Claims Management

Office of Workers' Compensation and Claims Management

ILLINOIS

Self-Insured and Self-Administered

- Claims are handled in-house by the Claims Office
- No third-party company handling claims
- We are U of I employees
- Coverage wherever a University employee is working – UIC, UIUC, Extension Offices, Peoria and Rockford, worldwide

What is Workers' Compensation?

Medical Benefits	Wage Benefits	Permanency Settlement
• *Doctor visits* • *Prescriptions* • *Physical Therapy* • *Imaging studies*	• *Temporary total disability pay (TTD)* • *TTD = 66-2/3% of average weekly wage*	• Paid at the conclusion of a claim – injury resulted in permanent disability • Approved by an arbitrator • Permanent partial disability (PPD)

Illinois Workers' Compensation Act

- Pre-established "benefit schedule" for medical bills, TTD pay, and PPD settlements
- Allows employees two choices in medical care providers
- Exclusive remedy
- No-fault coverage for injured employees

LIFE CYCLE OF A CLAIM

Injury Reported-FROI

Employee and supervisor complete their sections – supervisor sends to Claims Office – workcomp@uillinois.edu

Incident vs Claim

If benefits sought, incident becomes a claim and adjuster assigned

Compensable Claim?

Adjuster investigates and accepts/denies claim – notifies employee

Claim Updates

Medical records, work statuses updated after each appointment – timesheets sent to Claims Office

Benefits Paid Out

Medical and wage benefits owed are paid

Claim Closure

Once all benefits owed are paid and/or claim settled, claim closed

- Immediately report – complete FROI
- Seek medical attention and provide updated work status
- Cooperate with accident investigation
- Adhere to restrictions at all times
- Participate in temporary transitional assignments as available
- Work with supervisor and payroll to get properly coded timesheets

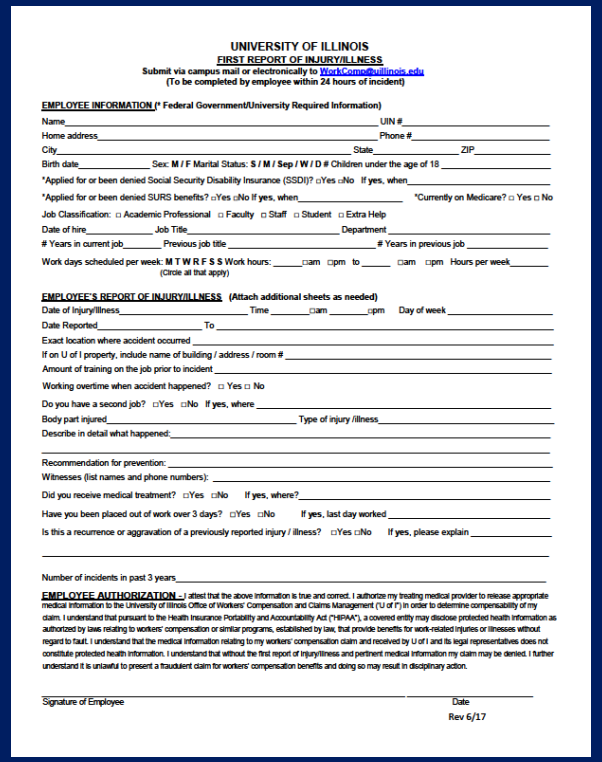
EMPLOYEE RESPONSIBILITIES

- Complete Supervisor's FROI and submit entire report to Claims Office
- Work with payroll to ensure timesheets are being submitted to Claims Office
- Advise employee to submit work statuses to the department routinely
- Get employees back to work as soon as possible – restricted duty or transitional assignments
- Refer to Office of Access and Equity when appropriate

DEPARTMENT REPSONSIBILITIES

FIRST REPORT OF INJURY

Employee Section



UNIVERSITY OF ILLINOIS
FIRST REPORT OF INJURY/ILLNESS
Submit via campus mail or electronically to WorkComp@uillinois.edu
(To be completed by employee within 24 hours of incident)

EMPLOYEE INFORMATION (* Federal Government/University Required Information)

Name_____ UIN #_____
Home address_____ Phone #_____
City_____ State_____ ZIP_____
Birth date_____ Sex: **M / F** Marital Status: **S / M / Sep / W / D** # Children under the age of 18 _____
*Applied for or been denied Social Security Disability Insurance (SSDI)? □Yes □No **If yes, when**_____
*Applied for or been denied SURS benefits? □Yes □No **If yes, when**_____ *Currently on Medicare? □ Yes □ No
Job Classification: □ Academic Professional □ Faculty □ Staff □ Student □ Extra Help
Date of hire_____ Job Title_____ Department _____
Years in current job_____ Previous job title _____ # Years in previous job _____
Work days scheduled per week: **M T W R F S S** Work hours: _____□am □pm to _____ □am □pm Hours per week_____
(Circle all that apply)

