Workers' Compensation First Notice of Loss

Please complete the following comprehensive list of questions to report your Workers' Compensation Loss. You can use this template for phone, fax or e-mail submission. Asterisks (*) denote information that is critical to proper handling office assignment. Please be sure to obtain this information prior to reporting a claim.

SECTION 1: EMPLOYER / LOSS LOCATION INFORMATION

Policy Number: _____ Account Number: _____ IRC / Loc. Code: _____
*Filing State: TENNESSEE *Date of Loss: _____ Time of loss: _____
Account Name: Southern Adventist University Employer Name: Southern Adventist University
Address: 4881 Taylor Circle
City: Collegedale State: TN Zip Code: 37315
Business Phone: (423)236-2266
Mailing Address: 4881 Taylor Circle
City: Collegedale State: TN Zip Code: 37315
Accident Location Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Did the injury occur on the insured's premises? ☐ Yes ☐ No If no, where did injury occur? _____

SECTION 2: PERSON REPORTING CLAIM TO THE HARTFORD – INFORMATION

Name: _____ Title: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Mobile Phone: _____ Fax Number: _____
Email Address: _____

SECTION 3: INSURED CONTACT INFORMATION

Name: ANDREW MYAING
Address: 4881 TAYLOR CIRCLE
City: COLLEGEDALE State: TN Zip Code: 37315
Day Phone: (423)236-2266 Mobile Phone: _____ Fax Number: (423)236-1566
Email Address: amyaing@southern.edu Contact Preference: ☒ Email ☐ Mail ☒ Phone

SECTION 4: EMPLOYEE/CLAIMANT INFORMATION

Employee Name: _____
Employee Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Night Phone: _____ Mobile Phone: _____
Email Address: _____
Social Security Number: _____ Date of Birth: _____ # of Dependents: _____
Gender: _____ Marital Status: _____ Preferred Language: _____

SECTION 5: EMPLOYMENT INFORMATION

Date of Hire: _____ State of Hire: _____ Date Shift Begin: _____
Time Shift Begin: _____ ☐ AM ☐PM Time Shift Ends: _____ ☐ AM ☐PM
Hours Worked Per Day: _____ Days Worked Per Week: _____
Pay Type: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Salary
Pay Check Frequency: ☐ Bi Weekly ☐ Weekly ☐ Monthly ☐ Twice Monthly
Is the claimant's typical work schedule Monday through Friday? ☐ Yes ☐ No ☐ Unknown
Is it a fixed or varied schedule? ☐ Fixed ☐ Varied ☐ Unknown
Scheduled Work Days: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat
Employment Status: ☐ Full Time ☐ Part Time ☐ Seasonal/Temporary ☐ Other/Unknown
Recent Disciplinary Action: ☐ Yes ☐ No ☐ Unknown
Occupation: _____ Regular Department: _____
Injured in Regular Occupation? ☐ Yes ☐ No ☐ Unknown
Department Where Injury Occurred: _____

Describe Physical Demands of the Employee's Job:

☐ Sedentary (sitting most of the time)
☐ Light (usually walking or standing)
☐ Medium (exerting up to 10lbs of force constantly)
☐ Heavy (exerting up to 20lbs of force constantly)
☐ Very Heavy (exerting excess 20lbs of force constantly)
☐ Unknown

NCCI (Job Class Code): _____ Officer/Owner/Partner? ☐ Yes ☐ No ☐ Unknown
Supervisor Name: _____
Supervisor Address: _____
City: _____ State: _____ Zip Code: _____
Supervisor Day Phone: _____ Supervisor Mobile Phone: _____
Supervisor Email Address: _____

SECTION 6: LOSS INFORMATION

*Please provide a description of the accident (what was employee doing at time of injury and what type of injury was sustained):

Injury Result in Death? ☐ Yes ☐ No
Was the employee injured while performing normal job duties? ☐ Yes ☐ No ☐ Unknown
Did the injury occur during normal work hours? ☐ Yes ☐ No ☐ Unknown
Do you question the injury? (If yes, provide Reason in Additional Information below) ☐ Yes ☐ No ☐ Unknown
Date of Notice (Reported to Employer): _____ Time Reported: _____
Who was the injury reported to? _____
Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Mobile Phone: _____
Email Address: _____
Does the employee have Group Health Insurance? ☐ Yes ☐ No ☐ Unknown
Name of Group Health Carrier: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Has the employee received treatment? ☐ Yes ☐ No ☐ Unknown

SECTION 7: INITIAL TREATMENT INFORMATION

Incident only: ☐ Yes ☐ No ☐ Unknown

Where did employee receive treatment?
☐ Clinic ☐ Emergency Room ☐ First Aid ☐ Other ☐ Admitted to Hospital ☐ Unknown

Emergency transportation required? ☐ Ambulance ☐ Helicopter ☐ Other _____

Medical Provider Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone: _____ Name of Physician: _____

Treatment Type: ☐ Stitches ☐ X-ray ☐ Physical Therapy ☐ Other: _____

Additional Treatment Received: _____

Do you expect further medical treatment? ☐ Yes ☐ No ☐ Unknown

If Yes: Will the injury require surgery? ☐ Yes ☐ No ☐ Unknown

SECTION 8: LOST TIME

Has the employee lost time from work? ☐ Yes ☐ No ☐ Unknown

IF YES

Last Date Worked: _____ First Day Missed: _____

Salary/Wages Continued: ☐ Yes ☐ No ☐ Unknown

Paid for Date of Injury? ☐ Yes ☐ No ☐ Unknown

*Has the employee returned to work? ☐Yes ☐No ☐ Unknown

Date returned or expected to return to work: _____

Will or has the employee returned to: ☐ Regular Duty ☐ Light Duty ☐ Unknown

Will or has the employee returned to reduced hours or wage? ☐ Yes ☐ No ☐ Unknown

Is there any intermittent lost time? ☐ Yes ☐ No ☐ Unknown

SECTION 9: ADDITIONAL INCIDENT INFORMATION

Was the employee performing an unsafe act? ☐ Yes ☐ No ☐ Unknown
Did the injury involve equipment or machinery? ☐ Yes ☐ No ☐ Unknown
If Yes: Was the equipment or machinery defective? ☐ Yes ☐ No ☐ Unknown
Safety equipment provided? ☐ Yes ☐ No ☐ Unknown
Safety equipment used? ☐ Yes ☐ No ☐ Unknown

Is a 3rd party potentially responsible for the injury? ☐ Yes ☐ No ☐ Unknown

IF YES
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Night Phone: _____
Mobile Phone: _____ Email Address: _____

Are there any witnesses? ☐ Yes ☐ No ☐ Unknown

IF YES
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Night Phone: _____
Mobile Phone: _____ Email Address: _____

Has the employee had previous injuries? ☐ Yes ☐ No ☐ Unknown

IF YES:
Please describe**:**

SECTION 10: ADDITIONAL INFORMATION