Eastern Alliance Insurance Group Claim Reporting Worksheet
Report 24/7 through Teleclaim: 1.800.336.3658 or online: www.EasternAlliance.com
DO NOT FAX OR EMAIL THIS FORM TO US (FOR INFORMATION GATHERING PURPOSES ONLY)

Injury Information

*Date of loss/injury: _____ *Jurisdiction/State Injured Worker was hired: _____

Time of Injury_____

Injured Worker-Personal/Wage Information

*Injured Worker's name: _____

**Birth date: ____/____/_____ **Injured Worker's Social Security Number: _____-____-_____

**Injured Worker's mailing address: _____

**Hire date: ____/____/_____ Gender: _____ Marital status: _____ Primary Language_____

Job Title:_____

Employee Status (Full-time/Part-time)_____

**Injured Worker's phone # with area code: (____) _____

Injured Worker's Email_____ # of dependents: _____

**Days Worked Per Week _____ **Hours Worked Per Day_____

**Full Wages Paid for Date of Injury? (Yes/No/Unknown)_____ Did Salary continue?_____

*Location where injured worker reports to/works :_____

*Class Code: _____

Department (location code):_____ Sub Department_____

Occurrence -Accident Information

Last Day Worked: ____/____/_____ Employer first knowledge of Injury Date ____/____/_____

Claim Administrator First Knowledge of Injury Date ____/____/_____

Initial Date Disability Began ____/____/_____ Employer Knowledge of Disability Date ____/____/_____

Preexisting Disability? Y/N

*Nature of Injury:_____

*Part of Body Injured:_____

Part Injured Location (L/R/Bilateral):_____Finger/Toe:_____

Address where accident occurred: _____

Accident Site Narrative (any additional information):_____

*Accident/Injury Description:_____

*Cause of Injury (drop-down online): _____

Injury Severity (drop-down online):_____

**Initial Return to Work Date:_____

Initial Return to Work Type:_____

Initial Return to Work Physical Restriction (Y/N):_____

Restrictions:_____

Initial Date of Lost Time:_____ Date of Death: _____

*Death Result of Injury (Y/N):_____

*Accident Result on Employer Premises (Employer/Lessee/Other):_____

Describe the events that caused the injury:_____

Object that directly injured the employee:_____

Activity the employee was engaged in when event occurred:_____

Additional comments about accident:_____

Witness Name and phone number (up to 3):_____

Supervisor Name and phone number:_____

Treatment Information

Provider:_____

Provider Address:_____

Provider Phone:_____

Hospital:_____

Hospital Phone:_____

*Initial Treatment (drop-down online):_____

Follow-Up Treatment:_____

Was Panel Provided (Y/N)? _____

Hospital Address:_____

Contact Information

Preparer Name and email:_____

Preparer Work Phone:_____ *Is Preparer the contact (Y/N):_____

Contact Name:_____

Contact Phone:_____ Contact Email:_____

Contact Title:_____

Insured Comments:_____