

Workers Comp Claims Reporting

Claims Reporting – Direct to Carrier (AmTrust)

AmTrust North America

Toll Free Phone – 888-239-3909

Email - WorkersCompClaimsReport@AmTrustgroup.com

Fax – 877.669.9140

When Reporting a Claim by Phone

Please Have the Following Information Available:

- 1) Name of the insured (Indiana Conference of the UMC).
- 2) Policy number (TWC4379332)
- 3) Name and contact information of injured worker.
- 4) Injured employee's SSN
- 5) Date, time, and place of accident
- 6) Description of accident or incident
- 7) Name, phone and/or email of person making the report.
- 8) Any information on the injured worker's lost time

When Reporting a Claim by Email

- 1) Please complete the Indiana First Report of Injury Form (Attached)
- 2) Please do not alter the pre-filled sections as they are correct
- 3) Please indicate if a claim is questionable or there are complicated factors

Workers Comp Claims Reporting

Claims Questions & Assistance

Sovereign Insurance Group

Kali Simpkins – Claims Director

Direct Line – 484.654.3335

Email – ksimpkins@sovinsurance.com

Fax – 610.535.6810

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.
2. Enter all dates in MM/DD/YY format.
3. Please return completed form electronically by an approved EDI process.
4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME AND CODE NUMBER: Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (e.g. *Acetylene cutting torch, metal plate, etc.*).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME / TELEPHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc.*)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwise deigned by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc.*).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: (*FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK*)).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (*e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall.*)

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc.*)

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (Return to Work Date): Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting.*)

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc.*)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).



INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION									
Social Security number	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Occupation / Job title				NCCI class code		
Name (last, first, middle)		Marital status <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		Date hired	State of hire	Employee status <input type="checkbox"/> Paid Day of Injury <input type="checkbox"/> Salary Continued			
Address (number and street, city, state, ZIP code)			Hrs / Day	Days / Wk	Avg Wg / Wk				
Telephone number (include area)		Number of dependents		Wage Per \$		<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year <input type="checkbox"/> Other			
EMPLOYER INFORMATION									
Name of employer			Employer ID#		SIC code	Insured report number			
Address of employer (number and street, city, state, ZIP code)			Location number		Employer's location address (if different)				
			Telephone number						
			Carrier / Administrator claim number		OSHA log number	Report purpose code			
Actual location of accident / exposure (if not on employer's premises)									
CARRIER / CLAIMS ADMINISTRATOR INFORMATION									
Name of claims administrator			Carrier federal ID number		Check if appropriate <input type="checkbox"/> Self Insurance				
Address of claims administrator (number and street, city, state, ZIP code)			<input type="checkbox"/> Insurance Carrier <input type="checkbox"/> Third Party Admin.		Policy / Self-insured number				
Telephone number					Policy period From		To		
Name of agent			Code number						
OCCURRENCE / TREATMENT INFORMATION									
Date of Inj./ Exp.	Time of occurrence <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Cannot be determined		Date employer notified	Type of injury / exposure			Type code		
Last work date	Time workday began	Date disability began		Part of body			Part code		
RTW date	Date of death	Injury / Exposure occurred on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of contact			Telephone number		
Department or location where accident / exposure occurred				All equipment, materials, or chemicals involved in accident					
Specific activity engaged in during accident / exposure				Work process employee engaged in during accident / exposure					
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.									Cause of injury code
Name of physician / health care provider									
Hospital or offsite treatment (name and address)							INITIAL TREATMENT <input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinic / Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/> Future Major Medical / Lost Time Anticipated		
Name of witness			Telephone number		Date administrator notified				
Date prepared	Name of preparer		Title	Telephone number					

An employer's failure to report an occupational injury or illness may result in a \$50 fine (IC 22-3-4-13).