UnitedHeartland.com
1-800-258-2667

Report a Claim Form Sample

Report a Claim Form
Here is a sample of the form you will need to fill out at the time of injury. Below is a list of drop-down field options that you will be able to choose from. To report a claim online or access training materials, please go to www.unitedheartland.com. In a case of catastrophic or fatality claims, please contact United Heartland immediately at 800-258-2667.

Fields in Bold Are Required Fields

First Notice of Loss
Date of Injury: ____/____/____ State of Employment: ______

Policyholder Information

OSHA Log Code: ______ If used, this number should agree with the OSHA Log Entry Number

Employee Information

First Name: ___________ Middle Name: ___________ Last Name: ___________
Address: ____________________________________________________________
City: ___________ State: _______ Zip: _______ Country: ___________
Phone Number: (____) ____-____ Birth Date: ____/____/____

Claimant ID type: ___________ (this is a drop-down field) Claimant ID: ___________

Gender: M or F Marital Status: ___________ (this is a drop-down field)
Date of Hire: ____/____/____ State of Hire: __________________

Occupation: __________________ Class Code: __________________
Employment Location Code: ___________ Department Code: ___________
Rate of Pay: _______ Hours Worked per Day: ___________ Days Worked per Week: _______
Gross Wage: _______

Injury Information

Time of Injury: _______ a.m. p.m
Full Pay for Date of Injury: ____ Yes ____ No
Did Salary Continue: ____ Yes ____ No
Last Day Worked: ___________ Will Employee Miss Time from Work? ____ Yes ____ No

Return to Work Date or Expected Return to Work Date: ____/____/____
Date Employer Notified: ____/____/____

Our safety evaluations, reports and recommendations are made solely to assist your organization in reducing hazards and the potential of hazards and accidents. These recommendations were developed from conditions observed and information provided at the time of our visit. They do not attempt to identify every possible loss potential, hazard or risk, nor do they guarantee that workplace accidents will be prevented. These safety evaluations, reports and recommendations are not a substitute for ongoing, well-researched internal safety and risk management programs. This report does not warrant that the property inspected and its operations are compliant with any law, rule or regulation.

United Heartland is the marketing name for United Wisconsin Insurance Company, a member of AF Group. All policies are underwritten by a licensed insurer subsidiary of AF Group.
Cause of Injury/Source: ____________ (this is a drop-down field – find selection online that best fits)
Type of Injury/Illness: ____________ (this is a drop-down field – find selection online that best fits)
Affected Body Part: General: _______ (this is a drop-down field – find selection online that best fits)
Detailed: _______ (this is a drop-down field – find selection online that best fits)
Did Injury Occur on Premises? ___ Yes ___ No
Describe Cause and Nature of Injury:

Witness:
First Name: __________________________ Last Name: __________________________
If fatal, give date of death: ____/____/____
Were Safeguards or Safety Equipment Provided: ___ Yes ___ No
If yes, were they used? ___ Yes ___ No

Treatment Information
Initial Treatment: _________________ (this is a drop-down field – find selection online that best fits)

Physician/Health Care Provider
Name: _________________________________________________________________
Address: _______________________________________________________________
City: _____________________ State: _____ Zip: ________ Country: ______________
Phone Number: (____) _____ - ______

Hospital
Name: _________________________________________________________________
Address: _______________________________________________________________
City: _____________________ State: _____ Zip: ________ Country: ______________
Phone Number: (____) _____ - ______

General Information
Preparer’s
First Name: __________________________ Last Name: __________________________
Phone Number: (____) _____ - ______ Title: __________________________
Email Address: __________________________________________________________
Are you the Claim Contact?: ___ Yes ___ No
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### Drop Down Field Options

**Claimant ID Type:**
- SSN
- Employment Visa Number
- Green Card Number
- Employee ID Assigned by Jurisdiction
- Passport Number

**Marital Status:**
- Single
- Single – Head of Household
- Married
- Married – Filing Separately
- Divorced
- Spouse Deceased
- Common Law Spouse

**Rate of Pay:**
- Hour
- Day
- Week
- Two Weeks
- Twice a Month
- Month
- Year
- Piece Rate
- Mile
- Commission

**Gross Wage:**
- Daily
- Weekly
- Every Two Weeks
- Monthly
- Twice a Month

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### Cause of Injury/Source:

- Allergic Reaction
- Bitten by Animal
- Bitten by Human
- Bitten by Insect
- Caught In/On/Under/Between Object
- Cut, Puncture or Scrape
- Dust, Gases, Fumes or Vapors
- Electrical Current
- Exposure to Body Fluids
- Exposure to Chemicals
- Fall-Different Level
- Fall-Ladder or Scaffolding
- Fall-on Snow or Ice
- Fall-Slip Trip on Same Level
- Fall-Stairs
- Foreign Body in Eye
- Hearing Loss
- Holding or Carrying
- Jumping
- Latex Allergy
- Lifting and Lowering
- Misc-Unknown and/or Insufficient Info
- Motorized Non Licensed Vehicle
- Motor Vehicle
- Needle Stick
- Occupational Disease
- Pushing or Pulling
- Reaching or Bending
- Repetitive Motion
- Resident/Patient – Assisting
- Resident/Patient – Combative
- Resident/Patient – Lifting from Floor
- Resident/Patient – Repositioning
- Resident/Patient – Transfer
- Robbery or Criminal Assault
- Stress
- Struck by/Against Object
- Struck by Human
- Temperature Extremes
- Using Tool or Machine
- Walking/Running (non specific)
- Welding Operation

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