Service Insurance Companies

BROADSPIRE WORKERS COMPENSATION REPORTING FORM

Dial **1-888-599-8567 or**
Fax to **1-800-245-9927**,
E-mail to **paragon@choosebroadspire.com**

(*) 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)**					
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		***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?**			

E. 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. 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