EMPLOYEE'S REPORT OF INJURY/ILLNESS **(Attach additional sheets as needed)**

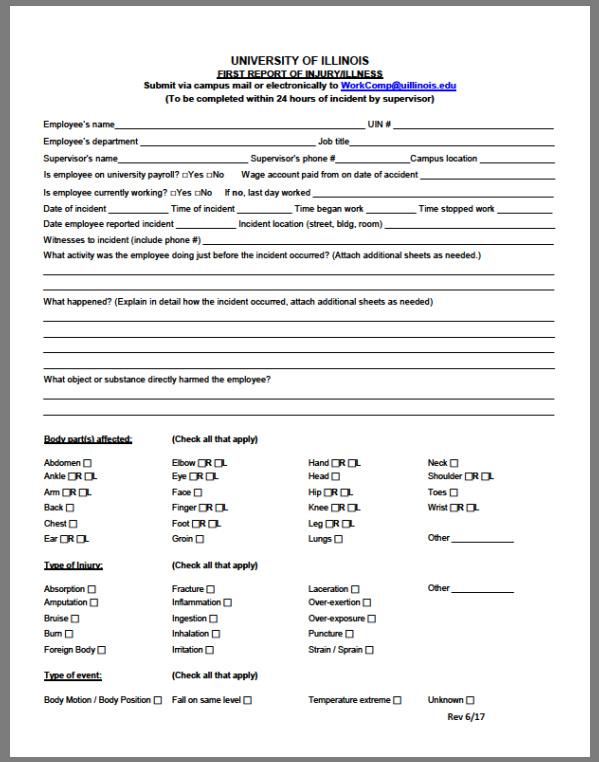
Date of Injury/Illness_____ Time _____□am _____□pm Day of week _____
Date Reported_____ To _____
Exact location where accident occurred _____
If on U of I property, include name of building / address / room # _____
Amount of training on the job prior to incident _____
Working overtime when accident happened? □ Yes □ No
Do you have a second job? □Yes □No **If yes, where** _____
Body part injured_____ Type of injury /illness_____
Describe in detail what happened:_____
_____
Recommendation for prevention: _____
Witnesses (list names and phone numbers): _____
Did you receive medical treatment? □Yes □No **If yes, where?**_____
Have you been placed out of work over 3 days? □Yes □No **If yes, last day worked** _____
Is this a recurrence or aggravation of a previously reported injury / illness? □Yes □No **If yes, please explain** _____
_____
Number of incidents in past 3 years_____

EMPLOYEE AUTHORIZATION – I attest that the above information is true and correct. I authorize my treating medical provider to release appropriate medical information to the University of Illinois Office of Workers' Compensation and Claims Management ('U of I') in order to determine compensability of my claim. I understand that pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), a covered entity may disclose protected health information as authorized by laws relating to workers' compensation or similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault. I understand that the medical information relating to my workers' compensation claim and received by U of I and its legal representatives does not constitute protected health information. I understand that without the first report of injury/illness and pertinent medical information my claim may be denied. I further understand it is unlawful to present a fraudulent claim for workers' compensation benefits and doing so may result in disciplinary action.

_____ _____
Signature of Employee Date

Rev 6/17

Supervisor Section – P1



UNIVERSITY OF ILLINOIS
FIRST REPORT OF INJURY/ILLNESS
Submit via campus mail or electronically to WorkComp@uillinois.edu
(To be completed within 24 hours of incident by supervisor)

Employee's name_____ UIN # _____
Employee's department _____ Job title_____
Supervisor's name_____ Supervisor's phone #_____Campus location _____
Is employee on university payroll? □Yes □No Wage account paid from on date of accident _____
Is employee currently working? □Yes □No If no, last day worked _____
Date of incident _____ Time of incident _____ Time began work _____ Time stopped work _____
Date employee reported incident _____ Incident location (street, bldg, room) _____
Witnesses to incident (include phone #) _____
What activity was the employee doing just before the incident occurred? (Attach additional sheets as needed.)
_____
_____
What happened? (Explain in detail how the incident occurred, attach additional sheets as needed)
_____
_____
_____
_____
What object or substance directly harmed the employee?
_____
_____

Body part(s) affected: **(Check all that apply)**

Abdomen □	Elbow □R □L	Hand □R □L	Neck □
Ankle □R □L	Eye □R □L	Head □	Shoulder □R □L
Arm □R □L	Face □	Hip □R □L	Toes □
Back □	Finger □R □L	Knee □R □L	Wrist □R □L
Chest □	Foot □R □L	Leg □R □L	
Ear □R □L	Groin □	Lungs □	Other _____

Type of Injury: **(Check all that apply)**

Absorption □	Fracture □	Laceration □	Other _____
Amputation □	Inflammation □	Over-exertion □	
Bruise □	Ingestion □	Over-exposure □	
Burn □	Inhalation □	Puncture □	
Foreign Body □	Irritation □	Strain / Sprain □	

Type of event: **(Check all that apply)**

Body Motion / Body Position □	Fall on same level □	Temperature extreme □	Unknown □

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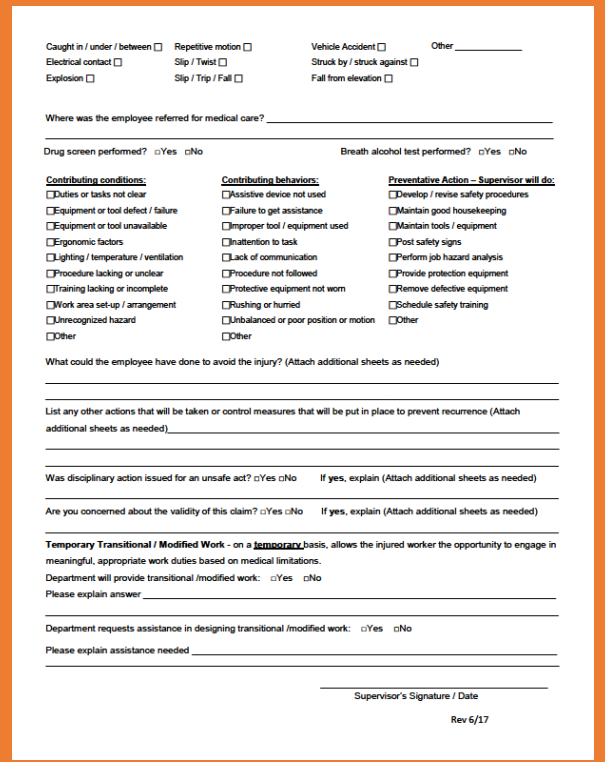
Supervisor Section – P2



Caught in / under / between □ Repetitive motion □ Vehicle Accident □ Other _____
Electrical contact □ Slip / Twist □ Struck by / struck against □
Explosion □ Slip / Trip / Fall □ Fall from elevation □

Where was the employee referred for medical care? _____
_____
Drug screen performed? □Yes □No Breath alcohol test performed? □Yes □No

