

LANGSTON UNIVERSITY
RISK MANAGEMENT

OFFICE OF HUMAN RESOURCES



2013-2014

State Risk Management's Mission

State Risk Management's mission is to protect the assets of the State of Oklahoma and political subdivisions as authorized by law.

What is Risk Management?

Risk Management is the identification, assessment, and prioritization of risks followed by coordinated and economical application of resources to minimize, monitor, and control the probability and/or impact of unfortunate events or to maximize the realization of opportunities.

Risk Management Fundamental Functions

1. Risk Identification

- What is Risk Identification?
 - Determining what risks or hazards exist or are anticipated, their characteristics, remoteness in time, duration period, and possible outcomes.

2. Risk Control

- What is Risk Control?
 - Risk control is used to identify all practicable measures for eliminating or reducing the likelihood of injury, illness or disease in the workplace, to implement the measures and to continually review the measures in order to ensure their effectiveness.
- Employer Responsibility
 - As an employer, there are business objectives as well as moral and legal obligations that are put into place to provide and maintain a safe and healthy workplace. The employer responsibility should be to identify and eliminate any potentially hazardous situations in the workplace.
- Employee Responsibility
 - The employee should make sure they stay aware of their surroundings at all times and use common sense to ensure their own personal safety. Also the employee should assist the employer in identifying any possible hazards that may have been overlooked to prevent any injuries.
 - Some factors that contribute to hazards:
 - Human Behavior: common to all accidents; not limited to the person involved in the accident
 - Environment: noise, vapors, fumes, dust, light, heat, pests
 - Design: workplace layout, design tools & equipment, maintenance
 - Systems & Procedures: lack of systems & procedures, inappropriate systems & procedures, training procedures, housekeeping

3. Incident and Accident Investigation

- What is an incident?
 - An unexpected, unintended, undesirable event that does not result in financial loss or bodily injury.
- What is an accident?
 - An unexpected, unintended, undesirable event that will result in financial loss or bodily injury.
- Investigation Strategy
 - Gather information
 - Search for and establish facts
 - Isolate essential contributing factors
 - Find root causes
 - Determine corrective actions
 - Implement corrective actions

4. Claims Management

- What is claims management?
 - Involves proper and timely notification and record keeping of specific claims and overall loss history for the organization.
- Liability Claims
 - Government Tort Claims Act (GTCA)
 - What is the Government Tort Claims Act?
 - The GTCA is the exclusive remedy against a governmental agency or political subdivision and dictates the manner by which recovery may be made against the State for tortuous conduct of state employees.
 - According to the Act, the state generally assumes liability for the tortuous conduct of its employees while acting within the scope of their employment. 51 O.S. 1991, § 153 (A).
 - What is a Tort Claim?
 - A formal monetary demand by a third party as a result of bodily injury or property damage.

- Auto
 - Physical Damage to state owned vehicles
 - Covers damage to your agency's university or college vehicle when your vehicle hits, or is hit by, another vehicle, or other object. Pays to fix your vehicle less the deductible you choose.
 - Third Party Liability
 - A formal monetary demand by a third party as a result of bodily injury or property damage.
- Property
 - Damage to State owned property
- D&O/ELL/EPL
 - D&O: Directors and Officers Liability
 - What is D & O?
 - Directors and Officers Liability Insurance provides financial protection for the directors and officers of your company in the event they are sued in conjunction with the performance of their duties as they relate to the company.
 - Elements of Coverage
 - Provides coverage to Directors and Officers in the event of allegations citing errors, omissions or breach of duty within the scope of their duties
 - Provides coverage to the State of Oklahoma for reimbursement of indemnified amounts
 - Provides "entity" coverage to the State of Oklahoma
 - Coverage is extended to include employment practices allegations
 -
 - D & O Key Policy Exclusions
 - Claims covered under the Governmental Tort Claims Act
 - Unlawful Gain or Profit
 - Criminal Misconduct
 - Deliberately Fraudulent Acts
 - Insured vs. Insured

