



BROADSPIRE WORKERS' COMPENSATION REPORTING FORM - STATE OF COLORADO
 E-mail to nol@choosebroadspire.com

IS THIS AN EMERGENCY CLAIM?	NO
IS THIS A CONFLICT CLAIM?	NO

(* Indicates a Mandatory Field)

* REPORTED BY PERSON'S NAME:							
* TITLE:		* BUSINESS PHONE:		EXT:			
FAX NUMBER:		E-MAIL ADDRESS:					
* DATE OF ACCIDENT: MM/DD/YYYY		* TIME OF ACCIDENT: (HH:MM AM/PM)					
A. LOSS LOCATION INFORMATION							
* DEPARTMENT NAME							
* ADDRESS:							
* CITY, STATE, ZIP:					* COUNTY:		
* BUSINESS PHONE:		EXT.		FAX NUMBER:			
* LOCATION CODE:		POLICY NUMBER:	NOT APPLICABLE - SELF INSURED CLIENT				
NATURE OF BUSINESS:			UNEMPLOYMENT COMPENSATION #:				
* FEDERAL ID NUMBER:	84-0666739			SIC CODE:			
B. LOSS LOCATION INFORMATION							
* LOCATION NAME:							
* DID ACCIDENT OCCUR ON THE INSURED'S PREMISES? (X)	YES		NO				
* IF NO, ENTER PHYSICAL ADDRESS:							
* CITY, STATE, ZIP:					* COUNTY:		
C. INSURED CONTACT INFORMATION							
* WOULD YOU LIKE TO BE THE CONTACT PERSON?: (X)	YES		NO				
IF NO, ENTER CONTACT PERSON NAME:				TITLE:			
CONTACT PHONE:				E-MAIL ADDRESS:			
D. EMPLOYEE INFORMATION							
* SOCIAL SECURITY NUMBER:				* EMPLOYEE NAME:			
* ADDRESS:							
* CITY, STATE, ZIP:					COUNTY:		
RESIDENCE PHONE:			BUSINESS PHONE:		EXT:		
BIRTHDATE: MO/DAY/YR		* AGE:		* SEX: (X)	FEMALE	MALE	
NUMBER OF DEPENDENTS:		* MARITAL STATUS:					
* REGULAR OCCUPATION:			* REGULAR DEPARTMENT:			* CLASS CODE:	
DATE OF HIRE: MM/DD/YY		HIRE COUNTRY:		HIRE STATE:		STATE HIRE DATE: MM/DD/YY	
SUPERVISOR NAME:				BUSINESS PHONE:			
EMPLOYMENT STATUS: (Full/Part Time)			* PAY TYPE: (Weekly, Bi-Weekly, etc.)				
* GROSS WAGES: (Based on Pay Type)							
HOURS WORKED PER DAY?		DAYS WORKED PER WEEK?		HOURS PER WEEK?			

(* indicates a Mandatory Field)

E. LOSS INFORMATION									
EMPLOYEE START TIME: (HH:MM AM/PM)						* DATE EMPLOYER NOTIFIED: (MM/DD/YY)			
* QUESTIONABLE CASE?			YES		NO				
* DESCRIPTION OF ACCIDENT:									
* REMOVED BY AMBULANCE? (X)			YES		NO		UNKNOWN		
* ANY STITCHES/SURGERY REQUIRED? (X)			YES		NO				
* WAS A FATALITY INVOLVED? (X)			YES		DATE		NO		
* DESCRIBE INJURY OR ILLNESS:									
* BODY PART INJURED?:						* INDICATE RIGHT/LEFT SIDE OF BODY:			
* WORK PROCESS INJURED WAS DOING?									
* DIRECT CAUSE: (X)			SPECIFIC INJURY:		OCCUPATIONAL DISEASE OR CUMULATIVE INJURY :				
SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?: (Y/N/U)					SAFEGUARDS OR SAFETY EQUIPMENT UTILIZED?: (Y/N/U)				
* EMPLOYEE ON RESTRICTED DUTY? (X)			YES		NO		UNKNOWN		
* FULL PAY FOR DAY OF INJURY?			YES		NO		UNKNOWN		
* ANY LOST TIME? (X)			YES		NO		UNDETERMINED		
LAST DAY WORKED: MM/DD/YY						START DATE OF DISABILITY:			
DATE RETURNED TO WORK: MM/DD/YY						EXPECTED RETURN TO WORK: MM/DD/YY			
* SALARY CONTINUED DURING DISABILITY?			YES		NO		UNKNOWN		
F. MEDICAL INFORMATION									
* INITIAL TREATMENT? (X) ONLY SELECT ONE			* NO MEDICAL TREATMENT			* MINOR BY EMPLOYER			
			* MINOR HOSP/CLINIC			* EMERGENCY CARE			
			* HOSPITALIZED 24 HRS			* FUTURE MEDICAL/LOST TIME			
			* UNKNOWN						
PHYSICIAN					HOSPITAL INFORMATION				
* NAME:					* NAME:				
ADDRESS:					ADDRESS:				
CITY, STATE, ZIP:					CITY, STATE, ZIP:				
BUSINESS PHONE:					BUSINESS PHONE:				
G. WITNESS INFORMATION									
* NAME:					* NAME:				
ADDRESS:					ADDRESS:				
CITY, STATE, ZIP:					CITY, STATE, ZIP:				
PHONE:					PHONE:				
H. ADDITIONAL CONFIRMATION LETTERS (If different than local business address)									
COMPANY NAME:									
ADDRESS:									
CITY, STATE, ZIP:									
FAX NUMBER:									
I. GENERAL LOSS INFORMATION									
GENERAL REMARKS:									

(* indicates a Mandatory Field)