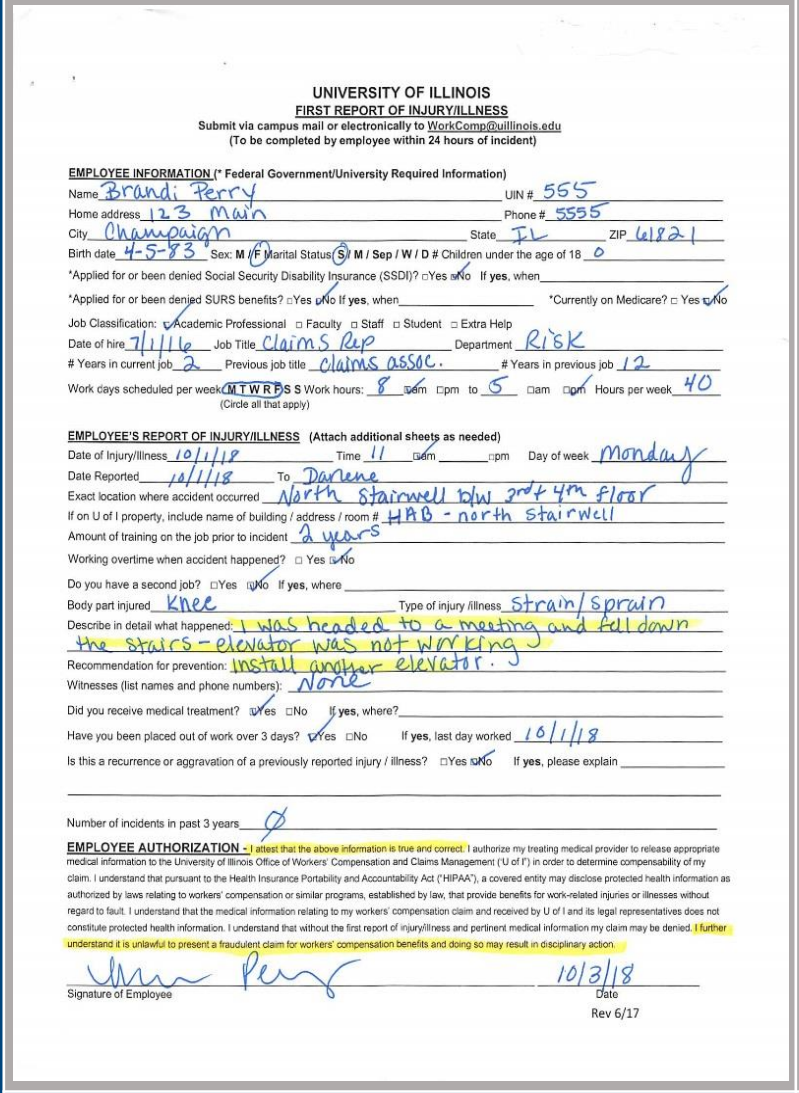
Contributing conditions:	Contributing behaviors:	Preventative Action – Supervisor will do:
□Duties or tasks not clear	□Assistive device not used	□Develop / revise safety procedures
□Equipment or tool defect / failure	□Failure to get assistance	□Maintain good housekeeping
□Equipment or tool unavailable	□Improper tool / equipment used	□Maintain tools / equipment
□Ergonomic factors	□Inattention to task	□Post safety signs
□Lighting / temperature / ventilation	□Lack of communication	□Perform job hazard analysis
□Procedure lacking or unclear	□Procedure not followed	□Provide protection equipment
□Training lacking or incomplete	□Protective equipment not worn	□Remove defective equipment
□Work area set-up / arrangement	□Rushing or hurried	□Schedule safety training
□Unrecognized hazard	□Unbalanced or poor position or motion	□Other
□Other	□Other	

What could the employee have done to avoid the injury? (Attach additional sheets as needed)
_____
_____
List any other actions that will be taken or control measures that will be put in place to prevent recurrence (Attach additional sheets as needed)_____
_____
_____
Was disciplinary action issued for an unsafe act? □Yes □No **If yes**, explain (Attach additional sheets as needed)
_____
Are you concerned about the validity of this claim? □Yes □No **If yes**, explain (Attach additional sheets as needed)
_____
Temporary Transitional / Modified Work - on a **temporary** basis, allows the injured worker the opportunity to engage in meaningful, appropriate work duties based on medical limitations.
Department will provide transitional /modified work: □Yes □No
Please explain answer _____
_____
Department requests assistance in designing transitional /modified work: □Yes □No
Please explain assistance needed _____
_____
_____
Supervisor's Signature / Date

Rev 6/17

FROI – UNACCEPTABLE SUPERVISOR SECTION

EMPLOYEE SECTION



UNIVERSITY OF ILLINOIS
FIRST REPORT OF INJURY/ILLNESS
Submit via campus mail or electronically to WorkComp@uillinois.edu
(To be completed by employee within 24 hours of incident)

EMPLOYEE INFORMATION (* Federal Government/University Required Information)
Name Brandi Perry UIN # 555
Home address 123 Main Phone # 5555
City Champaign State IL ZIP 61821
Birth date 4-5-83 Sex: M / F Marital Status: S / M / Sep / W / D # Children under the age of 18 0
*Applied for or been denied Social Security Disability Insurance (SSDI)? □Yes ☑No If yes, when
*Applied for or been denied SURS benefits? □Yes ☑No If yes, when *Currently on Medicare? □ Yes ☑No
Job Classification: ☑Academic Professional □ Faculty □ Staff □ Student □ Extra Help
Date of hire 7/1/16 Job Title Claims Rep Department Risk
Years in current job 2 Previous job title claims assoc. # Years in previous job 12
Work days scheduled per week (M T W R F S S) Work hours: 8 ☑am □pm to 5 □am ☑pm Hours per week 40
(Circle all that apply)

