AdvancedHR

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FIRST NOTICE OF LOSS

CONTACT INFORMATION

Name of Person Completing This Document: _____

Phone #: _____ Email: _____

Claims Contact Name if Different From Above: _____

Phone #: _____ Email: _____

POLICYHOLDER INFORMATION

Policyholder Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy #: _____

Claim Jurisdiction: _____

Employer Location/Client Company Name: _____

Client/Location #: _____

Address: _____

City: _____ State: _____ Zip: _____

INJURED EMPLOYEE INFORMATION

Injured Employee First Name: _____

Injured Employee Middle Name: _____

Injured Employee Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Email: _____

Social Security Number: _____ Date of Birth: _____

Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Unknown

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FIRST NOTICE OF LOSS

INJURED EMPLOYEE INFORMATION continued

Date of Hire: _____ Occupation: _____

Employment Status: ☐ Regular/Full Time ☐ Part Time ☐ Piece Worker ☐ Seasonal ☐ Volunteer

NCCI Class Code: _____ Wage Rate: _____

Wage Rate Per: ☐ Hour ☐ Day ☐ Week ☐ Commission

Number of Days Worked Per Week: _____ Hours Worked per Day: _____

Will the Employee be Paid in Full for the Date of Accident? ☐ Yes ☐ No

Will You Continue Paying the Employee? ☐ Yes ☐ No

CLAIM INFORMATION

Time Employee Began Work: _____ Date of Injury/Illness: _____

Time of Injury/Illness: _____ Date Employer Notified of Injury/Illness? _____

Last Day Worked: _____ Return to Work Date: _____

Accident Description: _____

Part of Body Affected: _____

Work Process Employee was Engaged in When the Incident Occurred: _____

Were Safeguards and Safety Equipment Used? ☐ Yes ☐ No

Did Accident Occur on Insured Premises? ☐ Yes ☐ No

Place of Accident: _____

Address: _____

City: _____ State: _____ Zip: _____

Is Claim Questionable? ☐ Yes ☐ No

If so, Why? _____

_____

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EMPLOYMENT APPLICATION

MEDICAL PROVIDERS

Initial Treatment:

- ☐ No Medical Treatment
- ☐ Minor On-site by Employer
- ☐ Minor Clinic/Hospital
- ☐ Emergency Evaluation
- ☐ Hospitalization

Provider #1 Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Diagnosis: _____

Released to Return to Work: ☐ Yes ☐ No

Work Restrictions: _____

Provider #2 Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Diagnosis: _____

Released to Return to Work: ☐ Yes ☐ No

Work Restrictions: _____

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EMPLOYMENT APPLICATION

WITNESSES

Witness #1 Name: _____

Is Witness a Co-Worker?: ☐ Yes ☐ No Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Witness #2 Name: _____

Is Witness a Co-Worker? ☐ Yes ☐ No Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

ADDITIONAL NOTES

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