CLAIM FILING FORM

encova INSURANCE

(Compatible with Encova Edge claim filing and OSHA Form 301 filing)

** Denotes required field*

Please note: The fields highlighted in grey are pre-populated in the online system.

Date of injury: *	Policy number: WCN6006935	~~Policy name:~~	Case # from OSHA Log (if applicable):
~~Filing date:~~	~~Claim type: *~~ ☐ ~~Incident~~ ☐ ~~Indemnity~~ ☐ ~~Medical only~~		~~Jurisdiction:~~

POLICY / DEMOGRAPHIC QUESTIONS

~~What is your name? *~~		~~What is your job title?~~		
~~What is your telephone number? *~~	~~What is your fax number?~~	~~What is your email address?~~		
~~Are you the contact for this claim?~~ ☐ ~~No~~ ☐ ~~Yes~~		~~If no, who should we contact for additional information?~~		
~~What is the contact's phone number?~~		~~What is the contact's email?~~		
~~Is this a Federal Longshore (USL&H) claim?~~ ☐ ~~No~~ ☐ ~~Yes~~		~~Are you reporting a fatality?~~ ☐ ~~No~~ ☐ ~~Yes~~		~~Date of death: *~~
~~Date of injury/date of last exposure: *~~		~~What is your policy number? *~~		
~~What is the employee's ID type? *~~	☐ ~~Employment Visa number~~ ☐ ~~Green Card number~~ ☐ ~~Passport number~~ ☐ ~~Social Security number~~	~~ID number: *~~		
What is the employee's name?	First: *	MI:	Last: *	Suffix:
What is the employee's mailing address? Street/P.O. Box: *				
Zip: *	City: *	State: *	Country:	
What is the employee's physical address? Street/P.O. Box:				
Zip:	City:	State:	Country:	
What is the employee's primary telephone number?		What is the employee's alternate telephone number?		
What is the employee's regular work schedule?				

DEMOGRAPHIC / WAGE QUESTIONS

What is the employee's date of birth? *		Gender: * ☐ Male	☐ Female	☐ Unknown		
Marital status: * ☐ Married	☐ Single	☐ Divorced	☐ Widowed	☐ Separated	☐ Common law	☐ Unknown
What is the industrial code? *		What is the job title? *				
Description of employee's job and regular duties:						

DEMOGRAPHIC / WAGE QUESTIONS

What is the employee's hire date? *
HR will provide information

What is the state of hire for this employee?
Pennsylvania

Employment type: ☐ Full-Time ☐ Part-Time ☐ Volunteer

Is the employee: An officer? ☑ No ☐ Yes
An owner/part owner? ☑ No ☐ Yes

What is the hourly rate of pay for this employee?

What are the number of hours worked per week for this employee?

What is the daily rate of pay for this employee? HR will provide information

How many hours per day did the employee work?

How many days per week did the employee work?

Is there any additional wage information not included in the daily rate (i.e. commissions, etc.)?
N/A

Is the employee continuing to receive full wages? ☐ No ☐ Yes HR will provide information

INJURY QUESTIONS

What is the primary work location? *
Name:

Address: *

Country:

Zip: *

City: *

State: *

What is the reporting location?

Did the accident occur on the employer's property? * ☐ No ☐ Yes

If no, where did the accident occur? *
Name: *

Address:

Zip:

City:

State:

Country:

Was this the employee's regular department? ☐ No ☐ Yes

In what department did the accident occur?

Was injury the result of a motor vehicle accident? ☐ No ☐ Yes

Was any equipment involved in the injury? ☐ No ☐ Yes
If yes, what equipment?

What was the employee doing just before the incident occurred?

How did the accident occur? *

What object or substance directly harmed the employee?

Was safety equipment provided? ☐ No ☐ Yes

Was safety equipment used? ☐ No ☐ Yes

If yes, what type?

What was the injured body part(s)? *

What is the body part location? * ☐ Bilateral ☐ Left ☐ Lower ☐ Middle ☐ Right ☐ Upper ☐ Not applicable

What is the nature of the injury (sprain, strain, etc.)? *

What was the cause of injury? *

Are you aware of a previous injury to this body part? * ☐ No ☐ Yes
If yes, please explain: *

Do you have knowledge of pre-existing disability, industrial or non-industrial? ☐ No ☐ Yes
If yes, please explain: *

Are there outside activities or medical conditions that would affect this injury? ☐ No ☐ Yes
If yes, please explain: *

INJURY QUESTIONS

List all **others** involved in the accident with contact information:

1.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
2.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
3.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			

List all **witnesses** to the accident (or enter "none"):

1.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
2.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
3.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			

RETURN-TO-WORK QUESTIONS

What time did the employee begin work? * (Include a.m. or p.m.)

What time did the accident occur? * (Include a.m. or p.m.)	Who was notified of the accident?
When did the injured worker notify the employer? * (Date)	Did the claimant stop work? ☐ No ☐ Yes

What is the loss type?
☐ Incident only ☐ Indemnity ☐ Medical only ☐ Modified duty with no wage loss ☐ Modified duty with wage loss

What was the last date worked?	What time did the employee stop work? (Include a.m. or p.m.)
Has the employee returned to work? ☐ No ☐ Yes	Date of return to work?
Did/will the claimant return to full duty? ☐ No ☐ Yes	Do you have transitional/modified work available? ☐ No ☐ Yes
Number of hours per week?	Modified daily rate of pay?

MEDICAL QUESTIONS

Was medical treatment provided? ☐ No ☐ Yes	Name of medical provider:

Medical facility/provider's address:

Zip:	City:	State:	Country:

Was employee treated in an emergency room? ☐ No ☐ Yes	Was employee hospitalized overnight as an in-patient? ☐ No ☐ Yes

What was the method of transportation? ☐ Helicopter ☐ Ambulance ☐ Personal vehicle ☐ Other

Do you require your employees to be drug tested? ☐ No ☐ Yes	If yes, when was the employee last tested?
Was an incident report completed? * ☐ No ☐ Yes	Do you have any reason to question this injury? * ☐ No ☐ Yes

Do you have any comments for the record?