Fax Reporting: 1-800-347-8197

Worker's Compensation Fax Template

The following script contains the comprehensive list of questions for your loss report. Asterisks denote information that is critical to proper handling office assignment. Please be sure to obtain this information prior to calling in a claim. Underlined questions are specific to your account.

Preparer Information	
Preparer Name:	**Preparer Phone:**
Filing State: *	**Employee Social Security Number:**
Employee Name:	**Location Address:**
Date of loss:	**Time of loss:**

Employer/Loss Location Information		
Policy Number: * 36WBRE3431	**Account Number:** *	**Location Code:**
Account Name: Ascot Enterprises, Inc.	**Employer Name:** Ascot Enterprises, Inc.	
Address: 503 S. Main St. **City:** Nappanee **State:**IN **Zip Code:** 46550		
Contact Work Phone: 574.773.4158	**FEIN:** 35-1381338	
Location Name:		
Address: **City:** **State:** **Zip Code:**		
Is this the employer's address? (check one) ☐Yes ☐No		

Employee Information			
Job Classification Code:			
Employee Address: **City:** **State:** **Zip Code:**			
Home Phone:	**Work Phone:**	**Alt Phone:**	
Date of Birth:	**Age:**	**Gender:**	**Marital Status:**
Number of Dependents:	**Primary Language:**		
Circle Correct Answer For Each: Is Employee a Partner: ☐Yes ☐No **Owner:** ☐Yes ☐No **Officer:** ☐Yes ☐No			
Supervisor Name:	**Supervisor Phone:**		

Employment Information		
Date of Hire:	**State of Hire:**	**Length of Employment:**
Date in Job:	**Length in Current Job:**	**Employment Status:**

Job End Date:	Hours Per Day:	Days Per Week:
Hours Per Week:	Pay Type:	Hourly Wage:
Daily Wage:	Weekly Wage:	Monthly Wage:

Gross Wages 30 days prior to accident: (AZ only)	
Average Weekly Wage:	Gross Wages 30 Days Prior to Accident:
Time Shift Begins:	Time Shift Ends:
Regular Days Off (check): ☐Mon ☐Tues ☐ Wed ☐Thurs ☐Fri ☐Sat ☐Sun	

Other Payments Not Reported:	Amount:	How Often is Other Payment Received: (Monthly, weekly, other)
Does Employee Consistently Receive Overtime:	Amount:	How is Overtime Payment Paid: (Monthly, weekly, other)

Date Injury Reported to Employer:	Employee Status at Time of Reporting: (CA only)
Date claim form provided to employee: (CA only)	

Loss Information

Loss Description (what was employee doing at time of injury):

Nature of injury:	Fatality Date:

Next Of Kin Information

Next of Kin name:	Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Alt Phone:		
Relationship to Employee:				

Injury Information

Has Employee previously reported a claim:	Loss Date:
Status:	Body Part:
Has Employee missed time from work, or are they expected to? ☐Yes ☐ No	Did Employee receive medical treatment? ☐Yes ☐No
Date returned or expected date to return:	First Date Missed:
Does employee have a Group Health Provider: (OR only)	If yes, name of Group heath provider:
Fifth day incapacity date: (MA only)	

Initial Treatment Information

Initial Treatment:	
Taken by Emergency Transportation? ☐Yes ☐ No ☐Unk	Airlifted/Medivac? ☐Yes ☐No ☐Unk

Facility Name:	Address:	City:	State:	Zip Code:
Phone:	Facility Type:	Treating Physician:		

Type of Medical Treatment Received:		
Admitted to Hospital: ☐Yes ☐No ☐ Unk	**Date Admitted:**	**Still in Hospital:** ☐Yes ☐No ☐ Unk
Intensive Care Unit: ☐Yes ☐No ☐Unk	**Burn Unit:** ☐Yes ☐No ☐Unk	

Additional Treatment

Physician Name:	**Address:**	**City:**	**State:**	**Zip Code:**
Phone:	**Specialty Type:**			
Type of Medical Treatment Received or Expected:				

Incident Information

Time Employee Began Work:	**Time Incident Reported:**
Department Where Injury Occurred:	**Were Safeguards or Safety Equipment provided:** ☐Yes ☐ No ☐ Unk
Were Safeguards or Safety Equipment Used: ☐ Yes ☐ No ☐ Unk	
Is the purpose of this claim a possible Dispute? (LA only) ☐Yes ☐ No ☐ Unk	**OSHA log Number: (UT only)**
Labor and Industrial claim number: (WA only)	**UBI Number (WA only)**
Could the employee have prevented the Accident: (VT only)	**Could the employer prevent this type of accident: (VT only)**

Additional Incident Information

Was a Machine Part Involved:	
Was Machine Part Defective:	**In What Way Was the Machine Defective:**
Is The Claim Questionable:	**Signs of Alcohol or Drug Use:**
Was Employee Engaged in an Unsafe Activity: ☐ Yes ☐ No ☐ Unk	**Describe Unsafe Activity:**

Responsible Party (if applicable)

Responsible Party Name:	**Address:**		
City:	**State:**	**Zip Code:**	**Phone:**

Witness Information (if applicable)

Witness Name:	**Address:**	**City:**	**State:**	**Zip Code:**
Home Phone:	**Work Phone:**	**Alt Phone:**		

Contact Information

Name: Kim Ator	**Address:** 503 S. Main St.	**City:** Nappanee	**State:** IN **Zip Code:** 46550
Work Phone: 574.773.4158	**Alt Phone:** 574.248.1067	**Fax Number:** 574.773.2894	
Email Address: kator@ascotent.com	**Contact Person's Title:** HR/Safety Mgr.	**When To Contact:** 8a-4p	

Additional Information

Jurisdictional Information
(Submit only for applicable states)

Nevada	
How is employee paid: (check one) ☐ Bi-weekly ☐ Monthly ☐ Semi-monthly ☐ Weekly ☐ Other	
Day of week pay period ends: (check one) ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat	
Are scheduled days off rotating: ☐ Yes ☐ No ☐ Unk	If part time, how many hours a week was the employee hired: hrs
How many months has the employee been Employed by the current employer in NV: months	OSHA log number:
Was more than one person injured in the Accident: ☐ Yes ☐ No ☐ Unk	Supervisor that injury or occupational disease was reported to:
Was employee in your employ when the injured or disabled by occupational disease? ☐ Yes ☐ No	Did employee return to next scheduled shift after accident: ☐ Yes ☐ No
Will you have light duty work available if necessary: ☐ Yes ☐ No	Last day wages earned:
Unemployment Compensation received during last 12 months: ☐ Yes ☐ No	If validity of claim is doubted, state reason:
New Hampshire	
Is a NH youth employment certificate on file: ☐ Yes ☐ No	Estimated length of disability:
Number of full time employees:	Number of part time employees:
Is there a written safety program: ☐ Yes ☐ No	Is there an active Safety Committee: ☐ Yes ☐ No
Managed Care Program: ☐ Yes ☐ No	If yes, Managed care provider name:
Texas	
Does Employee speak English: ☐ Yes ☐ No	
If no, native language: ☐ French ☐ German ☐ Italian ☐ Polish ☐ Russian ☐ Spanish ☐ Vietnamese ☐ Korean ☐ Other ☐ Unknown	
Race: ☐ Asian ☐ Black ☐ White ☐ Hispanic	
Tax ID number:	Last paycheck amount:
Last pay period hours worked:	Last pay period days worked:
Accident prevention services requested in past 12 months: ☐ Yes ☐ No	If yes, Accident prevention services received: ☐ Yes ☐ No