EMPLOYEE'S REPORT OF INJURY/ILLNESS (Attach additional sheets as needed)
Date of Injury/Illness 10/1/18 Time 11 ☑am □pm Day of week Monday
Date Reported 10/1/18 To Darlene
Exact location where accident occurred North stairwell b/w 3rd + 4th floor
If on U of I property, include name of building / address / room # HAB - north stairwell
Amount of training on the job prior to incident 2 years
Working overtime when accident happened? □ Yes ☑No
Do you have a second job? □Yes ☑No If yes, where
Body part injured knee Type of injury /illness Strain/sprain
Describe in detail what happened: I was headed to a meeting and fell down the stairs - elevator was not working
Recommendation for prevention: install another elevator.
Witnesses (list names and phone numbers): None
Did you receive medical treatment? ☑Yes □No If yes, where?
Have you been placed out of work over 3 days? ☑Yes □No If yes, last day worked 10/1/18
Is this a recurrence or aggravation of a previously reported injury / illness? □Yes ☑No If yes, please explain

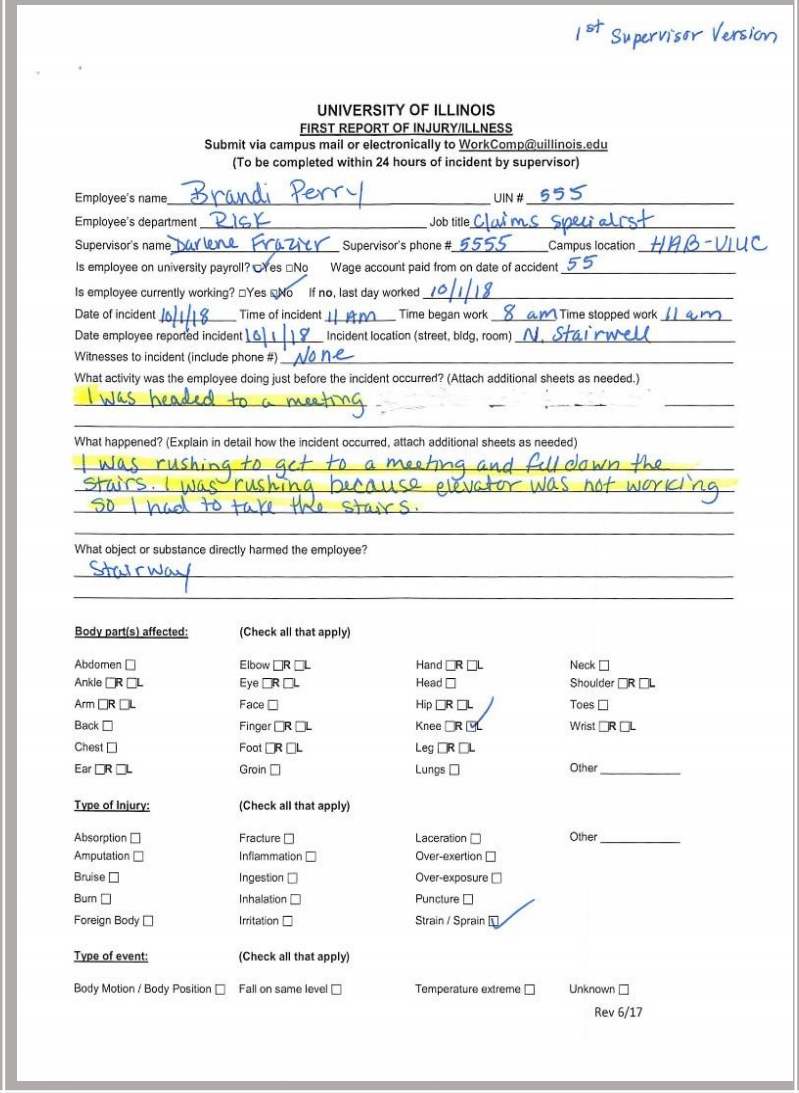
Number of incidents in past 3 years Ø

EMPLOYEE AUTHORIZATION - I attest that the above information is true and correct. I authorize my treating medical provider to release appropriate medical information to the University of Illinois Office of Workers' Compensation and Claims Management ('U of I') in order to determine compensability of my claim. I understand that pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), a covered entity may disclose protected health information as authorized by laws relating to workers' compensation or similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault. I understand that the medical information relating to my workers' compensation claim and received by U of I and its legal representatives does not constitute protected health information. I understand that without the first report of injury/illness and pertinent medical information my claim may be denied. I further understand it is unlawful to present a fraudulent claim for workers' compensation benefits and doing so may result in disciplinary action.

Brandi Perry 10/3/18
Signature of Employee Date

Rev 6/17

SUPERVISOR SECTION – P1



1st Supervisor Version

UNIVERSITY OF ILLINOIS
FIRST REPORT OF INJURY/ILLNESS
Submit via campus mail or electronically to WorkComp@uillinois.edu
(To be completed within 24 hours of incident by supervisor)

Employee's name Brandi Perry UIN # 555
Employee's department Risk Job title Claims specialist
Supervisor's name Darlene Frazier Supervisor's phone # 5555 Campus location HAB-UIUC
Is employee on university payroll? ☑Yes □No Wage account paid from on date of accident 55
Is employee currently working? □Yes ☑No If no, last day worked 10/1/18
Date of incident 10/1/18 Time of incident 11 AM Time began work 8 am Time stopped work 11 am
Date employee reported incident 10/1/18 Incident location (street, bldg, room) N. Stairwell
Witnesses to incident (include phone #) None
What activity was the employee doing just before the incident occurred? (Attach additional sheets as needed.)
I was headed to a meeting

What happened? (Explain in detail how the incident occurred, attach additional sheets as needed)
I was rushing to get to a meeting and fell down the stairs. I was rushing because elevator was not working so I had to take the stairs.

