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?
   o 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?
   o 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
   o 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
   o 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 over looked 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
  o Claims covered under the Governmental Tort Claims Act (GTCA)
  o Unlawful Gain or Profit
  o Criminal Misconduct
  o Deliberately Fraudulent Acts
  o Insured vs. Insured
  o Bodily Injury or Property Damage
  o Medical Malpractice
  o Sexual Misconduct & Child Abuse
  o 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)

• EPL: Employment Practices Liability
  • What is EPL?
    o 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).
5. 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
   o Identify State Risk Management (SRM) role
   o Identify programs managed by SRM
   o Identify actuary’s role
   o Identify agency’s risk management role
   o 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.
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
Diagram of Accident

N

W

E

S

Car #1 Employee
Car #2 Claimant

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 #: __________________
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
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?  
   □ Yes  □ No

2. 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:
   __________________________________________

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: ___________________________
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.

SECTION 1

INJURED PARTY LAST NAME ———— FIRST NAME ———— MIDDLE INITIAL ————
MAILING ADDRESS ———— PHONE NO.( ) ————
CITY ———— STATE ———— ZIP CODE+4 ————

INJURED PARTY GENDER O FEMALE O 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)

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

REPRESENTATIVE OF INJURED PARTY: (MARK APPROPRIATE BOX)

O PARENT
O ATTORNEY
O GUARDIAN/CONSERVATOR
O POWER OF ATTORNEY
O OTHER (EXPLAIN)__________________________

REPRESENTATIVE LAST NAME__________FIRST NAME__________

REPRESENTATIVE COMPANY NAME __________________________________________

REPRESENTATIVE FEDERAL TAX IDENTIFICATION NUMBER (TIN)__________________

REPRESENTATIVE MAILING ADDRESS:__________________________________________

________________________________________CITY_________STATE____ZIPCODE+4_____

REPRESENTATIVE PHONE NUMBER ( ) ____________________________ EXTENSION __________

SECTION 4

CLAIMANT FOR DECEASED INJURED PARTY:(MARK APPROPRIATE BOX)

D ESTATE
D FAMILY MEMBER
O 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 __________
SECTION 5

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

O PARENT
O ATTORNEY
O GUARDIAN/CONSERVATOR
O POWER OF ATTORNEY
O 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.
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?  O YES  O NO

IF YES, PROVIDE THE FOLLOWING:

PRODUCT GENERAL NAME--------PRODUCT BRAND NAME

PRODUCT MANUFACTURER PRODUCT ALLEGED HARM
**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.

| TOTALCLAIM | $ ________________ |

**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 I.D. No.
SECTION 13

COMMENTS

__________________________________________________________________________________________
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