Claim Reporting Procedures

Vensure Employer Services, Inc is dedicated to providing the best service possible to our clients.The Claims Department works diligently with our insurance companies to guarantee proper handling of claims and best treatment for injured employees. Workers' Compensation fraud is always a concern, and Vensure will work with our insurance carriers to properly investigate questionable claims. Any employee found to be making false reports in order to obtin benefits

Proper claims handling starts with you. It is imperative that all claims are reported to Vensure 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 or emailed to Vensure within 24 hours of an injury or illness.
2. 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.
3. Employee's Report of Injury: All injuries, no matter how minor the injury, must be reported by the employee to their respective supervisor using this form.

The Report of Injury forms must be completed immediately and sent to Vensure via email or fax. Our email address is: claims@vensure.com and our fax number is: 480-289-6220.

If you have any questions or concerns, please feel free to call Vensure's Claims department or Loss Control.

Claims email address:	claims@vensure.com
Claims fax:	480-289-6220
Claims department:	480-993-2650 option 7 (for Workers' Compensation)
Loss control:	480-993-2650 extension 1313 or 1360

Employer's Report of Injury

Reset Form

Vensure Employer Services

COMPLETE AND FAX OR EMAIL THIS REPORT WITHIN 24 HOURS FROM THE TIME OF ACCIDENT.

2600 W. Geronimo Place, Suite 100, Chandler, AZ 85224 | Fax (480) 289-6220 | Toll Free (800) 409-8958

The clients designated supervisor must notify Vensure (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:** **State:** **Zip:**

Phone Number: **Date of Birth:** **Department:**

History of Claims

Does Employee have any previous Work Comp Claims? ☐ No ☐ Yes. If "Yes" please provide details below such as date of claim and type of injury.

Employer

Current Employer: Vensure Employer Services, Inc. **Company Name:** **Date of Hire:**

Company

Office Address: **Suite:** **City:** **St:** **Zip:**

Phone: **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:**

Can a light duty position be accomodated? ☐ No ☐ Yes

Nature of Injury: **Part of body injured:** **On Company Premises?** ☐ No ☐ Yes

Was claimaint working at your company's client location? ☐ No ☐ Yes

Name/Address/Location of Accident:

Was the employee paid for the day of injury? ☐ No ☐ Yes **Time employee began work:** ☐ AM ☐ PM

Hospital or Clinic Name: **Phone:** **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 completed form to (480) 289-6220 or email to claims@vensure.com

Supervisor's Report of Injury

Reset Form

Vensure Employer Services

Please complete and submit within 24 hours no matter how minor the injury.

Company:

Injured Employee:

Date of Injury: Time of Injury: ☐ AM ☐ PM

Injury reported to: Date reported:

Was the employee paid for a full days work? ☐ No ☐ Yes

Did the employee lose at least one full day of work after the injury? ☐ No ☐ Yes

Date last worked: Time: ☐ AM ☐ PM

Has the employee returned to work? ☐ No ☐ Yes Date:

Was the employee performing assigned duties? ☐ No ☐ Yes

Location where the injury occured:

What was the employee doing when injured?

How did the injury occur?

Object or substance that injured the employee?

Type of injury: Part of body:

What type of treatment was received?

Who witnessed the accident?

Was the injury caused by someone else? ☐ No ☐ Yes Name:

Did the accident involve employees or equipment from any other company? ☐ No ☐ Yes

What (if any) safety procedures were violated?

Is the employee an officer, partner, or relative, of the employer? ☐ No ☐ Yes

Please include any additional comments you feel are important on the other side.

Supervisor's Name (print): _____ Date: _____

Supervisor's Signature: _____

Please fax completed form to (480) 289-6220 or email to claims@vensure.com

Employee's Report of Injury

Reset Form

Vensure Employer Services

Please complete and submit no matter how minor the injury.

Last Name: First Name: M.I. SSN:

Street Address: Apt. City: State: Zip:

Phone Number: Email Address: Date of Birth:

Employer: Job Title: Department:

Injury reported to: Position: Date reported:

Date of injury: Last day worked: Return to work date:

Where did the injury occur?

What were you doing when the injury occured?

How did the injury occur?

What object or substance caused the injury?

Type of injury: Part of body:

What type of treatment was received?

Who witnessed the accident?

Was the injury caused by someone else? ☐ No ☐ Yes Name:

Did the accident involve employees or equipment from another company? ☐ No ☐ Yes

What actions (if any) were taken to prevent similar accidents from occuring?

Have you had a Workers' Comp claim in the last year? ☐ No ☐ Yes If Yes, when:

Have you had a previous injury to this body part? ☐ No ☐ Yes If Yes, when:

Note: *Any person who knowingly provides false, incomplete or misleading information to any party for the purpose of obtaining workers' compensation benefits is guilty of a felony and may be subject to imprisonment, fines and denial of insurance benefits.*

Employee's Name (print): _____ Date: _____

Employee's Signature: _____

Please fax completed form to (480) 289-6220 or email to claims@vensure.com