ARKANSAS WORKERS' COMPENSATION COMMISSION
324 Spring Street
P.O. Box 950
Little Rock, AR 72203-0950

TO: **Interested Parties**

FROM: **Carl Bayne**
Operations/Compliance

DATE: **November 20, 2012**

SUBJECT: **Form 2 Required Data, Effective January 1, 2013**

Following this notice you will find a Form 2 clearly marked showing what data is required, effective January 1, 2013.

If you are familiar with the Form 2 we are currently using, you will quickly see the changes this revision includes. Following the Form 2, we are providing for you explanations of what style of information you will be required to submit to satisfy our requirements.

Please note that failure to provide any of the data marked on the accompanying Form 2 will cause your submission to be rejected.

Form AR- 2	ARKANSAS WORKERS' COMPENSATION COMMISSION	2
Authority: Ark. Code Ann. §11-9-803, -810 Revised 1-1-2013	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

EMPLOYER'S INTENT TO ACCEPT OR CONTROVERT CLAIM

❑ **Initial Filing** **1** ❑ **Amended Filing**

2	3	4	5	
AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee SS Number	
6				
Employer Name			Fed. Employer I.D. No.	
Address		City	State	Zip Code
7				
Carrier or Self-Insured Name		Claims Office Name, Address, and Phone		

Is this a medical only claim? ❑ Yes ❑ No **8** **Is this a PPD-Only Claim?** ❑ Yes ❑ No

COMPENSATION (if not applicable, skip to next section)

Date of First Comp. Check	Dates Covered by First Check	Body Part Injured	First Day of Disability
	.00	Was Disability Continuous During the First 8 Days? ❑ Yes ❑ No	
Average Weekly Wage	Wkly TTD Comp. Rate (rounded)		Date Indemnity Triggered

STATEMENT OF POSITION

Date of injury or death: **9** **City, State of Injury:** **10** State your position. If controverting, state the grounds therefore:

11

DEATH CASE DATA **12**

List all Dependents below: *(If more space is needed, attach supplemental sheet)* If no Dependents, check here: ❑
Attach Death Certificate of Deceased Employee and Birth Certificates for Dependent Children

Name of dependent	Date of birth	Relationship to deceased	Weekly benefit amount

CERTIFICATION

I certify that the foregoing is a complete and accurate report according to the records of the insurer pertaining to first payment, controversion and beneficiary information. I further certify that a copy of this report or equivalent information has been provided to the employee or beneficiaries.

13	14	Title:	16
Signature	Printed or Typewritten Name	Phone: **15**	Date

If insurer is represented by an attorney, that legal representative must sign below pursuant to Ark. Code Ann. § 11-9-717

Name and Address of Attorney	Signature

AWCC Form 2

(Employer's Intent to Accept or Controvert Claim)

A form used to accept a case and report payment or to controvert. **AWCC Form 2** also is used to amend positions taken earlier.

Help With AWCC Form 2:

1. The first payment to the employee is due by the 15th day after the employer has notice of the injury or death. **(Ark. Code Ann. §11-9-802)**

2. The AWCC is notified "upon making the first payment." **(Ark. Code Ann. §11-9-810)**

3. A controversion notice is due on or before the 15th day after notice of the death or alleged injury.
(Ark. Code Ann. §11-9-803)

4. Therefore, **AWCC Form 2** in all cases is required by the 15th day from (a) the day of disability or (b) the day the employer is aware of the alleged incident, whichever date is later.

The following are required fields on the AWCC Form 2:

5. A mark in either the Initial Filing Box or Amended Filing Box.

6. The AWCC File Number (obtained from **AWCC A-110 Spreadsheet**), your company's file number for this case, the employee's name (first and last name), the employee's Social Security Number, the employer name, the carrier or self-insured's name, date of injury or death, and the city, state of injury.

Be sure to bear in mind:

7. If respondents need additional time to obtain medical records, you may request an extension before the Form 2 due date.

8. If a case is opened at the AWCC on **Form 1** or **Form C**, an AWCC **Form 2** is required, even if the case upon investigation is determined to be a medical-only claim.

Form 2 questions may be directed to the AWCC Operations and Compliance Division, which processes this form. (1-800-622-4472 or 501-682-3930)

Ark. Code Ann. §11-9-106(a): Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission.

Ark. Code Ann. §11-9-717: Any person or attorney signing a claim, request for benefits, controversion of benefits request for hearing or other paper of a party, certifies the action is taken after reasonable inquiry; is well grounded in fact; is warranted by existing law or a good faith argument for extension, modification or reversal of existing law; and is not interposed for any improper purpose or for delay. Violators of this provision may be subject to sanctions, which may include payment of reasonable expenses incurred by others and reasonable attorney fees for responding to the claim, request or motion, or for failure to appear at a hearing, deposition or other scheduled matter.

REQUIRED FORM 2 DATA

Revised Form 2, effective January 1, 2013

1. INITIAL OR AMENDED FILING: Each Form 2 filing must be marked to show if it is an Initial or an Amended filing. If it is an Amended filing, circle the information that is being added to or amended from your previous filing.

