FRONTLINE HRO

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CLAIMS REPORTING PROCEDURES

Frontline HRO 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 Frontline HRO will work with our insurance carriers to properly investigate questionable found to be making false reports in order to obtain benefits is subject to prosecution.

Proper claims handling starts with you. It is imperative that all claims are reported to Frontline HRO 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

To be completed by a representative of the company and faxed or emailed to risk@frontlinehro.com within 24 hours of an injury or illness.

1. **First Report of Loss (FROL):**
2. **Employee Report of Injury:**
3. **Consent Release of Medical Information**
4. **Employee Refusal of Medical Treatment Form**

*The FROL and Employee Report of Injury forms must be completed immediately and sent to Frontline HRO via email or fax. Our email address is: **risk@frontlinehro.com** and our fax number is: (888) 252-5217. If you have any questions or concerns, please feel free to call Frontline HRO's Risk Department.*

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FIRST NOTICE OF LOSS

Contact Information:

Name of Person Completing this Document: _____

Phone Number: _____ Email: _____

Claims Contact Name if Different from Above: _____

Phone Number: _____ Email: _____

Policy Holder Information:

Policy Holder Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Claims Contact Name if Different from Above: _____

Policy Number: _____ Claims Jurisdiction: _____

Employer Location/Client Company Name: _____

Client/Location Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Injured Employee Information:

Injured Employee First Name: _____

Injured Employee Middle Name: _____

Injured Employee Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____

Work Phone Number: _____

Please email to risk@frontlinehro.com or fax completed form to 888-252-5217.

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FIRST NOTICE OF LOSS

Cell Phone Number: _____

Email: _____

Social Security Number: _____

Date of Birth: _____

Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Unknown

Date of Hire: _____

Occupation: _____

Employment Status: ☐ Regular/Full Time ☐ Part Time ☐ Piece Worker ☐ Seasonal ☐ Volunteer

NCCI Class Code: _____

Wage Rate: _____

Wage Rate Per: ☐ Hour ☐ Day ☐ Week ☐ Commission

Number of Days _____ Worked Per Week: _____

Hours Worked per Day: _____

Will the employee be paid in full for the date of accident? ☐ Yes ☐ No

Will you continue paying the employee? ☐ Yes ☐ No

Claim Information:

Date of injury/illness: _____

Time of injury/illness: _____

Date employer notified of injury/illness? _____

Last day worked: _____

Return to work date: _____

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FIRST NOTICE OF LOSS

Accident Description: _____

_____

Part of body affected: _____

Work process employee was engaged in when the incident occurred: _____

_____

Were safeguards and safety equipment used? ☐ Yes ☐ No

Did accident occur on Insured premises? ☐ Yes ☐ No

Place of accident: _____

Address: _____

City: _____ State: _____ Zip: _____

Is claim questionable? ☐ Yes ☐ No

If so, why? _____

_____

Medical Providers:

- ☐ Initial Treatment:
- ☐ No medical treatment
- ☐ Minor on-site by Employer
- ☐ Minor clinic/hospital
- ☐ Emergency Evaluation
- ☐ Hospitalization

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FIRST NOTICE OF LOSS

Provider #1 Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Diagnosis: _____

_____

Released to return to work: ☐ Yes ☐ No

Work Restrictions: _____

Provider #2 Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Diagnosis: _____

Released to return to work: ☐ Yes ☐ No

Work Restrictions: _____

Witnesses: _____

Witness #1 Name: _____

Is witness a co-worker? ☐ Yes ☐ No

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____

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FIRST NOTICE OF LOSS

Witnesses:

Witness #2 Name: _____

Is witness a co-worker? ☐ Yes ☐ No

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____

Work Phone Number: _____

Cell Phone Number: _____

Additional Notes:

_____

_____

_____

_____

_____

_____

_____

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EMPLOYEE'S REPORT OF INJURY

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 Name (print): _____

Employee Signature:_____ Date: _____

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CONSENT RELEASE OF MEDICAL INFORMATION

Employee

I hereby authorize representatives of Frontline HR to be permitted to obtain and review copies of all medical records related to any current or past injury or related to my medical history. Any pertinent information will be discussed with other professionals involved in my medical treatment and any institution that, through the "Workers' Compensation Program" or otherwise, is paying all or part of the costs associated with my medical care.

Employee's Printed Name: _____

Social Security Number: _____

Telephone Number: _____

Claim Number: _____

Name of Employer: _____

Date of Injury: _____

Employee's Signature : _____ Date : _____

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