WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG CASE #	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX M MALE F FEMALE U UNKNOWN	MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

AWCC Form 1
(Employer's First Report of Injury or Illness)

Ark. Code Ann. § 11-9-529 allows employers 10 days to report injuries. Those involving either more than 7 days of lost time or indemnity payments require **Form 1**. Also, a Form 1 is required for all controversions including a medical-only case. Self-insured employers file **Form 1** with the AWCC; other employers send it to their insurance representatives.

Employers do **NOT** fill in the shaded areas.

On **Form 1**, employers/carriers must:

1. In the **Occurrence Section** list the date the employer first knew of the injury. The 10 days to report begin either on the date of disability **or** the date the employer was notified, whichever date is later.

2. Give the name of the carrier. An insurance agency or third party administrator should be listed in the **Preparer's Section**. A carrier can pre-print its name and address in the **Carrier Section** to help clients properly report.

3. Specify the carrier Federal Employer Identification Number (FEIN) in the **Carrier Section**.

4. Type or print in ink. An illegible, incomplete **Form 1** will be returned.

Neglect of **Form 1**: Late employee benefits, exposing employers to fines.

Lack of **Form 1**: Delays in insurance investigation.

General inquiries on Form 1 can be answered by the AWCC Support Services Division. Questions on a specific Form 1 may be directed to the Research and Statistics Section, which processes the accident reports. (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

(Revised 1-1-2001)

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

Form AR- 2	ARKANSAS WORKERS' COMPENSATION COMMISSION	2
Authority: Ark. Code Ann. §11-9-803, -810 Revised 1-1-2013	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

EMPLOYER'S INTENT TO ACCEPT OR CONTROVERT CLAIM

❑ **Initial Filing** ❑ **Amended Filing**

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee SS Number
Employer Name			Fed. Employer I.D. No.
Address	City	State	Zip Code
Carrier or Self-Insured Name	Claims Office Name, Address, and Phone		

Is this a medical only claim? ❑ Yes ❑ No **Is this a PPD-Only Claim?** ❑ Yes ❑ No

COMPENSATION (if not applicable, skip to next section)

Date of First Comp. Check	Dates Covered by First Check	Body Part Injured	First Day of Disability
	.00	Was Disability Continuous During the First 8 Days? ❑ Yes ❑ No	
Average Weekly Wage	Wkly TTD Comp. Rate (rounded)		Date Indemnity Triggered

STATEMENT OF POSITION

Date of injury or death: _____ City, State of Injury: _____ State your position. If controverting, state the grounds therefore:

_____

_____

_____

_____

_____

DEATH CASE DATA

List all Dependents below: *(If more space is needed, attach supplemental sheet)* If no Dependents, check here: ❑

Attach Death Certificate of Deceased Employee and Birth Certificates for Dependent Children

Name of dependent	Date of	Relationship to deceased	Weekly benefit amount

CERTIFICATION

I certify that the foregoing is a complete and accurate report according to the records of the insurer pertaining to first payment, controversion and beneficiary information. I further certify that a copy of this report or equivalent information has been provided to the employee or beneficiaries.

		Title:	
Signature	Printed or Typewritten Name	Phone:	Date

If insurer is represented by an attorney, that legal representative must sign below pursuant to Ark. Code Ann. § 11-9-717

Name and Address of Attorney	Signature

AWCC Form 2

(Employer's Intent to Accept or Controvert Claim)

A form used to accept a case and report payment or to controvert. **AWCC Form 2** also is used to amend positions taken earlier.

Help With AWCC Form 2:

1. The first payment to the employee is due by the 15th day after the employer has notice of the injury or death. **(Ark. Code Ann. §11-9-802)**

2. The AWCC is notified "upon making the first payment." **(Ark. Code Ann. §11-9-810)**

3. A controversion notice is due on or before the 15th day after notice of the death or alleged injury. **(Ark. Code Ann. §11-9-803)**

4. Therefore, **AWCC Form 2** in all cases is required by the 15th day from (a) the day of disability or (b) the day the employer is aware of the alleged incident, whichever date is later.

Be sure to include on **AWCC Form 2**:

5. A mark in either the Initial Filing Box or Amended Filing Box.

6. The AWCC File Number (obtained from **AWCC Form A-110**) and your company's file number for this case.

Be sure to bear in mind:

7. **Form 2** is NOT interchangeable with the required written response to the 15-day letter for **Form C**.