- Bodily Injury or Property Damage
 - Medical Malpractice
 - Sexual Misconduct & Child Abuse
 - Contractual Liability
 - Employee Retirement Income Security Act (ERISA)
 - Fair Labor Standards Act (FLSA)
 - National Labor Relations Act (NLRA)
 - Consolidated Omnibus Budget Reconciliation Act (COBRA)
 - Worker Adjustment and Retraining Notification Act (WARN)
 - Occupational Safety and Health Administration (OSHA)
 - Absolute Wrongful Imprisonment Exclusion
 - Absolute Affirmative Action Exclusion
 - Pollution
- ELL: Educators Legal Liability
 - What is ELL?
 - Designed to cover a broad range of non-bodily injury/non-property damage liability claims made against the administrators, employees, and staff members of both schools and colleges.
 - Elements of Coverage
 - Provides coverage to Directors and Officers in the event of allegations citing errors, omissions or breach of duty within the scope of their duties
 - Provides coverage to the State of Oklahoma for reimbursement of indemnified amounts
 - Provides “entity” coverage to the State of Oklahoma for Colleges, Universities, and Board of Regents
 - Coverage is extended to include employment practices allegations

- ELL Key Policy Exclusions
 - Claims covered under the Governmental Tort Claims Act (GTCA)
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 - Employee Retirement Income Security Act (ERISA)
 - Fair Labor Standards Act (FLSA)
 - National Labor Relations Act (NLRA)
 - Consolidated Omnibus Budget Reconciliation Act (COBRA)
 - Worker Adjustment and Retraining Notification Act (WARN)
 - Occupational Safety and Health Administration (OSHA)

- EPL: Employment Practices Liability
 - What is EPL?
 - Claim alleging an employment practice violation. Provides coverage to Directors and Officers in the event of allegations citing errors, omission or breach of duty with the scope of their duties.

Employment Practices Violation(s) means any actual or alleged:

1. Wrongful dismissal, discharge or termination (either actual or constructive) of employment, including breach of an implied contract;
2. Harassment (including sexual harassment whether “quid pro quo”, hostile work environment or otherwise);

3. Discrimination, (including but not limited to discrimination based upon age, gender, race, color, national origin, religion, sexual orientation or preference, pregnancy, or disability).
4. Retaliation (including lockouts)
5. Employment-related misrepresentation(s) to an employee or applicant for employment organizations.
6. Employment-related libel, slanders, humiliation, defamation or invasion of privacy;
7. Wrongful failure to employ or promote;
8. Wrongful deprivation of career opportunity, wrongful demotion or negligent employee evaluation, including the giving of negative or defamatory statements in connection with an employee reference;
9. Wrongful discipline;
10. Failure to grant tenure or practice privileges;
11. Failure to provide or enforce adequate or consistent organization policies or procedures relating to any other Employment Practices Violations;
12. Violation of any individual's civil rights relating to any of the above.

However, only if the Employment Practices Violation relates to an individual insured, or applicant for employment, with the organization or an Outside Entity, whether direct, indirect, intentional or unintentional.

○ Fine Arts Policy

- Covers fine arts and collectible objects of every description including but not limited to paintings, drawings, prints, rare books and manuscripts, rugs, tapestries, etchings, photographs, rare or art glass, numismatic objects, antique jewelry, bric-a-brac, porcelain, sculpture, ceramics, video artwork and other bonafide works of art, or rarity, historic value, or artistic merit, VALUABLE PAPERS, RECORDS AND BOOKS (excluding automobiles, coins, stamps, furs, jewelry, precious stones, precious metals, watercraft, aircraft, money or securities).

- Crime and Fidelity Policy or Employee Dishonesty Coverage
 - Coverage is meant to cover your agency, university or college against criminal acts of any kind by your employees.
 - Coverage provides:
Loss or damage to “money”, “security”, and “other property”, as resulting directly from the failure of any “employee” to faithfully perform his or her duties as prescribed by law, when such failure has as its direct and immediate result a loss of your covered property.

