Service Insurance Companies

WORKERS COMPENSATION REPORTING FORM

Dial 1-**844-740-7007**
Fax **1-512-231-8248**
E-mail to **claims@serviceinsurance.com**

(*) Indicates a Mandatory Field. **IS THIS AN EMERGENCY CLAIM? YES NO**

* REPORTED BY PERSON'S NAME:									
* TITLE:				* BUSINESS PHONE:				EXT:	
FAX NUMBER:				E-MAIL ADDRESS:					
* DATE OF ACCIDENT: MM/DD/YYYY					* TIME OF ACCIDENT: (HH:MM AM/PM)				
LOCAL BUSINESS ADDRESS INFORMATION									
* PARENT CO. NAME:					SUBSIDIARY NAME:				
* ADDRESS:									
* CITY, STATE, ZIP:						*COUNTY:			
* BUSINESS PHONE:				EXT.		FAX NUMBER:			
* LOCATION CODE:				POLICY NUMBER:					
* NATURE OF BUSINESS:									
* FEDERAL ID NUMBER:					SIC CODE:				
LOSS LOCATION INFORMATION									
* LOCATION NAME:									
* DID ACCIDENT OCCUR ON THE INSUREDS PREMISES? (X)				YES		NO			
*IF NO, ENTER PHYSICAL ADDRESS:									
* CITY, STATE, ZIP:						*COUNTY:			
INSURED CONTACT INFORMATION									
* WOULD YOU LIKE TO BE THE CONTACT PERSON?: (X)				YES		NO			
* IF NO, ENTER CONTACT PERSON NAME:						TITLE:			
ADDRESS:									
CONTACT PHONE:					E-MAIL ADDRESS:				
EMPLOYEE INFORMATION									
*SOCIAL SECURITY NUMBER:				* EMPLOYEE NAME:					
* ADDRESS:									
* CITY, STATE, ZIP:						COUNTY:			
RESIDENCE PHONE:				BUSINESS PHONE:				EXT:	
EMPLOYEE EMAIL ADDRESS:									
BIRTHDATE: MO/DAY/YR			* AGE:		*GENDER:(X)	FEMALE		MALE	
NUMBER OF DEPENDENTS:			* MARITIAL STATUS:						
* REGULAR OCCUPATION:				* REGULAR DEPARTMENT:				CLASS CODE:	
DATE OF HIRE: MM/DD/YY			HIRE COUNTRY:		HIRE STATE:		STATE HIRE DATE: MM/DD/YY		
SUPERVISOR NAME:					BUSINESS PHONE:				
SUPERVISOR EMAIL ADDRESS:									
EMPLOYMENT STATUS: (Full/Part Time)				* PAY TYPE: (Weekly, Bi-Weekly, etc.)					
* GROSS WAGES: (Based on Pay Type)									
HOURS WORKED PER DAY?			DAYS WORKED PER WEEK?			HOURS PER WEEK?			

LOSS INFORMATION

EMPLOYEE START TIME: (HH:MM AM/PM)			** DATE EMPLOYER NOTIFIED: (MM/DD/YY)*				
** QUESTIONABLE CASE?*	YES		NO				
** DESCRIPTION OF ACCIDENT:*							
** REMOVED BY AMBULANCE? (X)*	*YES*		*NO*		*UNKNOWN*		
** ANY STITCHES/SURGERY REQUIRED? (X)*	*YES*		*NO*				
** WAS A FATALITY INVOLVED? (X)*	*YES*		*DATE*		*NO*		
** DESCRIBE INJURY OR ILLNESS:*							
** BODY PART INJURED?:*			INDICATE RIGHT/LEFT/UPPER/LOWER BODY:				
** WORK PROCESS INJURED WAS DOING?*							
** DIRECT CAUSE: (X)*	*SPECIFIC INJURY:*		OCCUPATIONAL DISEASE OR CUMULATIVE INJURY :				
SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?: (Y/N/U)			SAFEGUARDS OR SAFETY EQUIPMENT UTILIZED?: (Y/N/U)				
** EMPLOYEE ON RESTRICTED DUTY? (X)*	YES		NO		UNKNOWN		
** FULL PAY FOR DAY OF INJURY?*	YES		NO		UNKNOWN		
** ANY LOST TIME? (X)*	YES		NO		UNDETERMINED		
LAST DAY WORKED: MM/DD/YY			START DATE OF DISABILITY:				
DATE RETURNED TO WORK: MM/DD/YY			EXPECTED RETURN TO WORK: MM/DD/YY				
** SALARY CONTINUED DURING DISABILITY?*	YES		NO		UNKNOWN		

MEDICAL INFORMATION

** INITIAL TREATMENT? (X)* *ONLY SELECT ONE*	* NO MEDICAL TREATMENT		* MINOR BY EMPLOYER	
	* MINOR HOSP/CLINIC		* EMERGENCY CARE	
	* HOSPITALIZED 24 HRS		* FUTURE MEDICAL/LOST TIME	
	* UNKNOWN			

** EMPLOYEE HOSPITALIZED OVERNIGHT AS INPATIENT?*	YES		NO		UNKNOWN	

PHYSICIAN		HOSPITAL INFORMATION	
** NAME:*		** NAME:*	
ADDRESS:		ADDRESS:	
CITY, STATE, ZIP:		CITY, STATE, ZIP:	
BUSINESS PHONE:		BUSINESS PHONE:	

WITNESS INFORMATION

** NAME:*		** NAME:*	
ADDRESS:		ADDRESS:	
CITY, STATE, ZIP:		CITY, STATE, ZIP:	
PHONE:		PHONE:	

GENERAL REMARKS/COMMENTS

GENERAL REMARKS:	