COVENTRY HEALTH CARE
Workers' Compensation Services

APPROVED MEDICAL CARE PLAN

EMPLOYER APPLICATION FORM

Employer Name: _____
(Please print)

Employer Representative: _____ **Telephone:** _____
(Please print)

Business Location(s): _____
(Include number of employees per site, if more than one location)

_____

_____

DBAs & Subsidiaries: _____

Total No. of Employees: _____ **Type Of Business:** _____

Average Number of Work-Related Injuries Per Year: _____

INSURANCE INFORMATION

Please Check One: ___ Workers' Compensation Carrier ___ Third Party Administrator

Name: _____

Address: _____

_____

_____

Insurance Representative: _____ **Phone:** _____

Policy Number: _____ **Policy Term:** _____

AGENT INFORMATION (If Applicable)

Agency: _____

Agency Address: _____

_____

Agent Representative: _____ **Telephone:** _____

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ALTERNATE/MODIFIED DUTY INFORMATION

Indicate the type of Return-to-Work Program currently in place *(choose from the following):*

___Temporary modified duty program (attach description) ___ Case by case modified duty plan

COLLECTIVE BARGAINING INFORMATION

Are any employees covered by a collective bargaining agreement? Yes __ No __

Are you subject to any collective bargaining agreement which prevents your participation in an Approved Medical Care Plan? Yes __ No __

Note: The collective bargaining agreement must be provided to the Commissioner upon request.

PLAN PARTICIPATION

Has the employer agreed to the performance of all obligations as outlined in the original Coventry Plan application? Yes __ No __

If no, please attach a detailed description of any employer responsibilities, which have been amended by a new client-sponsor contract.

If different from the original network filing, attach a copy of the plain-language explanation to be distributed to employees.

We, _____ consent to participate in and
(Company Name)
adopt the Medical Care Plan filed as noted herein.

_____ _____
Employer Representative Signature Date

_____
Printed Name

_____
Title:

Coventry Contact:

Mike Read
5130 Eisenhower Boulevard, #150
Tampa, FL 33634
MPRead@cvty.com
(813) 806-2151
(813) 806-2220

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TRANSITIONAL WORK PROGRAM

As your employer we are committed to the success of our Transitional Work Program. Regarding this program, we will review each claimant's restrictions, on a case-by-case basis, to determine the injured employee's ability to safely return to work in a modified duty position. Assignments will be made in accordance with the medical restrictions and shall be within the same union, and to the extent possible, shall be within the same department and related to the type of work normally performed by the employee. If a transitional work duty position is unavailable, the employee can qualify for continued benefits under section 31-308 (a).

In the event that an employee receives work restrictions from his or her treating physician and is therefore unable to return to his or her regular job, the following alternate duty work positions are examples of those which would be made available, consistent with the employee's medical restrictions:

_____

_____

_____

_____

_____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

_____

EMPLOYER REPRESENTATIVE NAME: _____
(Please print)

EMPLOYER REPRESENTATIVE SIGNATURE: _____

TITLE: _____

PHONE: _____

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SAFETY COMMITTEE INFORMATION

Employer Name_____

Address_____

Telephone _____ **Date** _____

SAFETY COMMITTEE MEMBERS

Representation must consist of an equal ratio of employees and employers or in favor of employees.

MANAGEMENT

NAME	WORK-SITE ADDRESS	WORK-SITE TELEPHONE #

NON-MANAGEMENT

NAME	WORK-SITE ADDRESS	WORK-SITE TELEPHONE #