5. Risk Financing

- What is risk financing?
 - The means of addressing potential losses in a cost effective manner to financially stabilize the organization.
- Risk Financing Objectives
 - Identify State Risk Management (SRM) role
 - Identify programs managed by SRM
 - Identify actuary’s role
 - Identify agency’s risk management role
 - TORT loss history example
 - Agency “X” vs. Agency “Y”

Forms

All forms are to be completed by one the following:

Risk Management Team Contacts

1. Risk Management Coordinator: Cecilia Taft
405-466-3387/2985

2. Contract & Buildings: Ruben Oliver
405-466-3454

3. Safety Officer: Daryl Hughes
405-466-3360

4. Campus Police: Chief Frank Atkinson
 - Non-Emergencies: 405-466-3366/3367/3368
 - Emergencies: 405-466-2222

Standard Liability Incident Report

The Standard Liability Incident Report is documentation that the accident occurred and a record of the details surrounding it. It also shows that the employer has high health and safety standards in regards to their employees and therefore helps the employees to comply with health and safety legislation compliance.

Scope of Employment Form

An employer is legally responsible for the actions of its employees. However, this rule only applies if the employee is acting within the course and scope of employment. In other words, the employer will generally be liable if the employee was doing his or her job, carrying out company business, state agencies, college and university or otherwise acting on the employer's behalf when the incident took place.

Proof of Loss Form

Proof of loss details the insured losses such as the property involved, what caused the damage, the extent of the damage, and the estimated dollar amount of the damage.

The Medicare, Medicaid and SCHIP Extension Act (MMSEA)

MMSEA requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist the Center for Medicare Services (CMS) and other insurance plans to properly coordinate payment of benefits among plans so that claims are paid promptly and correctly.



**State of Oklahoma
Department of Central Services
Risk Management Division**

Standard Liability Incident Report

DCS-RISK MGMT P.O. BOX 53364

OKLAHOMA CITY, OKLAHOMA 73152

TEL: 405/521-4999 (24h), FAX: 405/522-4442

Claim No: _____

Agency Information:

Agency Name _____ Agency # _____ Phone _____

Type of Employment: Full Time Temporary Volunteer Contract

Driver or Employee: _____ Job Title: _____

Div. or Dept: _____ Address: _____ Phone: _____

Specific Duty Being Performed:

Vehicle Information:

Owned By: State _____ Other _____ Make _____ Year _____

Body Type: _____ Vehicle Tag #: _____ Vehicle #: _____

Amount Damage: _____ Where Damaged: _____

Claimant's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Was Claimant or Passenger Injured? Yes No

Describe _____

Name of Doctor or Hospital: _____

Claimant Vehicle: _____
 Make Yr Body Type Damage Amt.

Where Damaged: _____

Claim Form Requested? Yes No

Incident Date: _____ Time: _____

Location:

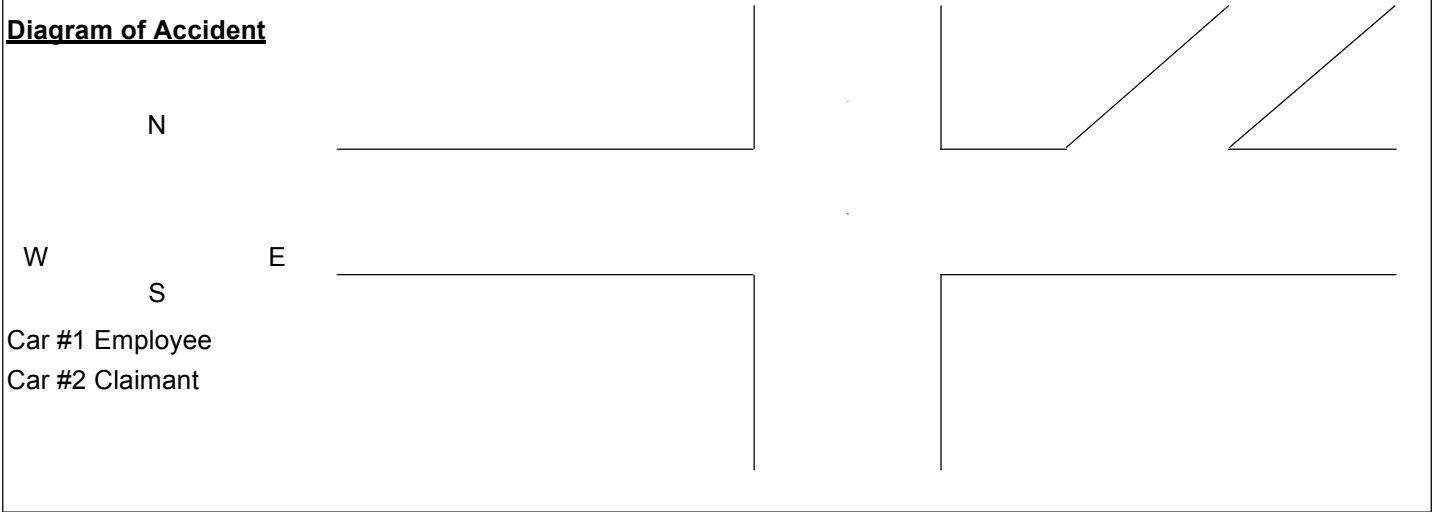
_____ City Street Highway County

Describe Incident:

Was Employee Aware Of Incident? Yes No

Remarks:

Diagram of Accident



Witnesses

Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Incident Citations

Authorities reported to: _____ Name: _____

Were there any citations: Yes No

Who: _____ What: _____

Reported by: _____ Date: _____ Phone: _____

Driver's signature: _____ Driver's license #: _____



**State of Oklahoma
Department of Central Services
Risk Management Division**

Scope of Employment

DCS-RISK MGMT P.O. BOX 53364

OKLAHOMA CITY, OKLAHOMA 73152

TEL: 405/521-4999, FAX: 405/522-4442

Incident Date: _____ Time: _____ Claim No (DCS use only): _____

Employee Name: _____ Job Title: _____

State Agency Name _____ Code _____

Division or Dept: _____ Phone _____

Address: _____ City: _____ State: _____ Zip: _____

Type of Employment: Full Time Temporary Volunteer Contract

Who Authorized This Specific Duty: _____

Please describe in detail what specific duty was being performed at the time of the incident.

Employee Signature

Supervisor Signature

Please Type or Print Name (Supervisor)

Date

Date



**State of Oklahoma
Department of Central Services
Risk Management Division**

**Summary Sheet for Insured
Structures/Buildings**

DCS-RISK MGMT P.O. BOX 53364

OKLAHOMA CITY, OKLAHOMA 73152

TEL: 405/521-4999, FAX: 405/522-4442

IMPORTANT

1. Is this the first time you have reported this building to Risk Management? Yes No
- Is this an update or change to a building you have previously reported to Risk Management?
2. Management? Yes No
3. If this is an update, **provide Risk Management's Generic Building Number:** _____