What object or substance directly harmed the employee?
Stairway

Body part(s) affected: (Check all that apply)

Abdomen ☐	Elbow ☐R ☐L	Hand ☐R ☐L	Neck ☐
Ankle ☐R ☐L	Eye ☐R ☐L	Head ☐	Shoulder ☐R ☐L
Arm ☐R ☐L	Face ☐	Hip ☐R ☐L	Toes ☐
Back ☐	Finger ☐R ☐L	Knee ☐R ☑L	Wrist ☐R ☐L
Chest ☐	Foot ☐R ☐L	Leg ☐R ☐L	
Ear ☐R ☐L	Groin ☐	Lungs ☐	Other

Type of Injury: (Check all that apply)

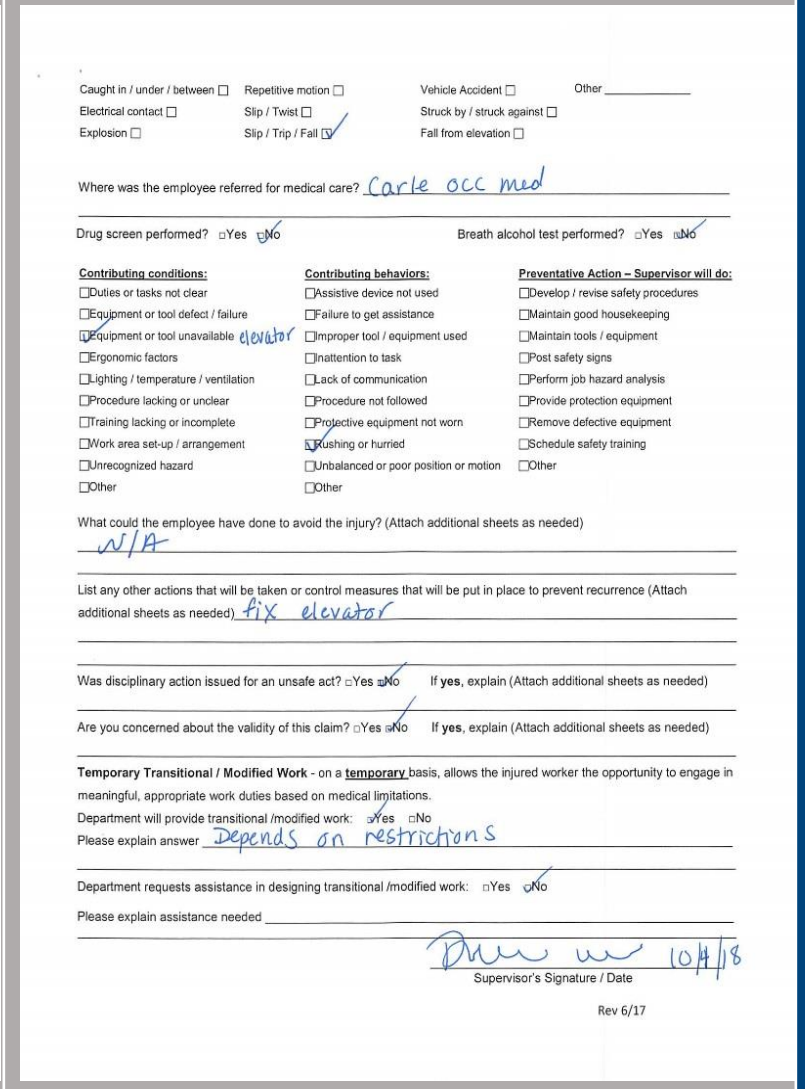
Absorption ☐	Fracture ☐	Laceration ☐	Other
Amputation ☐	Inflammation ☐	Over-exertion ☐	
Bruise ☐	Ingestion ☐	Over-exposure ☐	
Burn ☐	Inhalation ☐	Puncture ☐	
Foreign Body ☐	Irritation ☐	Strain / Sprain ☑	

Type of event: (Check all that apply)

Body Motion / Body Position ☐	Fall on same level ☐	Temperature extreme ☐	Unknown ☐

Rev 6/17

SUPERVISOR SECTION – P2



Caught in / under / between ☐ Repetitive motion ☐ Vehicle Accident ☐ Other
Electrical contact ☐ Slip / Twist ☐ Struck by / struck against ☐
Explosion ☐ Slip / Trip / Fall ☑ Fall from elevation ☐

Where was the employee referred for medical care? Carle occ med

Drug screen performed? □Yes ☑No Breath alcohol test performed? □Yes ☑No

Contributing conditions:	Contributing behaviors:	Preventative Action – Supervisor will do:
☐Duties or tasks not clear	☐Assistive device not used	☐Develop / revise safety procedures
☐Equipment or tool defect / failure	☐Failure to get assistance	☐Maintain good housekeeping
☑Equipment or tool unavailable elevator	☐Improper tool / equipment used	☐Maintain tools / equipment
☐Ergonomic factors	☐Inattention to task	☐Post safety signs
☐Lighting / temperature / ventilation	☐Lack of communication	☐Perform job hazard analysis
☐Procedure lacking or unclear	☐Procedure not followed	☐Provide protection equipment
☐Training lacking or incomplete	☐Protective equipment not worn	☐Remove defective equipment
☐Work area set-up / arrangement	☑Rushing or hurried	☐Schedule safety training
☐Unrecognized hazard	☐Unbalanced or poor position or motion	☐Other
☐Other	☐Other	

What could the employee have done to avoid the injury? (Attach additional sheets as needed)
N/A

List any other actions that will be taken or control measures that will be put in place to prevent recurrence (Attach additional sheets as needed) fix elevator

Was disciplinary action issued for an unsafe act? □Yes ☑No If yes, explain (Attach additional sheets as needed)

Are you concerned about the validity of this claim? □Yes ☑No If yes, explain (Attach additional sheets as needed)

Temporary Transitional / Modified Work - on a **temporary** basis, allows the injured worker the opportunity to engage in meaningful, appropriate work duties based on medical limitations.
Department will provide transitional /modified work: ☑Yes □No
Please explain answer Depends on restrictions