8. If respondents need additional time for investigation, an extension request must be sent in before the **Form 2** deadline. Using **Form 2** to report that the respondent needs more time is invalid.

9. If a case is opened at the AWCC on **Form 1** or **Form C**, an AWCC **Form 2** is required, even if the case upon investigation is determined to be a medical-only claim.

Questions about a specific Form 2, or general information or assistance on completing or filing a Form 2, may be directed to the AWCC Operations and Compliance Division, which processes this form (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission.

Ark. Code Ann. §11-9-717: Any person or attorney signing a claim, request for benefits, controversion of benefits request for hearing or other paper of a party, certifies the action is taken after reasonable inquiry; is well grounded in fact; is warranted by existing law or a good faith argument for extension, modification or reversal of existing law; and is not interposed for any improper purpose or for delay. Violators of this provision may be subject to sanctions, which may include payment of reasonable expenses incurred by others and reasonable attorney fees for responding to the claim, request or motion, or for failure to appear at a hearing, deposition or other scheduled matter.

Form AR-4	ARKANSAS WORKERS' COMPENSATION COMMISSION	4
Authority: Ark. Code Ann. §11-9-810 Revised: 1-1-2011	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

REPORT OF COMPENSATION PAID/SUSPENSION OF PAYMENTS

☐ **AMENDED REPORT**

☐ **Closing Report** ☐ **Death/PTD Maximum Liability**
☐ **Report of Payment Suspension** ☐ **Update Report (additional payments only)**

AWCC File No.	**Carrier Claim No.**	**Employee Name (Last, First, MI)**	**Employee S.S. Number**
Employer Name	**City**	**State**	**Zip Code**
Carrier or Self-Insured Name	**Claims Office Location (mailing address)**		

DISABILITY INFORMATION

Date of Injury	**Last Day Employee Worked**	**Date Employee Able to RTW**	**Return - to - Work Date**

Total days worked between injury and date able to RTW _____

COMPENSATION INFORMATION:

COMPENSATION PAYMENTS MADE:

(1) TTD Weeks _____ **Days** _____ **$** _____

(2) TPD Weeks _____ **Days** _____ _____

(3) PPD Weeks _____ **Days** _____ _____

(4) _____ **Weeks PTD** _____

(5) _____ **Weeks for Death** _____

(6) Lump Sum payment _____

(7) Joint Petition settlement _____

(8) Claimant Attorney Fees _____

(9) Defense Attorney Fees _____ _____

***(10) Other (Compensation Related)** _____

(11) Hospital Expenses _____

(12) Medical Expenses _____

(13) Drugs, Medicine _____

(14) Funeral Expenses _____

(15) Rehabilitation _____

***(16) Other (Expense Related)** _____

(1 - 16) GRAND TOTAL _____

SUSPENSION OF PAYMENTS OF COMPENSATION

Date of Suspension of Compensation: _____ Reason for Suspension:

Compensation paid through _____ (date).

CERTIFICATION

I certify that the foregoing is a complete and accurate report according to the records of the insurer pertaining to payments of compensation and suspensions of payment information. I further certify that a copy of this report or equivalent information has been provided to the employee or beneficiaries.

Signature	Printed or Typewritten Name	Title	Date

AWCC Form 4

(Report of Payment)

A Final Report is due within 30 days of the last compensation payment. **[Ark. Code Ann. § 11-9-810(b)(1)]**

Every **Form 4** must provide the AWCC file number.

Form 4 is for all end-of-payment reports, i.e.:

1. The suspension of benefits; reason for suspension must be given.

2. The closing of a medical-only case that was accidentally opened by the respondent on **Form 1** or by a claimant on **Form C**.

3. The Final Report of a compensable case, detailing all payments. **Forms 1, 2,** and **3** (or narrative medical report) are required for these cases.

4. Maximum liability being reached in cases involving death or permanent total disability (both the Compensation Section and the Suspension of Payments Section are to be completed). The box for Death/PTD Maximum Liability must be marked.

5. ***Other*** in (10) of the Compensation Information Section includes benefits not listed elsewhere, such as interest and penalties.

Other in (16) would include court reporter fees and mileage reimbursement.