COMPLETE THE FOLLOWING

Agency: _____ Agency #: _____

Structure / Building Name: _____

Physical Location (Address): _____

Owned by: _____ County: _____

Type of Security: _____ Date of Construction: _____

Total # of Square Feet: _____ # of Floors: _____ Sprinkler System: Yes No

Type of Air Conditioner: _____ Type of Heating System: _____

Type of Construction: _____ Type of Roof: _____

Date Last Roof Was Installed: _____ Roof Maintenance Program: Yes No

Heat or Smoke Detection: Yes No Fire Extinguisher: Yes No Fire Hydrants: Yes No

Functional Use: _____

Special Comments and/or Instructions for Insurance: _____

YOU MUST COMPLETE THIS SECTION TO ASSURE COVERAGE

STRUCTURE/BLDG. REPLACEMENT VALUE: \$ _____

CONTENTS REPLACEMENT VALUE: \$ _____

COMPUTERS REPLACEMENT VALUE: \$ _____

OTHER REPLACEMENT VALUE: \$ _____

Form Completed By: _____ Name and Title _____ Date: _____

DEPARTMENT OF CENTRAL SERVICES-RISK MANAGEMENT DIVISION
P.O. BOX 53364-OKLAHOMA CITY, OKLAHOMA 73152
TELEPHONE (405) 521-4999-FAX (405) 522-4442
CLAIMANT'S REPORT
EACH PERSON MAKING A CLAIM MUST FILE A SEPARATE CLAIM

Under Federal law, Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) added new mandatory reporting requirements for liability insurance (including self-insurance), no-fault insurance, and Workers' Compensation, which includes coverage available for legitimate claims against the State of Oklahoma.

AGENCY NO. _____

PERSONAL INJURY

CLAIM NO. _____

SECTION 1

INJURED PARTY LAST NAME -----	FIRST NAME _____	MIDDLE INITIAL _____
MAILING ADDRESS _____	PHONE NO.(_____	
CITY _____	STATE _____	ZIP CODE+4 -----
INJURED PARTY GENDER	<input type="radio"/> FEMALE	<input type="radio"/> MALE
INJURED PARTY DATE OF BIRTH -----		
	MM/00/YY	
INJURED PARTY'S SOCIAL SECURITY NUMBER -----		
INJURED PARTY'S MEDICARE HEALTH INSURANCE CLAIM NUMBER (HICN) -----		
ALLEGED CAUSE OF INJURY, INCIDENT, OR ILLNESS:		

SECTION 2

INDIVIDUAL SUBMITTING CLAIM: {MARK APPROPRIATE BOX)

- INJURED PARTY
- REPRESENTATIVE OF INJURED PARTY
(IF THIS BOX MARKED, COMPLETE SECTION 3)
- CLAIMANT FOR DECEASED INJURED PARTY
(IF THIS BOX MARKED, COMPLETE SECTION 4)
- REPRESENTATIVE FOR CLAIMANT FOR DECEASED INJURED PARTY
(IF THIS BOX MARKED, COMPLETE SECTION 5)

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Claim# _____

SECTION 3

REPRESENTATIVE OF INJURED PARTY: (MARK APPROPRIATE BOX)

- PARENT
- ATTORNEY
- GUARDIAN/CONSERVATOR
- POWER OF ATTORNEY
- OTHER (EXPLAIN) _____

REPRESENTATIVE LAST **NAME**-----FIRST **NAME**-----

REPRESENTATIVE COMPANY NAME _____

REPRESENTATIVE FEDERAL TAX IDENTIFICATION NUMBER (**TIN**)-----

REPRESENTATIVE MAILING ADDRESS: _____

CITY _____ STATE _____ ZIP CODE+4 _____

REPRESENTATIVE PHONE NUMBER () ----- EXTENSION _____

SECTION 4

CLAIMANT FOR DECEASED INJURED PARTY:(MARK APPROPRIATE BOX)

- ESTATE
- FAMILY MEMBER
- OTHER (EXPLAIN) _____

CLAIMANT PARTY LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

REPRESENTATIVE FEDERAL TAX IDENTIFICATION NUMBER (**TIN**)-----

CLAIMANT MAILING ADDRESS: _____

CITY-----STATE _____ ZIP CODE+ 4 _____

CLAIMANT PHONE NUMBER () ----- EXTENSION-----

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CLAIMANT'S REPORT
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Claim# _____

SECTION 5

REPRESENTATIVE FOR CLAIMANT FOR DECEASED INJURED PARTY: (MARK APPROPRIATE BOX)