2. AWCC FILE NUMBER: If an AWCC File Number exists, you are required to place it legibly in this box. So, if this claim was opened by a Form C, if it was opened by the previous filing of a Form 1, if this is an Amended filing, etc., provide the AWCC Claim Number.

However, if this claim is being opened by a Form 1 which is being sent along with this Form 2, we understand that you don't have a current file number and we will, in this instance only, accept your Form 2 filing and enter the claim number for you.

Please note, though, that if you file a Form 2 without an AWCC file number and the Form 2 is not accompanied by a Form 1, you are likely to get a very nicely written "No Report" letter, telling you that while the Form 2 isn't being rejected (because it doesn't have a file number we can key a rejection to), we are returning it to you for completion. It will, also, be returned to the name and claims office address on the Form 2!

3. CARRIER CLAIM NUMBER: Make sure this claim number matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 2 data or file an Amended Form 1 correcting the Carrier Claim Number submitted on the Form 1, whichever is necessary.

4. EMPLOYEE NAME: Make sure this employee name matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 2 data or file an Amended Form 1 correcting the Employee Name submitted on the Form 1, whichever is necessary.

5. EMPLOYEE SOCIAL SECURITY NUMBER: Make sure this Social Security Number matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 2 data or file an Amended Form 1 correcting the Social Security Number submitted on the Form 1, whichever is necessary.

If you provide to us the AWCC File Number, Employee Name and the Date of injury or death, OR if filing this Form 2 with a Form 1 to open the claim, you provide the Carrier Claim Number, Employee Name and Date of injury or death, we will accept your Form 2 filing with only the last four numbers of the Social Security Number.

6. EMPLOYER NAME: Make sure this employer name matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 2 data or file an Amended Form 1 correcting the Employer Name submitted on the Form 1, whichever is necessary.

7. CARRIER OR SELF-INSURED NAME: Make sure this carrier or self-insured name matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 2 data or file an Amended Form 1 correcting the Carrier or Self-Insured Name submitted on the Form 1, whichever is necessary.

8. IS THIS A MEDICAL ONLY CLAIM? IS THIS A PPD-ONLY CLAIM?: If you've worked with the Arkansas Workers' Compensation Commission in the past, you will note first that we have eliminated the "Type of Claim" section from our revised Form 2. Now, the only information we want about the type of claim your filing is "Is this a medical only claim?" and "Is this a PPD-Only claim?".

Our reasons for asking this are for report card purposes only. If this is a med-only claim and you don't tell us so right here, your Form submissions will be graded for timeliness and included on your report card. If this is a PPD-only claim and you don't tell us so right here, we begin grading your

timeliness on filing your Form 2 from the date of disability, rather than from the Date Indemnity Triggered.

So, for report card purposes, you are better served to tell us when your claim is a Medical Only or a PPD-Only claim!

9. DATE OF INJURY OR DEATH: Make sure this date of injury or death matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 2 data or file an Amended Form 1 correcting the Date of Injury/Date of Death submitted on the Form 1, whichever is necessary.

If at the time of filing the Form 1 this was not a Death claim, but has subsequently become one, file an Amended Form 1 providing on the Form 1 the Date of Death and the Date of Hire. And file within 30 days of the Date of Death a Form D.

10. CITY, STATE OF INJURY: Double check this for accuracy. We gather this data for statistical purposes and for assigning the claim to an ALJ if a hearing is required.

11. STATEMENT OF POSITION: The second big change on our revised Form 2 is the change from the "Controversion" section to a "Statement of Position" section. In the past if you wrote anything at all in the Controversion section, we keyed the claim as controverted and notified all of the parties involved. This sometime led to confusion.

On our revised, effective January 1, 2013, Form 2, while you are still required to, if you are controverting a claim, state that you are controverting it and your reason(s), you can now enter any information you want to provide us, in this section.

We encourage, although do not require, you to tell us that you're "paying all medical and TTD benefits due", that you have "accepted the claim as compensable and are paying all appropriate benefits", etc.

12. DEATH CASE DATA: This is, naturally, only required if this is a Death claim. If it is a Death claim, you must provide to us one of the following: indication that the claimant has no Dependents; or, the name(s), date(s) of birth, relationship to the deceased, and weekly benefit amounts for which the dependents are eligible.

If you know that the claimant has dependents, but you are unable to provide the required information, you may write in this space that you are gathering that information and will file an Amended Form 2 as soon as you have it.

13. SIGNATURE: We will accept a computer generated signature if you aren't able to physically sign the Form 2.

14. PRINTED OR TYPEWRITTEN NAME: The name of the adjuster handling this claim.

15. PHONE: The direct phone number of the adjuster handling this claim, or the main office phone number and the direct extension to the adjuster handling this claim.

16. DATE: The date this Form 2 is completed.

One Comment: We do not list any of the Compensation section as being required, as you may or may not be paying compensation. However, if you pay any compensation to the claimant, then all of the compensation section, except for the Body Part Injured, is required to be provided.

Remember, the law in Arkansas is that if you pay compensation or wish to controvert a claim, you must notify AWCC, in writing, on the appropriate form, within fifteen days of the date of disability or date of employer notification, whichever is later, or within fifteen days of the date indemnity triggered for PPD-Only claims.