

UNIVERSITY OF ALABAMA AT BIRMINGHAM

ON-THE-JOB INJURY/ILLNESS PROGRAM BENEFITS APPLICATION

This is an application for medical and/or lost time benefits under the UAB On-the-Job Injury/Illness ("OJI") Program. UAB is not subject to the workers' compensation laws of the State of Alabama but offers an employer paid benefit, through the OJI Program, to an employee who is injured in the course of and whose injury arises out of employment at UAB. **PLEASE REFER TO THE ATTACHED FORM "HOW TO APPLY FOR ON-THE-JOB INJURY/ILLNESS PROGRAM BENEFITS" DOCUMENT FOR INSTRUCTIONS FOR COMPLETING THIS FORM, AND FURTHER INFORMATION ABOUT THE PROGRAM.**

Employee Name: _____ Date of Injury: _____

Employee Social Security #: _____ Department: _____

Supervisor's Name: _____ Dept. Phone #: _____

Current work schedule (ex. Five 8 hour shifts per week, three 12 hour shifts per week):

Do you currently work another job outside of UAB, receive compensation for duties in another department at UAB? _____ Yes _____ No

Employee Home Address (include street, City, State & Zip):

Employee Home Phone: _____ Work phone: _____

Describe the incident in detail, including what you were doing when the incident occurred and the resulting injury:

I understand that the On-The-Job Injury/Illness Program benefits will pay only 66 2/3% of my regular rate of pay (basically 2/3 of the hours missed) for time/wages lost as a result of an on-the-job injury/illness and that benefit is subject to all normal deductions (such as federal and state tax). I can supplement this reduced rate of pay with my accrued benefit time (sick leave, personal holiday or vacation time).

_____ I do want to use my accrued benefit time to supplement the OJI benefit.

_____ I do not want to use my accrued benefit time to supplement, or I do not have any accrued benefit time to use as a supplement.

Your signature below certifies that you have read and understand the information provided in this application and the accompanying documents that explain your OJI program benefits and your responsibilities. Your signature further certifies that the information you have provided in this application is true and complete to the best of your knowledge.

Furthermore, your signature below, and as a condition of receiving OJI benefits, and in consideration of any and all payments made by UAB, pursuant to its On-the-Job Injury/Illness ("OJI") program (the "Program"), and I, for myself, my spouse, dependent(s), beneficiary(ies), heir(s), personal representative(s), agent(s) and assign(s), jointly and severally (hereinafter, "We"), agree, consent, and covenant, that any right, title, interest, claim or demand that we have or may have against any third party(ies), including but not limited to any insurance company, for indemnification, compensation or other payment for damages with respect to my OJI injury and/or illness, including my death, is subrogated to any and all right, claim, interest or demand of UAB for reimbursement of all payments made by UAB, or any third party for or on its behalf, for any OJI benefit, which includes but is not limited to, any payment for medical treatment or benefits, lost

time/wages, long-term disability and any and all administrative costs incurred by UAB related to my OJI claim ("OJI Payments") to the full and complete extent of any and all OJI Payments made or to be made in the future. We agree, consent, and covenant, that UAB may take any and all actions necessary, including initiating or joining any litigation, to effectuate the intent of this provision.

Employee's Signature

Date

In order for your application to be processed, you must read and sign the attached authorization for release of medical records.

Forward completed signed application and authorization by fax to Krystal Gipson, Brentwood Services Administrators, 933-0373 ext. 127 (or 888-314-2667) and mail original as noted in the attached instructions.