# BROADSPIRE WORKERS COMPENSATION REPORTING FORM

Dial: **1-866-357-1097 (Brady)**
Fax to **1-800-245-9927**,
E-mail to **nol@choosebroadspire.com or**
or visit www.choosebroadspire.com to FileAClaim via the Internet

**(*)** Indicates a Mandatory Field. **IS THIS AN EMERGENCY CLAIM?** **YES** **HIRE DATE: MM** **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)** | | | |
| **A. 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:** | | | |
| **B. LOSS LOCATION INFORMATION** | | | | | | | |
| *** LOCATION NAME:** | | | | | | | |
| *** DID ACCIDENT OCCUR ON THE INSUREDS PREMISES? (X)** | | **YES** | | **NO** | | | |
| ***IF NO, ENTER PHYSICAL ADDRESS:** | | | | | | | |
| *** CITY, STATE, ZIP:** | | | | ***COUNTY:** | | | |
| **C. 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:** | | | |
| **D. EMPLOYEE INFORMATION** | | | | | | | |
| ***SOCIAL SECURITY NUMBER:** | | | *** EMPLOYEE NAME:** | | | | |
| *** ADDRESS:** | | | | | | | |
| *** CITY, STATE, ZIP:** | | | | **COUNTY:** | | | |
| **RESIDENCE PHONE:** | | | **BUSINESS PHONE:** | | | **EXT:** | |
| **EMPLOYEE EMAIL ADDRESS:** | | | | | | | |
| **BIRTHDATE: MO/DAY/YR** | | | | ***GENDER:(X)** | **FEMALE** | | **MALE** |
| **NUMBER OF DEPENDENTS:** | | *** MARITIAL STATUS:** | | | | | |
| *** REGULAR OCCUPATION:** | | | *** REGULAR DEPARTMENT:** | | | **CLASS CODE:** | |
| **DATE OF HIRE: MM/DD/YY** | | | | **HIRE STATE:** | | **STATE HIRE DATE: MM/DD/YY** | |
| **SUPERVISOR NAME:** | | | | | | | |
| **SUPERVISOR EMAIL ADDRESS:** | | | | | | | |
| **EMPLOYMENT STATUS:** (Full/Part Time) | | | | | | | |
| *** GROSS WAGES: (Based on Pay Type)** | | | | | | | |
| **HOURS WORKED PER DAY?** | | **DAYS WORKED PER WEEK?** | | **HOURS PER WEEK?** | | | |

| 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)*<br>*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: | |

(*) indicates a Mandatory Field