

## **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](mailto:claims@vensureinc.com)*



# Reporte de herida o enfermedad del empleado

EMPLOYEE'S REPORT OF INJURY OR ILLNESS

Por favor complete y envíe el reporte aun cuando sea una lesión leve.  
Please complete and submit no mater how minor the injury.

Nombre: \_\_\_\_\_ SSN \_\_\_\_\_  
Name: \_\_\_\_\_ SSN \_\_\_\_\_

Dirección: \_\_\_\_\_  
Address \_\_\_\_\_

Teléfono: \_\_\_\_\_ Fecha de Nacimiento: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Empleador: \_\_\_\_\_ Cargo: \_\_\_\_\_  
Employor: \_\_\_\_\_ Job Title: \_\_\_\_\_

Reclamo Reportado: \_\_\_\_\_ Puesto: \_\_\_\_\_  
Claim reported to: \_\_\_\_\_ Position: \_\_\_\_\_

Ultimo día trabajo: \_\_\_\_/\_\_\_\_/\_\_\_\_ Fecha de regreso al trabajo: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last day worked: \_\_\_\_\_ Return to work date: \_\_\_\_\_

¿Dónde estaba cuando se lesionó o lastimó? \_\_\_\_\_  
Where did the injury occur?

¿Qué estaba haciendo cuando se lastimó, hirió o lesionó? \_\_\_\_\_  
What were you doing when the injury occurred?

¿Cómo ocurrió el incidente? \_\_\_\_\_  
How did the injury occur?

¿Qué objeto o substancia causó su herida lesión? \_\_\_\_\_  
What object or substance caused the injury?

Tipo de lesión: \_\_\_\_\_ Parte del cuerpo: \_\_\_\_\_  
Type of Injury: \_\_\_\_\_ Body Part: \_\_\_\_\_

Tipo de tratamiento recibido: \_\_\_\_\_  
Type of treatment received: \_\_\_\_\_

Testigos: \_\_\_\_\_  
Witnesses: \_\_\_\_\_

¿Fue la lesión causado por otra persona? \_\_\_\_\_  
Was the injury caused by someone else?

¿El accidente involucró a empleados o equipo de otra empresa? No Si  
Did the accident involve employees or equipment of another company? No Yes

¿Qué acciones fueron tomadas para prevenir que ocurran accidentes similares? \_\_\_\_\_  
What actions were taken to prevent similar accidents from occurring?

¿Ha hecho algún reclamo de compensación al trabajador en el último año? No Si  
Have you had a Workers' Comp claim in the last year? No Yes

**AVISO:** Cualquier persona que hace una declaración médica sabiendo que esta es falsa o fraudulenta con el propósito de obtener los beneficios de la compensación del trabajador, es culpable de felonía.

**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.

Firma del empleado: \_\_\_\_\_ Fecha: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# VENSURE

Human Resources

## Reporte de el supervisor en caso de un accident

Favor the llenar y entregar esta forma a uno mas tarde de 24 horas despues de el accidente.

**Compañía:** \_\_\_\_\_  
Company

**Empleado lastimado:** \_\_\_\_\_ **Numero de seguro social:** \_\_\_\_\_  
Injured Employee SSN

**Fecha de el accidente:** \_\_\_\_\_ **Hora de el accidente:** \_\_\_\_\_ am pm  
Date of Injury Time of Accident

**El accidente fue reportado a:** \_\_\_\_\_ **Fecha:** \_\_\_\_\_  
Injury Reported To Date

**¿Fue el empleado pagado por el día completo?** **Si** **No**  
Was Employee Paid for a Full Days Work? Yes No

**¿Falto el empleado, al siguiente día de el accidente?** **Si** **No**  
Did Employee Lose At Least One Full Day of Work After The Injury? Yes No

**¿Ultimo día laborado?** \_\_\_\_\_ **Hora(s):** \_\_\_\_\_ am pm  
Date Last Worked Time

**¿Ha regresado el empleado a laborar?** **Si** **No** **Fecha:** \_\_\_\_\_  
Has the Employee Returned To Work? Yes No Date

**¿Estaba el empleado trabajando en sus asignaciones?** **Si** **No**  
Was the Employee Performing Assigned Duties? Yes No

**Lugar donde paso el accidente:** \_\_\_\_\_  
Location Where Injury Occured

**¿Que hacía el empleado durante el accidente?** \_\_\_\_\_  
What was the Employee Doing When Injured?

**¿Como paso el accidente?** \_\_\_\_\_  
How Did Injury Occur?

**¿Con que objeto o substancia se lastimo el empleado?** \_\_\_\_\_  
Object or Substance That Injured the Employee

**Clase de lastimadura:** \_\_\_\_\_  
Type of Injury

**¿En que parte de el cuerpo?** \_\_\_\_\_  
Part of body?

**¿Que clase de tratamiento fue recibido?** \_\_\_\_\_  
What Type of Treatment was Received?

**¿Quién precenció el accidente?** \_\_\_\_\_  
Who Witnessed The Accident?

**¿Fue causado el accidente por alguien mas?** **Si** **No** **Nombre:** \_\_\_\_\_  
Was the Injury Caused by Someone Else? Yes No Name

**¿Fue el accidente involucrado con trabajadores o maquinaria de otra compañía?** **Si** **No**  
Did the Accident Involve Employees or Equipment of Any Other Company? Yes No

**¿Que reglas de prevencion fueron violadas? (Si hubo alguna):** \_\_\_\_\_  
What (if any) Safety Procedures Were Violated?

**¿Es el trabajador un oficial, un companero, o un pariente de el jefe de el trabajo?** **Si** **No**  
Is the Employee an Officer, Partner or Relative of the Employee? Yes No

**Por favor, añada cualquier dato extra en la parte de atras de esta forma.**

**Firma de el supervisor:** \_\_\_\_\_ **Fecha:** \_\_\_\_\_  
Supervisor Signature Date

*Favor de envíar esta forma lo mas pronto posible a: Vensure HR, Inc. Claims 480-993-2653*