Claim Reporting Worksheet

Promptly returning your employees to 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.***

Eastern Alliance 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 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 www.eains.com to report your claim online.

After you log-in to the website, click on the link to "*Submit a Claim.*" You will 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 on 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. There are other fields that we require as part of our quality review. If this information is not included on your initial claim report, please collect the information to provide to us later.

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*
Who the contact person will be for the claim	*Employer Name and Address (including county)*
Jurisdiction State (state where claim occurred)	*Location code/name if applicable*
Injured Worker's full name	*Policy number*
Is the Employer's physical address the same as the mailing address?	*Injured Worker's SSN*
Where the accident occurred	*Injured Worker's mailing address (including county)*
Whether the injury resulted in death	*Person submitting the claim and their title*

Direct all **claims** correspondence (including medical bills and reports) to us at:

Eastern Alliance Insurance Group
P.O. Box 83777, Lancaster, PA 17608-3777
Claims correspondence: irindexing@eains.com / fax: 717-481-5272

NOTE: Eastern Alliance has partnered with ACS Claim Service, Inc. to handle our claims in the state of New York. Please direct all inquiries to PO Box 257, Mechanicsburg, PA 17055. Telephone: 1.800.258.3675, Fax: 717.795.8516. Initial claim reporting remains at our Claim Support Center, online or call: 1.800.336.3658.

EASTERN ALLIANCE INSURANCE GROUP CLAIM REPORTING WORKSHEET

24/7 TELECLAIM: 1.800.336.3658 / ONLINE: WWW.EAINS.COM

- DO NOT FAX OR EMAIL THIS FORM TO US -

General Information

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

Submitter Phone #: (____) _____

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 #: _____ (____) _____

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 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 Information

Witness Name and Phone #: _____ (____) _____

Witness mailing address: _____

Treatment Information

What type of initial treatment did the Employee receive?: _____

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

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

_____ (____) _____

Was a physician panel provided?: _____

Additional Information

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 3):

_____ _____ _____

If you would like the First Report of Injury **faxed** to you, please provide a fax number (you can provide up to 3):

(____) _____ (____) _____ (____) _____