10. Mailing Address 1
11. Mailing Address 2
12. City 13. State 14. Zip

15. Federal ID Number
16. U.C. Account Number N/A
N/A

INSURER / CLAIMS ADMINISTRATOR

18. Insurer Name **SHEFFIELD RISK MANAGEMENT**
1800 CORPORATE DRIVE
BIRMINGHAM, AL 35242
19. Insurer Federal ID Number N/A
20. Insurer Type Code N/A

21. Administrator Name N/A
22. Mailing Address 1
23. Mailing Address 2
24. City 25. State 26. Zip
27. Administrator Federal ID Number

EMPLOYEE / WAGES

28. First Name
29. Middle Name
30. Last Name
31 Last Name Suffix (ie. Jr., Sr., III)

32. Employee SS #
33. ID Type Qualifier
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 (ccyymmdd)
42.Nbr of Dependents

43. Marital Status
Single ☐ Divorced ☐ Widowed ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown ☐

44. Date Hired (ccyymmdd)

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 (ccyymmdd)

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 SOURCE OF INJURY, PART OF BODY THAT WAS AFFECTED AND NATURE OF INJURY.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// DIR.ALABAMA.GOV/WC OR CALL 1-800-528-5166)
64. Nature of Injury N/A 65. Part of Body N/A 66. Cause of Injury N/A

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 (ccyymmdd)	78. Preparer's First Name	79. Last Name	80. Title	81. Preparer's Phone

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

WCC Form 2
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FAX #205-991-7978

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EMPLOYER

4. Employer Business Name
5. Physical Address 1
6. Physical Address 2
7. City 8. State 9. Zip

ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS
10. Mailing Address 1
11. Mailing Address 2
12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number N/A	N/A

INSURER / CLAIMS ADMINISTRATOR

18. Insurer Name **SHEFFIELD RISK MANAGEMENT**
1800 CORPORATE DRIVE
BIRMINGHAM, AL 35242
19. Insurer Federal ID Number N/A
20. Insurer Type Code N/A

21. Administrator Name N/A
22. Mailing Address 1
23. Mailing Address 2
24. City 25. State 26. Zip
27. Administrator Federal ID Number

EMPLOYEE / WAGES

28. First Name
29. Middle Name
30. Last Name
31 Last Name Suffix (ie. Jr., Sr., III)

32. Employee SS #
33. ID Type Qualifier
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 (ccyymmdd)

42.Nbr of Dependents

43. Marital Status
Single ☐ Divorced ☐ Widowed ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown ☐

44. Date Hired (ccyymmdd)

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 ☐
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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.)

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(FOR COMPLETE LIST OF CODES, GO TO HTTP:// DIR.ALABAMA.GOV/WC OR CALL 1-800-528-5166)
64. Nature of Injury N/A 65. Part of Body N/A 66. Cause of Injury N/A

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 (ccyymmdd)	78. Preparer's First Name	79. Last Name	80. Title	81. Preparer's Phone

SHEFFIELD

WEEKLY EARNINGS

Claim #: _____

Adj #: _____

Injured: _____ Employer: _____

Date of Accident: _____ Date Employed: _____

If injured <u>DID NOT</u> work 52 weeks before accident, please give all available earnings. However, if employee worked less than 6 weeks, please report the earnings of a similar employer on a separate form.

This is the payroll of _____

Week No.	Week Ending Date	Number of Days Worked	Amount Paid Including Overtime	Week No.	Week Ending Date	Number of Days Worked	Amount Paid Including Overtime
1				27			
2				28			
3				29			
4				30			
5				31			
6				32			
7				33			
8				34			
9				35			
10				36			
11				37			
12				38			
13				39			
14				40			
15				41			
16				42			
17				43			
18				44			
19				45			
20				46			
21				47			
22				48			
23				49			
24				50			
25				51			
26				52			
<u>Total</u>		<u>CARRY FORWARD</u>		<u>Total</u>			

<u>REMARKS: PLEASE INCLUDE ANY BENEFITS PAID TO OR FOR THE EMPLOYEE OTHER THAN SALARY. Examples: Mileage, gas allowance, insurance premiums, etc.</u>

SHEFFIELD

WORKERS' COMPENSATION QUESTIONNAIRE

Claim #: _____

Adj #: _____

IMPORTANT: In order to process your workman's compensation claim promptly, please complete and return this form.

Name (first, middle, last)			Social Security Number	
Address				
Date of Birth	Martial Status	Number of Dependents under 18 years of age _____	Average Weekly Wage $ _____	Phone Number _____
Employer		Nature of Worker		
Date of Injury		Time of Injury	Place of Injury	

List names & address of witnesses

State in your own words how injury happened.

Did you stop work immediately? [ ] yes [ ] no	If "NO" give last date worked _____	Have you returned to work? [ ] yes [ ] no	If "YES", date returned to work _____
Did you notify your employer IMMEDIATELY? [ ] yes [ ] no	If "NO" when did you notify your employer? _____ _____	Name of Person Notified _____	

What is the nature of your injury:

Name and Address of Attending Physician	Name and Address of Hospital
Who referred you to this physician?	
Have you had any previous injuries of this nature? [ ] yes [ ] no	If "yes" please give full details: (date, employer, doctor, etc.)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician, hospital or other person or institution to permit the insurance company or its representative to examine, make or be furnished with any information concerning illness or injury sustained by me including treatment, consultation, medical history, hospital records, prescriptions, diagnosis or findings, A photostatic copy of this authorization shall be considered as valid as the original.

DATE: SIGNATURE:

WORKERS' COMPENSATION MILEAGE CLAIM

IMPORTANT: In order to process your workers' compensation mileage, please complete this form and submit to your employer. **Please note that reimbursement for mileage can only be processed when verifying documents from medical providers have been received. You can speed the processing of this request by attaching supporting documents to this form.**

NAME: _____ Date of Accident: _____

Home Address: _____

Home Phone: _____ Social Security Number: _____

Employer: _____

DATE	LIST TRIP TAKEN BELOW SUCH AS: HOME TO (NAME) HOSPITAL; NAME OF DR. (NAME) AND RETURN HOME; OFFICE TO DR. (NAME) AND RETURN HOME, ETC. . . .	ROUND TRIP DAILY MILEAGE
	TOTAL MILEAGE	

I certify that the above information furnished by me is true and correct and, based on such information. I hereby claim pay for the mileage as indicated.

_____ _____

Employee Signature Employer Signature

_____ _____

Date Date