Eastern Alliance Insurance Group Claim Reporting Worksheet
24/7 Teleclaim: 1.800.336.3658 / Online: www.easternalliance.com
DO NOT FAX THIS FORM TO US

General Information

Date of loss/injury: _____ Submitter name and title: Tracy Troesch, Business Manager

Submitter phone #: (812) 817-0900

Who is the contact person for the claim?: Tracy Troesch

First Report of Injury distribution:

If you want the First Report of Injury **emailed**, please provide an email address (you can provide up to 2):

tracy.troesch@sedubois.k12.in.us

If you want the First Report of Injury **faxed**, please provide a fax number (you can provide up to 2):

(___) _____ (___) _____

Policyholder Information

Employer mailing address: Southeast Dubois County School Corporation 432 E 15th St Ferdinand, IN 47532

County: Dubois

Physical address if different than mailing address: _____

County: _____

Location code/name where accident occurred: _____

Policy number: 0000140086

Injured Worker Information

Injured Worker's Social Security Number: ___-___-___

Injured Worker's name: _____

Injured Worker's 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 full wages for the day of injury?: _____

Supervisor name and phone #: _____ (___) _____

Accident Information

Did the accident occur on the employer's premises?: _____

If no, provide the accident site's 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 (RTW)? _____ Date Returned: _____

If RTW, is the injured worker working with or without restrictions? _____

If working with restrictions: Will the injured worker lose any wages/hours/benefits?: _____

Please list any work restrictions: _____

_____

Date employer notified of the injury: _____ Name of person notified: _____

Did the injury result in death?: _____

Nature of injury: _____

Body part(s) injured: _____

If applicable: Right/Left/Both (circle one) Finger/Toes (which finger or toe): _____

Cause of injury: _____

Description of accident: _____

Were safeguards or safety equipment provided?: _____

Witness name and phone #: _____ (____) _____

Witness name and phone #: _____ (____) _____

Treatment Information

What type of initial treatment did the Injured Worker receive? _____

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

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

_____ (____) _____

Physician name: _____

Follow-up treatment information: _____

_____

Was a list of medical providers (panel) given to the Injured Worker? _____

Additional Information