



ASSOCIATED
CLAIMS
ADMINISTRATORS

Dear Employer:

Associated Claims Administrators (ACA) will be administering your Worker's Compensation claims on behalf of National Liability & Fire Insurance Company and in partnership with North American Risk Services (NARS).

ACA and NARS professionals are experienced in Worker's Compensation Law. Please feel free to call our office with any questions you may have regarding your Worker's Compensation concerns.

Early involvement in a claim is important. It is not only cost effective for you, but it also can help the injured employee get proper medical care and return to work as soon as possible. We look forward to working with to accomplish these goals.

You, the employer, are a vital part of making this happen. Listed below are some things you can do:

1. Report all work-related injuries as soon as you are aware of them.
2. You may report all work-related injuries by email at claims@acaworkcomp.com, fax to **1-800-988-4722**, or call **1-800-388-6268** for assistance reporting a claim.

After reporting your claim, you can contact NARS at **1-800-315-6090** for further assistance with your claim including:

1. Refer all medical authorization requests to NARS.
2. Communicate with your employee and NARS throughout the claim.
3. Have some light duty work available for restricted duty.
4. Advise NARS when the employee returns to work.

Please keep copies of the attached forms to have on hand if needed. Fillable forms can also be downloaded at <https://aiamga.com/workers-compensation/states-covered/>.

We look forward to a long and pleasant working relationship with you and your employees.

Please call anytime between 8:00am and 5:00pm Central Time, Monday through Friday if you have any questions regarding Worker's Compensation claims procedures.

Best regards,

Associated Claims Administrators

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCLUDING ZIP)		CARRIER/Administrator CLAIM NUMBER		OSHA LOG NUMBER		REPORT PURPOSE CODE					
		JURISDICTION		JURISDICTION CLAIM NUMBER							
		INSURED REPORT NUMBER									
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION # (IF AVAILABLE)					
INDUSTRY CODE		EMPLOYER FEIN						PHONE #			
CARRIER/CLAIMS ADMINISTRATOR											
CARRIER (NAME, ADDRESS & PHONE #)			POLICY PERIOD			CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE #)					
			TO								
			CHECK IF APPROPRIATE:								
			SELF-INSURANCE								
CARRIER FEIN			POLICY/SELF-INSURED NUMBER				ADMINISTRATOR FEIN				
AGENT NAME & CODE NUMBER											
EMPLOYEE/WAGE											
NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH		SOCIAL SEC. # (IF THERE IS ONE)		DATE HIRED		STATE OF HIRE		
ADDRESS (INCLUDING ZIP)			SEX		MARITAL STATUS		OCCUPATION/JOB TITLE				
			M MALE F FEMALE U UNKNOWN		U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN		EMPLOYMENT STATUS				
PHONE #			# OF DEPENDENTS		NCCI CLASS CODE						
RATE PER	DAY WEEK	MONTH OTHER	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		YES	NO			
					DID SALARY CONTINUE?		YES	NO			
OCCURRENCE/TREATMENT											
TIME EMPLOYEE BEGAN WORK		AM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		AM	LAST WORK DATE		DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
		PM			CANNOT BE DETERMINED		PM				
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED				
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?			YES	TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE			
			NO								
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED					ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED						
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED					WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED						
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.									CAUSE OF INJURY CODE		
DATE RETURNED TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?				YES	NO		
				WERE THEY USED?				YES	NO		
PHYSICIAN/HEALTH-CARE PROVIDER (NAME & ADDRESS)				HOSPITAL OR OFF-SITE TREATMENT (NAME & ADDRESS)				INITIAL TREATMENT			
								NO MEDICAL TREATMENT			
								MINOR: BY EMPLOYER			
								MINOR: CLINIC/HOSPITAL			
								EMERGENCY CARE			
								HOSPITALIZED > 24 HOURS			
								FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED			
OTHER											
WITNESS(ES) NAME(S) & PHONE #(S)											
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER			

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg.

Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.