Department requests assistance in designing transitional /modified work: □Yes ☑No

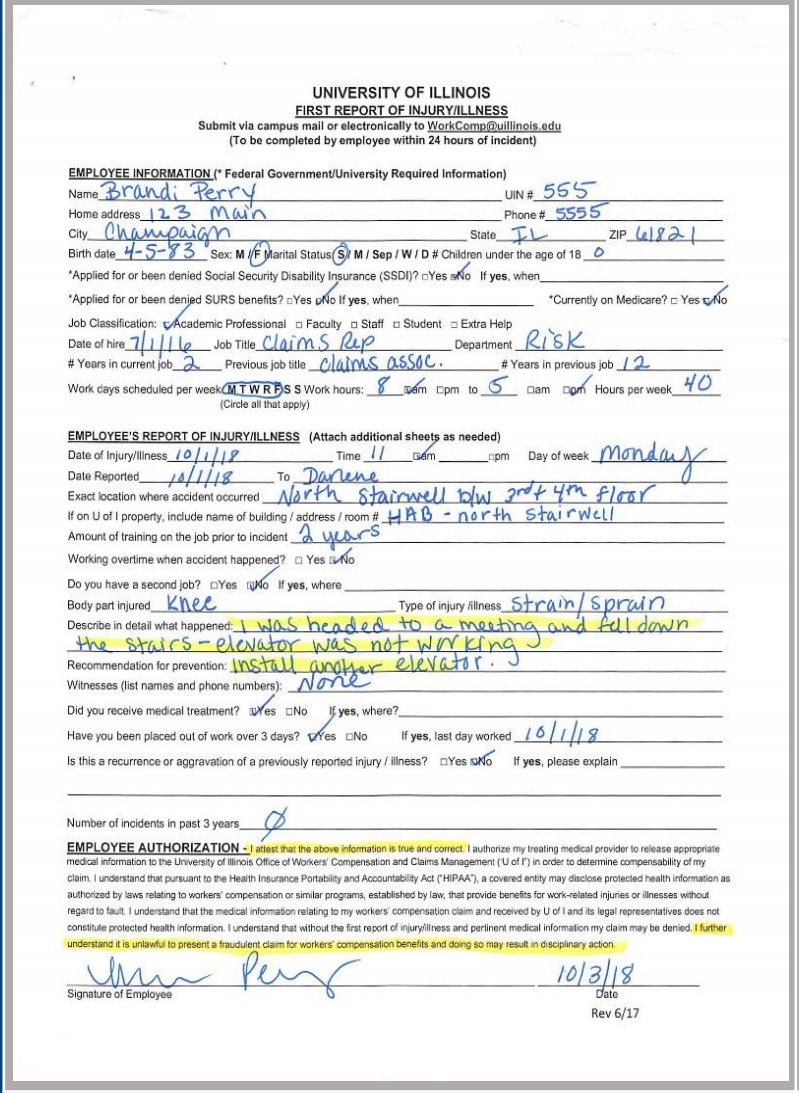
Please explain assistance needed

Darlene 10/4/18
Supervisor's Signature / Date

Rev 6/17

FROI – ACCEPTABLE SUPERVISOR SECTION

EMPLOYEE SECTION



UNIVERSITY OF ILLINOIS
FIRST REPORT OF INJURY/ILLNESS
Submit via campus mail or electronically to WorkComp@uillinois.edu
(To be completed by employee within 24 hours of incident)

EMPLOYEE INFORMATION (* Federal Government/University Required Information)

Name Brandi Perry UIN # 555
Home address 123 Main Phone # 5555
City Champaign State IL ZIP 61821
Birth date 4-5-83 Sex: M / F Marital Status: S / M / Sep / W / D # Children under the age of 18 0
*Applied for or been denied Social Security Disability Insurance (SSDI)? □Yes ☑No If yes, when
*Applied for or been denied SURS benefits? □Yes ☑No If yes, when *Currently on Medicare? □ Yes ☑No
Job Classification: ☑Academic Professional □ Faculty □ Staff □ Student □ Extra Help
Date of hire 7/1/16 Job Title Claims Rep Department RISK
Years in current job 2 Previous job title claims assoc. # Years in previous job 12
Work days scheduled per week (M T W R F S S) Work hours: 8 ☑am □pm to 5 □am ☑pm Hours per week 40
(Circle all that apply)

EMPLOYEE'S REPORT OF INJURY/ILLNESS (Attach additional sheets as needed)

Date of Injury/Illness 10/1/18 Time 11 ☑am □pm Day of week Monday
Date Reported 10/1/18 To Darlene
Exact location where accident occurred North stairwell btw 3rd + 4th floor
If on U of I property, include name of building / address / room # HAB - north stairwell
Amount of training on the job prior to incident 2 years
Working overtime when accident happened? □ Yes ☑No
Do you have a second job? □Yes ☑No If yes, where
Body part injured knee Type of injury /illness Strain/sprain
Describe in detail what happened: I was headed to a meeting and fell down the stairs - elevator was not working
Recommendation for prevention: install another elevator.
Witnesses (list names and phone numbers): None
Did you receive medical treatment? ☑Yes □No If yes, where?
Have you been placed out of work over 3 days? ☑Yes □No If yes, last day worked 10/1/18
Is this a recurrence or aggravation of a previously reported injury / illness? □Yes ☑No If yes, please explain