Information on Form 4 may be supplied by the Support Services Division. For a specific case, refer to the Office Services Division, which processes Form 4 and closes the case. (1-800-622-4472 or 501-682-3930)

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

Form AR-M	ARKANSAS WORKERS' COMPENSATION COMMISSION	M
Authority: Ark. Code Ann. § 11-9-528, 529 AWCC Rule 8 Revised: 1-1-2001	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

MONTHLY REPORT ON MEDICAL - ONLY INJURY DATA

TO BE COMPLETED BY CARRIERS AND SELF-INSURED EMPLOYERS EACH MONTH ON CASES NOT OPENED BY FORM 1 OR FORM C.

Report Period (Month, Year)	Carrier or Self-Insured Name		FEIN No.	
Claim Office/TPA Filing Report	Mailing Address	City	State	Zip Code

MONTHLY MEDICAL-ONLY INJURY DATA

Total No. of Medical-Only Injury Reports Received	Total No. of Days Lost	Total Medical Expense

Give Total Number of Reported Injuries by Body Part (Must Equal Total No. of Injuries Reported Above)

Head, Face and Neck: _____ Eyes, Ears, Nose and Mouth: _____ Hands, Arms and Fingers: _____
Back and Hip: _____ Chest and Lungs: _____ Legs, Feet and Toes: _____
Abdomen: _____ Other or Multiple: _____

CERTIFICATION

I certify that the foregoing is a complete and accurate report for the above referenced carrier or self-insured employer of all medical-only claims reported and paid by that entity for the report period.

Signature	Printed or Typewritten Name	
Title	Date	Telephone Number (including Area Code)

(See Instructions on Back of This Sheet)

AWCC Form M

(Monthly Report on Medical-Only Injury Data)

Instructions for **Form M**:

1. Send **Form M** to the AWCC Research & Statistics Section after the close of each month and by the 15th day of the next month.

2. Spell out the name of the carrier or self-insured; do not abbreviate.

3. Count calendar days lost rather than just work days.

4. All accidents/injuries resulting in disability of more than seven days, death cases, or those involving payment of weekly compensation shall be reported to the Commission on Form 1. In the event cases reported as medical-only develop into compensable cases, these previously-counted totals should be subtracted in subsequent Form M Monthly Reports.

5. All accidents/injuries, other than death, resulting in disability of seven days or less, must be reported on this form. This report is to be completed by all insurance carriers and self-insured employers providing workers' compensation coverage in Arkansas. Companies/employers that have coverage with an insurance carrier are not required to complete this form.

6. Report expenses each month. When medicals are carried over into another month, expenses should be included on future **M Forms**, but the accident should only be counted once.

7. Separate reports must be submitted for each separate carrier or self-insured FEIN number.

8. Third-party administrators/service companies should NOT complete this form unless designated to do so by the carrier or self-insured. Reports with "No Activity" during the period must be completed and so indicated.

9. **NOTE**: The Commission has the authority to levy a fine up to $500 per report per carrier or self-insured FEIN for failure to submit or late submittal of this form. FAX reports are acceptable. The fax number is (501)682-2777.

Help with the Form M is available from the Research and Statistics Section. General information is available from the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

Form AR-S	ARKANSAS WORKERS' COMPENSATION COMMISSION	S
Authority: Ark. Code Ann. § 11-9-529 Revised: 1-1-2001	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

SUPPLEMENTAL REPORT

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee SS Number

Employer Name	FEIN No.	City	State	Zip Code
Carrier Or Self-Insured Name	NAIC No.	Claims Office Address		

1. Date of injury: _____

2. Date employee began losing time from work: _____

3. Has employee returned to work? ❑ Yes ❑ No If yes, give date _____

4. If employee has returned to work, is he/she earning the same wages as before the injury? ❑ Yes ❑ No

   If not, please explain:

5. Has employee died? ❑ Yes ❑ No If yes, give date of death: _____

ADDITIONAL INFORMATION

CERTIFICATION

I certify that the information above is accurate according to the employer's/carrier's records.

Signature	Printed or Typewritten Name	Title	Date

AWCC Form S
(Supplemental Report)

This form reports any change-in-status, including, but not limited to:

1. The injured employee is back at work and drawing wages;
2. The injured employee is losing time again;
3. The injured employee has died;

Employers need to file **Form S** promptly.

Carriers file the form to fill in any "gaps" in time on **AWCC Form 4** when the case is being closed.

Contact the AWCC Office Services Section for help with the Form S. General information is available from the Support Services Division (1-800-622-4472 or 501-682-3930) .

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."