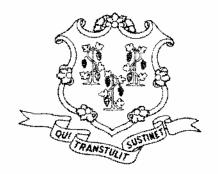
NOTICE TO EMPLOYEES



State of Connecticut Workers' Compensation Commis	sion Revised 10-01-2017		
The Workers' Compensation Act (Connecticut General St	atutes Chapter 568) requires your employer,		
to provide benefits to you in case of injury or occupational disease in the course of employment.			
Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the commissioner may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employee." An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement. NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim. The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:			
		Name Workers' Compensation Trust	
		Address 47 Barnes Industrial Road South	Telephone(203) 678-0100
		City/Town Wallingford	StateCT Zip Code06492
Approved Medical Care Plan X Yes No			
The State of Connecticut Workers' Compensation Commission office for this workplace is located at:			
Address 55 West Main Street	Telephone(203) 596-4207		
City/Town Waterbury	State CT Zip Code06702		
Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation. If your employer has listed a location below, you MUST file your compensation claim there. When filing your claim, you are also required – by law – to send it by certified mail. If blank below, ask your employer where to file your claim.			
Employer Name Advanced Behavioral Health, Inc. ABH - Human Resources Department			
Address 213 Court Street, 8th Floor	Telephone <u>(860) 638-5309</u>		
City/Town Middletown	State CT Zip Code _06457		
THISNOTICE MUST BEINTY PEOFNOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE	Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed		

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to the employer, the insurance company, or

the Workers' Compensation Commission

(1-800-223-9675).

Date Posted: ___

TO POST THIS NOTICE WILL SUBJECT THE EMLOYER

TO STATUTORY PENALTY (Section 31-279 C.G.S.).