Service Insurance Companies

BROADSPIRE WORKERS COMPENSATION REPORTING FORM

Dial **1-866-357-1299,**
Fax to **1-678-937-8210**,
E-mail to **servicelloyds@choosebroadspire.com or**
or visit www.choosebroadspire.com to FileAClaim via the Internet

(*) 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:	