Claim Reporting

Promptly returning your employees to wellness and productivity is our central focus. Our efforts are most effective when you report your claims to us immediately. ***All work-related injuries should be reported to us as soon as possible.*** The worksheet on the following pages will help you gather information needed to report the claim to us.

Eastern Alliance Insurance Group offers two options to report your claims:

Option #1: **Call our Claim Support Center** at 1.800.336.3658 (available 24/7) to speak with an Eastern Associate Claim Specialist. The Associate Claim Specialist will provide you with a claim number. After a quality control review, copies of the First Report of Injury form will be distributed to the policyholder, agent, and appropriate state agency (as required).

Option #2: **Report your claim online**. First, log-in to www.easternalliance.com and click on the "Report a Claim" heading that is to the right of the Eastern logo. On the Report a Claim page, click on the orange Report a Claim Online box. A new window will open requesting the date of injury for your claim and the state in which it occurred. If your website user account is associated with more than one Eastern policy that was active during the date of injury, you will be prompted to select which policy the claim should be filed under. Click on "Next" to proceed to the Intake claim submission portal, where you will verify the contact and policy information and complete the remainder of the form. A confirmation message will appear on the final page when your claim has been submitted. At that point, you may click on "Close Application" to exit the portal.

After a quality control review, copies of the First Report of Injury form will be distributed to the policyholder, agent, and appropriate state agency (as required). This distribution will contain the claim number.

Please note, some fields are required to submit the claim and other fields that are required as part of our quality review. If you do not have this information initially, please obtain and provide it to us after you submit the claim.

Information Required to Submit a Claim:	**Additional information needed after the claim is submitted (due to state reporting requirements):**
Date of Loss (injury)	
Person submitting the claim and their title	*Injured Worker's:* *Social Security Number* *Address* *Phone number* *Date of Birth* *Date of Hire*
Employer name	*Return to Work information*
Jurisdiction state (state of the claim)	
Injured Worker's full name	
Is the employer's physical address the same as their mailing address?	
Injury cause, body part and nature of injury	
Accident description	
Where the accident occurred	
Whether the injury resulted in death	

Eastern Alliance Insurance Group Claim Reporting Worksheet
24/7 Teleclaim: 1.800.336.3658 / Online: www.easternalliance.com
DO NOT FAX THIS FORM TO US

General Information

Date of loss/injury: _____ Submitter name and title: _____

Submitter phone #: (____) _____

Who is the contact person for the claim?: _____

First Report of Injury distribution:

If you want the First Report of Injury **emailed**, please provide an email address (you can provide up to 2):

_____ _____

If you want the First Report of Injury **faxed**, please provide a fax number (you can provide up to 2):

(____) _____ (____) _____

Policyholder Information

Employer mailing address: _____

County: _____

Physical address if different than mailing address: _____

County: _____

Location code/name where accident occurred: _____

Policy number: _____

Injured Worker Information

Injured Worker's Social Security Number: _____-____-_____

Injured Worker's name: _____

Injured Worker's mailing address: _____

Injured Worker's phone # with area code: (____) _____ Gender: _____ Marital status: _____

Birth date: ____/____/_____ # of dependents: _____

Hire date: ____/____/_____ State of hire: _____ Job title: _____

Employment status: _____ Was the injured worker paid full wages for the day of injury?: _____

Supervisor name and phone #: _____ (____) _____

Accident Information

Did the accident occur on the employer's premises?: _____

If no, provide the accident site's name/address:_____

Time of Injury: _____ Time shift began: _____

Did the injured worker lose time as a result of the injury?: _____

Date last work or # of days off: _____ First day off of work: _____

Has the injured worker returned to work (RTW)? _____ Date Returned: _____

If RTW, is the injured worker working with or without restrictions? _____

If working with restrictions: Will the injured worker lose any wages/hours/benefits?: _____

Please list any work restrictions: _____

_____

Date employer notified of the injury: _____ Name of person notified: _____

Did the injury result in death?: _____

Nature of injury: _____

Body part(s) injured: _____

If applicable: Right/Left/Both (circle one) Finger/Toes (which finger or toe): _____

Cause of injury: _____

Description of accident: _____

Were safeguards or safety equipment provided?: _____

Witness name and phone #: _____ (____) _____

Witness name and phone #: _____ (____) _____

Treatment Information

What type of initial treatment did the Injured Worker receive? _____

Was there emergency medical/ambulance service provided at time of loss? _____

Name, address, phone # of medical provider/facility: _____

_____ (____) _____

Physician name: _____

Follow-up treatment information: _____

_____

Was a list of medical providers (panel) given to the Injured Worker? _____

Additional Information