

**Eastern Alliance Insurance Group Claim Reporting Worksheet**  
**24/7 Teleclaim: 1.800.336.3658 / Online: [www.easternalliance.com](http://www.easternalliance.com)**

**DO NOT FAX THIS FORM TO US**

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](http://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 Alliance 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.

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

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**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** to you, please provide an email address (you can provide up to 2):

\_\_\_\_\_

If you want the First Report of Injury **faxed** to you, 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 #: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

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**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 #: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

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**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**