



## WORKERS COMPENSATION REPORTING FORM

Dial 1-833-294-0968

Fax 1-512-231-8248

E-mail to [claims@serviceamerican.com](mailto:claims@serviceamerican.com)

(\*) Indicates a Mandatory Field.

**IS THIS AN EMERGENCY CLAIM?**

**YES**

**NO**

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



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:							