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

Promptly returning your employees to the wellness and productivity is our central focus. Our efforts will be most effective when you report your claims to us immediately. ***All work related injuries should be reported to us as soon as possible.*** A worksheet is provided on the following page to assist you in gathering claim information for reporting the claim to us.

Eastern Alliance Insurance Group offers two options for reporting 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 is performed, copies of the First Report of Injury form will be distributed to the policyholder, the agent, and the appropriate state agency (when required).

Option #2: Log-in to report your claim online. After you log-in to the site, (www.eains.com) click on the link to "Submit a Claim." You will then arrive at a page that contains helpful information regarding our Intake system for reporting claims. When you are ready to report the claim, simply click on the blue button ("Ready to Submit a Claim through Intake Click Here) or the link that reads "Click here to open a new window and begin submitting your claim."

Please note, some fields are required to submit the claim to us. There are other fields that we require as part of our quality review. Please work to obtain this information after you submit the claim to us.

Information Required to Submit a Claim:	**Additional information needed after the claim is submitted (due to state reporting requirements):**
Date of Loss (injury)	*Location code/name if applicable*
Person submitting the claim and their title	*Policy number*
Employer Name	*Injured Worker's SSN*
Jurisdiction State (state of the claim)	*Injured Worker's mailing address (including county)*
Injured Worker's full name	
Is the Employer's physical address the same as the mailing address?	
Injury cause, body part and nature of injury	
Accident description	
Where the accident occurred	
Whether the injury resulted in death	

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General Information

Date of Loss/Injury: _____ Submitter Name and Title: _____

Submitter Phone #: (____) _____

Who will be the contact person for the claim?: _____

First Report of Injury Distribution:

If you would like the First Report of Injury **Emailed** to you please provide an email address (you can provide up to 2):

_____ _____

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

(____) _____ (____) _____

Insured 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 SSN: _____-____-_____

Injured Worker's Name and 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 for the day of injury?: _____

Supervisor Name and Phone #: _____ (____) _____

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Incident Information

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

If No, provide the accident Site 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? _____ Date Returned: _____

If RTW, working without restrictions or working with restrictions? _____

Work restrictions: _____

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

Did the injury result in death?: _____

Nature of injury: _____ Body part injured: _____

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/ambulance service provided at time of loss?: _____

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

_____ (____) _____

Name of Physician: _____

Follow up treatment information: _____

_____

Was a physician panel provided to the Injured Worker?: _____

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Additional Information