- PARENT
- ATTORNEY
- GUARDIAN/CONSERVATOR
- POWER OF ATTORNEY
- OTHER (EXPLAIN), _____

REPRESENTATIVE LAST **NAME**-----FIRST **NAME**-----

REPRESENTATIVE COMPANY NAME _____

REPRESENTATIVE FEDERAL TAX IDENTIFICATION NUMBER (**TIN**)-----

REPRESENTATIVE MAILING ADDRESS: _____

CITY-----STATE. _____ ZIP CODE+ 4 _____

REPRESENTATIVE PHONE NUMBER () ----- EXTENSION _____

SECTION 6

INCIDENT DATE: _____ TIME: _____ AM/PM

INCIDENT LOCATION-CITY-STREET-HIGHWAY-COUNTY

DESCRIBE INCIDENT:

FOR ADDITIONAL COMMENTS CONTINUE IN SECTION 13

SECTION 7

Describe any evidence that will prove that the State or a State employee was negligent.

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CLAIMANT'S REPORT
EACH PERSON MAKING A CLAIM MUST FILE A SEPARATE CLAIM

Claim# _____

SECTION 8

DESCRIPTION OF ILLNESS/INJURY

NAME OF **PHYSICIAN**-----NAME OF HOSPITAL / CARE **CENTER**-----

NAME OF **PHYSICIAN**-----NAME OF HOSPITAL / CARE **CENTER**-----

NAME OF PHYSICIAN _____ NAME OF HOSPITAL / CARE **CENTER**-----

NAME OF PHYSICIAN _____ NAME OF HOSPITAL / CARE CENTER _____

NAME OF **PHYSICIAN**-----NAME OF HOSPITAL / CARE **CENTER**-----

PROVIDE COPIES OF ALL MEDICAL BILLS AND MEDICAL REPORTS

TOTAL DOLLAR AMOUNT FOR HOSPITAL \$-----

TOTAL DOLLAR AMOUNT FOR PHYSICIAN \$-----

TOTAL DOLLAR AMOUNT FOR PRESCRIPTIONS \$-----

TOTAL DOLLAR AMOUNT FOR AMBULANCE \$-----

TOTAL DOLLAR AMOUNT FOR OTHER MEDICAL EXPENSE \$-----

LIST OTHER MEDICAL EXPENSE

\$ _____

\$ _____

SECTION 9

WAS THE INJURY ILLNESS OR INCIDENT ALLEGEDLY CAUSED BY/CONTRIBUTED TO BY A PARTICULAR PRODUCT? YES NO

IF YES, PROVIDE THE FOLLOWING:

PRODUCT GENERAL **NAME**-----PRODUCT BRAND NAME. _____

PRODUCT MANUFACTURER _____ PRODUCT ALLEGED **HARM**-----

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Claim# _____

SECTION 10

LOST WAGES

PROVIDE ON COMPANY LETTERHEAD FROM EMPLOYER, WITH THE AMOUNT OF LEAVE USED, THE
HOURLY RATE AND THE TOTAL AMOUNT OF WAGES LOST.
LOSTWAGES \$ _____

SECTION 11

PROVIDE THE EXACT AMOUNT OF COMPENSATION
YOU WOULD ACCEPT AS FULL SETTLEMENT OF THIS CLAIM.

TOTALCLMM
\$ _____

SECTION 12

"WARNING"

IT IS A FELONY TO MAKE OR PRESENT A FALSE,
FICTITIOUS OR FRAUDULENT CLAIM FOR
PAYMENT OF PUBLIC FUNDS. THE STATE OF
OKLAHOMA WILL PROSECUTE AND CONVICTION
MAY RESULT IN CRIMINAL PENALTIES.

(21 O.S. 358, 359)

The above information is true and correct to the best
of my knowledge.

Signature or Authorized Signature

Social Security no. or Federal ID No.

