

**GENEX SERVICES MEDICAL CARE PLAN A-Coventry Network**

**State of Connecticut Workers' Compensation Commission  
Workers' Compensation Medical Care Plan  
Employer Participation Form**

Fax to: Genex Services 1-855-253-3910 or E-Mail certifiedplans@mitchell.com  
Mailing Address: Genex Services. 440 E. Swedesford Road, Suite 1000, Wayne, PA 19087

**Plan Sponsor:** \_\_\_\_\_ **Genex Services Medical Care Plan A** \_\_\_\_\_

**Name of Employer:** \_\_\_\_\_

**Subsidiaries**  
or (CIRCLE ONE)  
**D/B/A:**

**Business Location(s):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Nature of Business:** \_\_\_\_\_ **Total Number of Employees:** \_\_\_\_\_  
*if more than one business location, attach addresses and numbers of employees at each site*

**Current Workers' Compensation Carrier:** \_\_\_\_\_

**Policy No.** \_\_\_\_\_ **Policy Term:** \_\_\_\_\_

**Claims Office Location:** \_\_\_\_\_

**Plan Participation**

1. Are any of your employees covered by a collective bargaining agreement.  
Yes \_\_\_\_\_ No \_\_\_\_\_

If yes....I confirm that the Employer's participation is not in violation of any collective bargaining agreement of which a copy will be made available to the chairman upon request.

2. Has the Employer agreed to the performance of all obligations as outlined in the original plan application  
Yes \_\_\_\_\_ No \_\_\_\_\_ (if no, provide detail of changes)

3. Has the Employer agreed to review each injured workers' restrictions, on a case by case basis to determine their 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 dept. or union and to the extent possible, be related to the type of work normally performed by the employee  
Yes \_\_\_\_\_ No \_\_\_\_\_

4. The employer is in compliance with the Safety Committee administrative regulation 31-40V-1 through 11  
Yes \_\_\_\_\_ No \_\_\_\_\_

► **Name and Title of Employer Representative:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **email address:** \_\_\_\_\_

► **Signature of Employer Representative:** \_\_\_\_\_