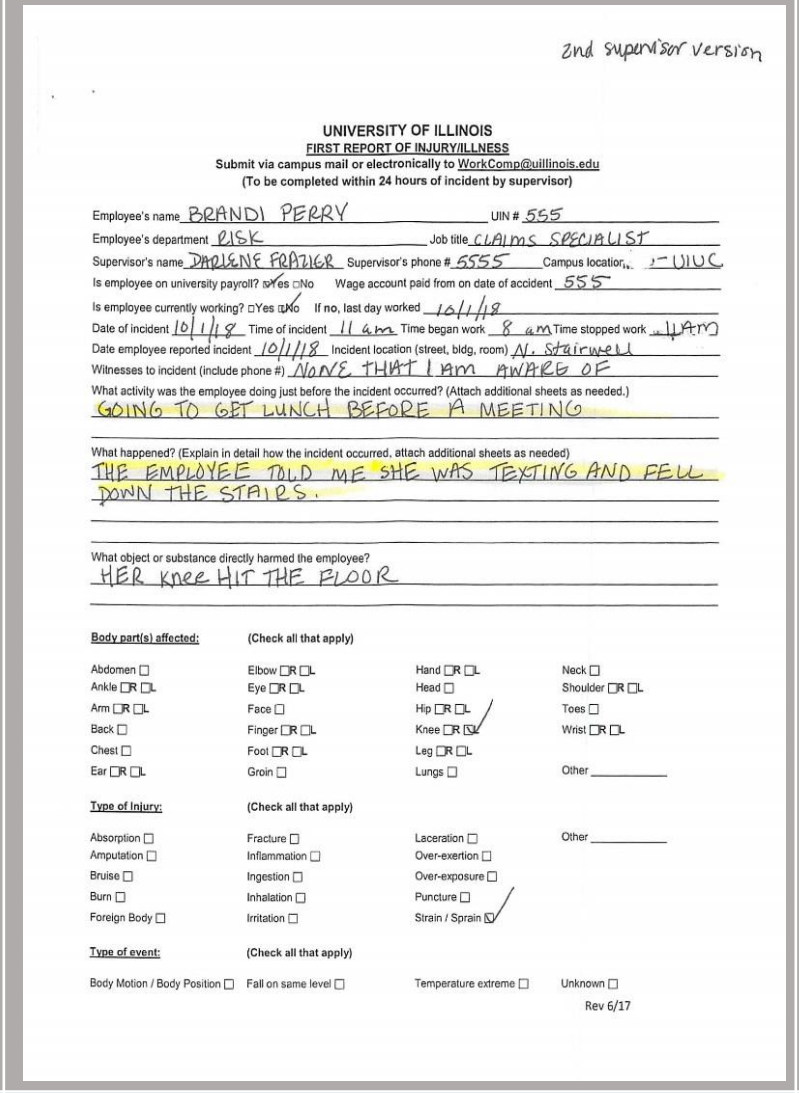
Number of incidents in past 3 years Ø

EMPLOYEE AUTHORIZATION - I attest that the above information is true and correct. I authorize my treating medical provider to release appropriate medical information to the University of Illinois Office of Workers' Compensation and Claims Management ('U of I') in order to determine compensability of my claim. I understand that pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), a covered entity may disclose protected health information as authorized by laws relating to workers' compensation or similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault. I understand that the medical information relating to my workers' compensation claim and received by U of I and its legal representatives does not constitute protected health information. I understand that without the first report of injury/illness and pertinent medical information my claim may be denied. I further understand it is unlawful to present a fraudulent claim for workers' compensation benefits and doing so may result in disciplinary action.

Brandi Perry 10/3/18
Signature of Employee Date

Rev 6/17

SUPERVISOR SECTION – P1



2nd supervisor version

UNIVERSITY OF ILLINOIS
FIRST REPORT OF INJURY/ILLNESS
Submit via campus mail or electronically to WorkComp@uillinois.edu
(To be completed within 24 hours of incident by supervisor)

Employee's name BRANDI PERRY UIN # 555
Employee's department RISK Job title CLAIMS SPECIALIST
Supervisor's name DARLENE FRAZIER Supervisor's phone # 5555 Campus location - UIUC
Is employee on university payroll? ☑Yes □No Wage account paid from on date of accident 555
Is employee currently working? □Yes ☑No If no, last day worked 10/1/18
Date of incident 10/1/18 Time of incident 11 am Time began work 8 am Time stopped work 11 am
Date employee reported incident 10/1/18 Incident location (street, bldg, room) N. stairwell
Witnesses to incident (include phone #) NONE THAT I AM AWARE OF
What activity was the employee doing just before the incident occurred? (Attach additional sheets as needed.)
GOING TO GET LUNCH BEFORE A MEETING

What happened? (Explain in detail how the incident occurred, attach additional sheets as needed)
THE EMPLOYEE TOLD ME SHE WAS TEXTING AND FELL DOWN THE STAIRS.

What object or substance directly harmed the employee?
HER KNEE HIT THE FLOOR

Body part(s) affected: (Check all that apply)

Abdomen □	Elbow □R □L	Hand □R □L	Neck □
Ankle □R □L	Eye □R □L	Head □	Shoulder □R □L
Arm □R □L	Face □	Hip □R □L	Toes □
Back □	Finger □R □L	Knee ☑R □L	Wrist □R □L
Chest □	Foot □R □L	Leg □R □L	
Ear □R □L	Groin □	Lungs □	Other

Type of Injury: (Check all that apply)

