

CLAIMS REPORTING PROCEDURES

Vensure HR, Inc is dedicated to providing the best service possible to our Clients. The loss control department works with the insurance company on each and every claim to ensure proper handling of the claim and best treatment for the employee. Workers Compensation fraud is a growing concern. Vensure HR will work with the Insurance carrier in claims investigation. Any employee found to be making false reports in order to obtain benefits is subject to prosecution.

Proper claims handling starts with you, It is imperative that all claims are reported to Vensure HR within 24 hours of knowledge of the claim, no matter how minor the incident. In the event of a workers compensation injury please follow the reporting procedures below:

Reports of Injury:

1. **Employer's Report of Injury:** To be completed by a representative of the company and faxed to Vensure HR within 24 hours of an injury or illness.
2. **Employees Report of Injury:** All injuries no matter how minor the injury must be reported by an employee to their supervisor using an employee's report of injury.
3. **Supervisor's Report of Injury:** All supervisors must have access and know the procedures for completing this form and submitting it to the right person.

If you have any questions or concerns please feel free to call the Vensure HR loss control department.

Claims fax: 480-993-2653

Loss control: 480-993-2650 ext 1312

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND FAX THIS REPORT WITHIN
24 HOURS FROM TIME OF ACCIDENT.
MAIL ORIGINAL WITHIN 10 DAYS OF ACCIDENT
TO:



IMPORTANT
To be completed
by Employer

4140 E. Baseline Rd., Suite 201 • Mesa, AZ 85206
Phone: (480) 993-2650 • Fax (480)-993-2653
Toll-Free 1-800-383-5403

The clients designated supervisor must notify his benefits carrier (on this form) of every injury or disease suffered by an employee, arising out of and in the course of employment.

Please fill out this form by clicking on the fields and typing the appropriate information on each line.

EMPLOYEE

Last Name: _____ First Name: _____ M.I. _____ SSN: _____
Street _____
Address: _____ Apt. # _____ City: _____ St: _____ ZIP: _____
Phone _____
Number: _____ Date of Birth: _____ Department: _____

HISTORY OF CLAIMS

Does Employee have any previous Work Comp Claims? YES NO If yes, please provide details below such as date of claim and type of injury.

EMPLOYER

Current Employer: Vensure HR, Inc. Client Company Name: _____ Date of Hire: _____

CLIENT COMPANY

Office Address: _____ Ste. #: _____ City: _____ St: _____ ZIP: _____
Phone Number: _____ Fax #: _____ Nature of Business: _____

ACCIDENT

Date of Injury: _____ Hour of Injury: _____ AM PM Date Employer Notified: _____ Last Day Worked: _____
Date Returned to Work: _____ Class Code: _____ Employees Occupation (Job Title) When Injured: _____ Department: _____
Nature of Injury: _____ Part of Body Injured: _____ On Client Premises? Yes No Address/Location of Accident: _____
Was the employee paid for the day of injury? Yes No Time employee began work: _____ AM PM
Hospital or Clinic Name: _____ Phone Number: _____ City: _____ St: _____ ZIP: _____

If validity of Claim is Doubted, State Reason: _____

CAUSE OF ACCIDENT

How Did Accident Happen? _____

Specify Machine, Tool, Substance, or Object most Closely Connected With Accident: _____
What was Employee Doing When Accident Occurred? _____

If Another Person Not in Company Employ Caused the Accident, Give name and Address: _____

Please fax to (480) 993-2653 or email to claims@vensureinc.com



SUPERVISORS REPORT OF INDUSTRIAL INJURY

Please complete and submit with
24 hours no matter how minor the injury.

Company: _____

Injured Employee: _____

Date of injury: _____ Time: _____

Injury reported to: _____ Date: _____

Was employee paid for a full days work? NO YES

Did employee lose at least one full day of work after the injury? NO YES

Date last worked: _____ Time: _____ am pm

Has the employee returned to work? NO YES Date: _____

Was the employee performing assigned duties? NO YES

Location where injury occurred: _____

What was the employee doing when injured? _____

How did injury occur? _____

Object or substance that injured the employee: _____

Type of injury: _____ Part of body: _____

What type of treatment was received? _____

Who witnessed the accident? _____

Was the injury caused by someone else? NO YES

Name: _____

Did the accident involve employees or equipment of any other company? NO YES

What (if any) safety procedures were violated? _____

Is the employee an officer, partner or relative of the employer? NO YES

Please include any additional comments you feel are important on the other side.

Supervisor Name (print): _____ Date: _____

Supervisor Signature: _____



EMPLOYEE'S REPORT OF INJURY OR ILLNESS

Please complete and submit no matter how minor the injury

Name: _____ SS# _____

Address: _____

Phone: _____ Date of Birth: ____/____/____

Employer: _____ Job Title: _____

Claim reported to: _____ Position: _____

Last day worked: ____/____/____ Return to work date: ____/____/____

Where did the injury occur? _____

What were you doing when the injury occurred? _____

How did the injury occur? _____

What object or substance caused the injury? _____

Type of Injury: _____ Body Part: _____

Type of treatment received: _____

Witnesses: _____

Was the injury caused by someone else? _____

Did the accident involve employees or equipment of another company? No Yes

What actions were taken to prevent similar accidents from occurring? _____

Have you had a Workers' Comp claim in the last year? No Yes

Note: Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purposes of obtaining workers' compensation benefits is guilty of a felony.

Employee Signature: _____ Date: ____/____/____

Please fax to (480) 993-2653 or email to claims@vensureinc.com