BROADSPIRE WORKERS COMPENSATION REPORTING FORM

Dial **1-888-510-3033, or**
Fax to **1-800-245-9927**,
E-mail to **tangram@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?**				

(*) indicates a Mandatory Field

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:	

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