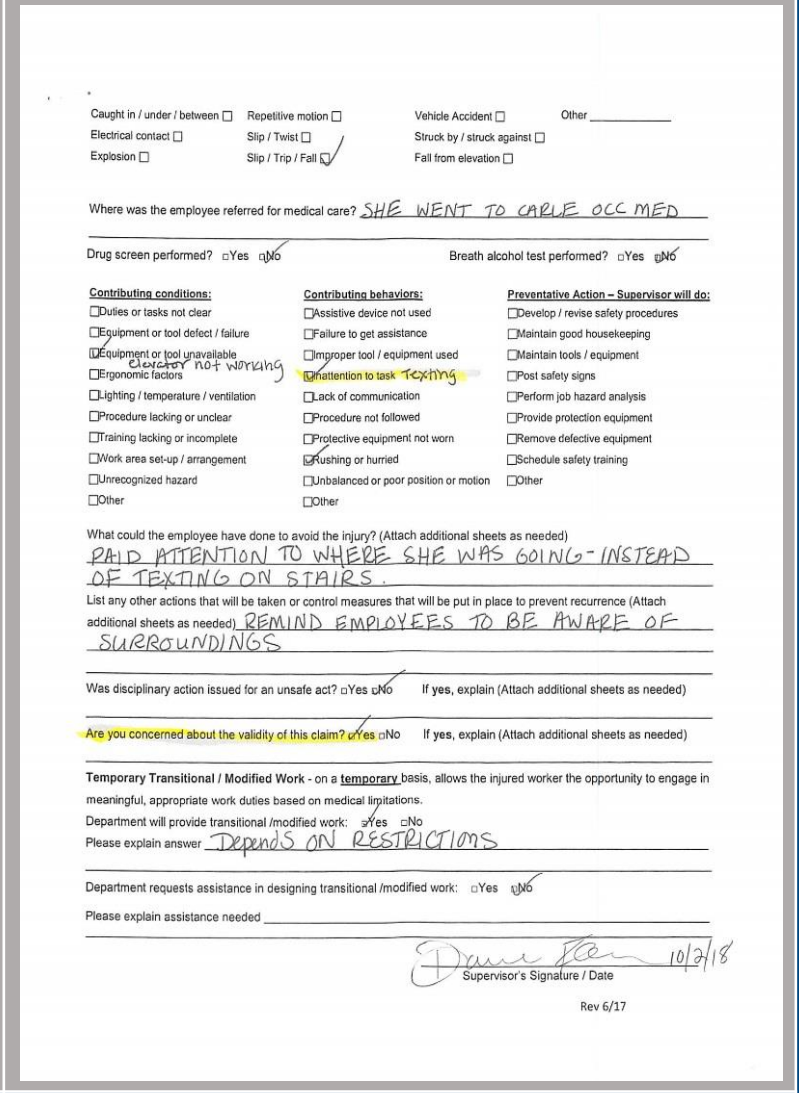
Absorption □	Fracture □	Laceration □	Other
Amputation □	Inflammation □	Over-exertion □	
Bruise □	Ingestion □	Over-exposure □	
Burn □	Inhalation □	Puncture □	
Foreign Body □	Irritation □	Strain / Sprain ☑	

Type of event: (Check all that apply)

Body Motion / Body Position □	Fall on same level □	Temperature extreme □	Unknown □

Rev 6/17

SUPERVISOR SECTION – P2



Caught in / under / between □ Repetitive motion □ Vehicle Accident □ Other
Electrical contact □ Slip / Twist □ Struck by / struck against □
Explosion □ Slip / Trip / Fall ☑ Fall from elevation □

Where was the employee referred for medical care? SHE WENT TO CARLE OCC MED

Drug screen performed? □Yes ☑No Breath alcohol test performed? □Yes ☑No

Contributing conditions:
- ☑Duties or tasks not clear
- ☑Equipment or tool defect / failure
- ☑Equipment or tool unavailable
- □Ergonomic factors
- □Lighting / temperature / ventilation
- □Procedure lacking or unclear
- □Training lacking or incomplete
- □Work area set-up / arrangement
- □Unrecognized hazard
- □Other

Contributing behaviors:
- □Assistive device not used
- □Failure to get assistance
- □Improper tool / equipment used
- ☑Inattention to task Texting
- □Lack of communication
- □Procedure not followed
- □Protective equipment not worn
- ☑Rushing or hurried
- □Unbalanced or poor position or motion
- □Other

elevator not working

Preventative Action – Supervisor will do:
- □Develop / revise safety procedures
- □Maintain good housekeeping
- □Maintain tools / equipment
- □Post safety signs
- □Perform job hazard analysis
- □Provide protection equipment
- □Remove defective equipment
- □Schedule safety training
- □Other

What could the employee have done to avoid the injury? (Attach additional sheets as needed)
PAID ATTENTION TO WHERE SHE WAS GOING - INSTEAD OF TEXTING ON STAIRS.

List any other actions that will be taken or control measures that will be put in place to prevent recurrence (Attach additional sheets as needed) REMIND EMPLOYEES TO BE AWARE OF SURROUNDINGS

Was disciplinary action issued for an unsafe act? □Yes ☑No If yes, explain (Attach additional sheets as needed)

Are you concerned about the validity of this claim? ☑Yes □No If yes, explain (Attach additional sheets as needed)

Temporary Transitional / Modified Work - on a **temporary** basis, allows the injured worker the opportunity to engage in meaningful, appropriate work duties based on medical limitations.
Department will provide transitional /modified work: ☑Yes □No
Please explain answer Depends ON RESTRICTIONS

Department requests assistance in designing transitional /modified work: □Yes ☑No
Please explain assistance needed

Diane Frazier 10/2/18
Supervisor's Signature / Date

Rev 6/17

“

If in doubt, fill it out!

Why does all of this matter?

- Safety of all employees matters
- Department productivity
- TTD and PPD benefits = 49% chargeback

IT MATTERS!

HOW DO WE BRING COSTS DOWN?

- The First Report of Injury needs to be filled out timely, accurately, and completely and submitted to our office as soon as possible.
- Limit the time on TTD/bring people back to work
  - #1 contributor to indemnity costs
  - The longer the TTD, the higher the settlements
- Address safety issues through discipline

CONTACT US

Office of Workers' Compensation and Claims Management
449 Henry Administration Building, MC-300
506 S. Wright Street, Urbana, IL 61801

(217) 333-1080; fax (217) 244-5152

Email: WorkComp@uillinois.edu

Claims Management Adjusters

- Darlene Norton-Frazier – *Senior Associate Director*
- Brandi Clemens – *Assistant Director*
- Courtney Montgomery – *Claims Analyst*
- Scott Livengood, *Claims Analyst*
- Courtney Beasley, *Claims Specialist*
- Mclain Engel, *Claims Specialist*

THANK YOU!