# WORKERS COMPENSATION CLAIMS REPORTING CHECKLIST

**Please Note:** Report all workers compensation injuries to OneBeacon. The OneBeacon Claims Service Center is open for claim intake 24/7. For more efficient service, please have the information on this checklist available for your Loss Representative. To report a claim, call 1.877.248.3455

## EMPLOYER INFORMATION

| POLICY #: | EMPLOYER NAME: |
|---|---|
| ACCIDENT DATE: | EMPLOYER PHONE #: |

| **ADDRESS** | | |
|---|---|---|
| STREET: | | |
| CITY: | STATE: | ZIP CODE: |
| LOCATION #: | INTERNAL REPORT #: | |
| ID # (FEIN): | | |
| ACCIDENT ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | | |
| NATURE OF BUSINESS: | | |

| **ACCIDENT LOCATION** | | |
|---|---|---|
| STREET: | | |
| CITY: | STATE: | ZIP CODE: |
| COUNTY: | STATE IAB TO WHICH REPORTED: | |

## EMPLOYEE INFORMATION

| LAST NAME: | |
|---|---|
| FIRST NAME: | M.I.: |

| **ADDRESS** | | |
|---|---|---|
| STREET: | | |
| CITY: | STATE: | ZIPCODE: |

# WORKERS COMPENSATION CLAIMS REPORTING CHECKLIST

| | |
|---|---|
| PHONE #: | SOC. SEC. #: |
| D.O.B. | DATE OF HIRE: |
| AVG. WEEKLY WAGE: | MARITAL STATUS: |
| SEX: | OCCUPATION: |
| EMPLOYMENT STATUS: | |
| # OF DEPENDENTS: | # DAYS SCHEDULED PER WEEK: |

## INJURY INFORMATION

| | |
|---|---|
| DID EMPLOYEE LOSE 1 OR MORE DAYS OF WORK? ☐ YES ☐ NO | DID EMPLOYEE RETURN TO WORK? ☐ YES ☐ NO |
| DATE LAST WORKED: | DATE INCAPACITATED: |
| DATE RETURNED: | DATE OF DEATH: |
| FULL PAY ON INJURY DATE? ☐ YES ☐ NO | EST. # OF SCHEDULED LOST TIME DAYS: |
| SALARY CONTINUED? ☐ YES ☐ NO | |

DESCRIBE HOW INJURY/EXPOSURE OCCURRED:

SOURCE OF INJURY:

**WITNESS INFORMATION**

| | |
|---|---|
| NAME: | PHONE #: |

**STATE INFORMATION**

| | |
|---|---|
| INJURY CODE: | DESCRIPTION: |
| BODY PART CODE: | DESCRIPTION: |

EQUIPMENT, MATERIALS, OR CHEMICALS USED:

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# WORKERS COMPENSATION CLAIMS REPORTING CHECKLIST

SPECIFIC ACTIVITY EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OCCURRED:

WORK PROCESS EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OCCURRED:

| CAUSE OF INJURY CODE: | TIME WORK BEGAN: ☐ A.M. ☐ P.M. |
|---|---|
| | TIME INJURY OCCURRED: ☐ A.M. ☐ P.M. |

SAFEGUARDS AND SAFETY EQUIPMENT:

| WERE THEY PROVIDED? ☐ YES ☐ NO | WERE THEY USED? ☐ YES ☐ NO |
|---|---|

COUNTY EMPLOYEE LIVES IN:

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ SEASONAL ☐ VOLUNTEER

**MEDICAL INFORMATION**

HOSPITAL NAME:

STREET:

| CITY: | STATE: |
|---|---|
| ZIPCODE: | PHONE #: |

PHYSICIAN NAME:

STREET:

| CITY: | STATE: |
|---|---|
| ZIPCODE: | PHONE #: |

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# WORKERS COMPENSATION CLAIMS REPORTING CHECKLIST

| **INITIAL EMPLOYER CONTACT** | |
|---|---|
| TARGET RTW DATE: | DID EMPLOYER DIRECT EMPLOYEE TO PHYSICIAN? ☐ YES ☐ NO |
| EMPLOYER WILLINGNESS/ABILITY TO PROVIDE MODIFIED DUTY: | |
| EMPLOYER ADDITIONAL COMMENTS: | |
| PREPARER'S NAME: | |
| TITLE: | PHONE #: |

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