|  |  |
| --- | --- |
| \*Blackboard Customer Care on behalf of Argo | \***Contract Number: *9369*** |
| ***Reporter Information*** |
| \*First Name:       | \*Last Name:       |
| Title:       | \*Phone:       | Ext:       |
| ***Location Information*** |
| \*Insured Name:        |  |
| Street Address:       |
| City:       | State:       | Zip Code:       |
| Phone Number        | Email:       |
| Is this for reporting purposes only? Yes [ ]  No [ ]   |
| \*Is this the Loss Location? Yes [ ]  No [ ]   |  |
| Did the incident occur on Employer’s premises? Yes [ ]  No [ ]   |
| ***Loss Location (If different from above)*** |
| \*Loss Location Name:        |
| Street Address:       |
| City:       State:       Zip Code:       |
| Phone Number:       |
| ***Claimant Information*** |
| Employee ID #:        | \*First Name:       | MI:       | \*Last Name:       |
| Home Phone:       | Work Phone:       | Ext:       |
| Home Address:       |
| City:       | State:       | Zip Code:       |
| Email Address:       | SSN:       | Primary Language:  |
| Date of Birth:       | Marital Status: |  | Gender:  |
| ***Claimant Employment Information*** |
| Employee Title:        | Department:       |
| Status:  |
| Full/Part Time: Full Time [ ]  Part Time [ ]  | Date of Hire:       | Date of Termination:       |
| Wage Amount:       | Frequency:  |
| Hours Per Day: | Mon       | Tue       | Wed       | Thur       | Fri       | Sat       | Sun        |
| ***Claimant Supervisor Information*** |
|  First Name:       | MI:       | Last Name:       |
| Title:       | Email Address:       |
| Phone:       | Ext:       |
| Do you question the validity of this claim? Yes [ ]  No [ ]   |
| ***Incident Information*** |
| \*Date of Incident:       | \*Time of Incident:       | AM [ ]  | PM [ ]  | \*Date Employer Notified:       |
|  Department Where Injury Occurred:       |
| \*Incident Description:       |
| Safeguards/Safety Equipment Provided? Yes [ ]  No [ ]   | Safeguards/Safety Equipment Used? Yes [ ]  No [ ]  |
| Cause: Choose an item. |
| Body Part: Choose an item. |
| Nature: Choose an item. |
| ***Medical Information*** |
| Facility Name:       |
| Street Address:       |
| City:       | State:       | Zip Code:       |
| Phone:       | Ext:       |
| Initial Treatment:  | Plan to seek future medical treatment? Yes [ ]  No [ ]  |
| Transportation Type:  | Date admitted to hospital:       |
| Physician Name:       |
| Street Address:       |
| City:       | State:       | Zip Code:       |
| Phone:       | Ext: |
| ***Witness Information*** |
| Name:       |
| Street Address:       |
| City:       | State:       | Zip Code:       |
| Phone:       | Ext:       |
| ***Lost Time Information*** |
| Will Claimant Miss Work Beyond Date of Injury?  |
| Last Date Worked:       | Returned to Work Date:       |
| If Employee did not return to work, anticipated Return to Work Date:       |
| Salary Continued:  |
| ***Escalation:*** Choose an item. |
| ***Contact Information*** |
| \*First Name:       | MI:       | \*Last Name:       |
| \*Phone:       | Ext:       | Email Address:       |
| ***Comments/Remarks:***  |

\*Indicates mandatory fields that must be completed in order accept a claim. However, in order to best process your request, please provide as much information as possible.