



**BROADSPIRE WORKERS COMPENSATION REPORTING FORM**

Dial 1-866-357-1299, or

Fax to 1-678-937-8210,

E-mail to [servicelloyds@choosebroadspire.com](mailto:servicelloyds@choosebroadspire.com) or  
or visit [www.choosebroadspire.com](http://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)			
<b>A. LOCAL BUSINESS ADDRESS INFORMATION</b>							
* 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:			
<b>B. LOSS LOCATION INFORMATION</b>							
* LOCATION NAME:							
* DID ACCIDENT OCCUR ON THE INSUREDS PREMISES? (X)	YES		NO				
* IF NO, ENTER PHYSICAL ADDRESS:							
* CITY, STATE, ZIP:				* COUNTY:			
<b>C. INSURED CONTACT INFORMATION</b>							
* WOULD YOU LIKE TO BE THE CONTACT PERSON?: (X)	YES		NO				
* IF NO, ENTER CONTACT PERSON NAME:				TITLE:			
ADDRESS:							
CONTACT PHONE:				E-MAIL ADDRESS:			
<b>D. EMPLOYEE INFORMATION</b>							
* 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:				* MARITAL 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?			

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E. 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
F. 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:			
G. WITNESS INFORMATION							
* NAME:				* NAME:			
ADDRESS:				ADDRESS:			
CITY, STATE, ZIP:				CITY, STATE, ZIP:			
PHONE:				PHONE:			
H. GENERAL REMARKS/COMMENTS							
GENERAL REMARKS:							

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