Dear Policyholder/Claimant:

You are about to complete our online Workers' Compensation Claims Report. Ideally, both you (or your designated representative) and the employee should be present. Information gathered in this way expedites (but does not replace) a formal First Report of Injury. Once the form has been completed, you should save a copy to either (1) upload the file by selecting ***For Businesses>Info/Picture Upload*** at **www.guard.com** OR (2) e-mail the pdf to **claims3@guard.com**. (Printing the pages will not be possible.) Upon receipt by us, you can expect a Berkshire Hathaway GUARD Representative to be contacting you in the near future to complete the process and get the official paperwork filed on your behalf.

Reminders:

- With the current policy, a list of suggested medical providers was sent. These practitioners:
    - Are located a reasonable distance from your operations
    - Represent a mix of specialties relevant to your business
    - Are experienced in dealing with occupational health concerns

  If a particular provider or category of providers is not included on the mailed panel, we also post an on-line directory.

- We want to remind you that we have a pharmacy benefit program in place that should be used in obtaining prescriptions.
- Finally, we ask that you complete the contact information below so we can follow-up this report at a convenient time and with the individual in the best position to be helpful in finalizing the official First Report.

NAME OF PERSON TO CONTACT:

TITLE/ROLE:

PHONE NUMBER(S): [primary] [secondary]

BEST TIME TO CALL (EASTERN STANDARD TIME):

We thank you for your cooperation. (The Claims Report form immediately follows.)

Reminder:

Claims can also be reported by phone by simply calling 1-888-NEW-CLMS (i.e., 1-888-639-2567).

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	INSURED REPORT NUMBER	OSHA LOG NUMBER
	JURISDICTION / LOCATION #	PHONE #
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	FAX #
INDUSTRY CODE / EMPLOYER FEIN		EMAIL

INSURANCE CARRIER

CARRIER	POLICY/SELF-INSURED NUMBER	POLICY PERIOD TO
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE, SUFFIX)	DATE OF BIRTH	LANGUAGE	DATE HIRED	STATE OF HIRE
ADDRESS (INCLUDE ZIP)	SEX MALE FEMALE UNKNOWN	MARITAL STATUS UNMARRIED/SINGLE/ DIVORCED MARRIED SEPARATED UNKNOWN	OCCUPATION/JOB TITLE	
			EMPLOYMENT STATUS (Full-Time, Part-Time)	
PHONE (HOME, CELL)	# OF DEPENDENTS		NCCI CLASS CODE	
EMAIL	EMPLOYEE ID	EMPLOYEE ID TYPE (SSN, GREEN CARD, PASSPORT)		
RATE PER: DAY WEEK MONTH OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? YES NO DID SALARY CONTINUE? YES NO		

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK AM PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE CANNOT BE DETERMINED AM PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER	DATE EMPLOYER AWARE EMPLOYEE MISSING TIME DUE TO INJURY	MODIFIED DUTY AVAILABLE?			
	DESCRIPTION OF INJURY/ILLNESS	DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?			
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL					
DATE RETURN(ED) TO WORK	PART-TIME OR FULL	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS/SAFETY EQUIPMENT PROVIDED? YES NO WERE THEY USED? YES NO		

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT NO MEDICAL TREATMENT MINOR: BY EMPLOYER MINOR CLINIC/HOSP EMERGENCY CARE HOSPITALIZED > 24 HOURS FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED OTHER
FOLLOW-UP CARE (NAME AND PHONE)	PROVIDER PANEL POSTED	TREATMENT WITH PANEL PROVIDER

OTHER

WITNESSES (NAME & PHONE #)
ADDITIONAL CLAIM INFORMATION/NOTES:
HAS EMPLOYEE SIGNED/DATED ACKNOWLEDGEMENT LETTER REGARDING WORKER'S COMPENSATION LAW, IF APPLICABLE?

NOTIFICATION ONLY?	DATE PREPARED	PREPARER'S NAME AND TITLE	PHONE NUMBER