



OCCUPATIONAL ACCIDENT WELCOME KIT

OccuSafe by Trawick Occupational Accident Program

Welcome!

Gallagher Bassett is your claims administrator. When accidents do occur, the faster Gallagher Bassett receives notice of a loss, the sooner we can:

- Provide you with the best possible medical care.
- Compensate you for lost wages (when applicable).

Prompt notification of the loss information through Gallagher Bassett's dedicated toll- free reporting lines addresses the immediate needs of your occupational accident.

Our services will:

- Verify premium to ensure that premium is paid and coverage is in effect.
- Loss information will be sent to the Platform.
- A letter will be sent to the insured with a Proof of Loss form.
- Pay Benefits.

Enclosed is the following information:

1	Summary of Our Services.	Page 3
2	Toll-free Claims Reporting Quick Reference Sheet: a general list of questions that will be asked when reporting a claim.	Page 4
3	Sample Proof of Loss Claim Reporting Form	Page 5
4	Claim Handling Branch information, where to call with questions or comments on specific claims.	Page 7

Summary of Services

LOSS REPORTING

- A single toll free call to **(833) 226-3371**.

PREMIUM VERIFICATION

Premium verification is sent to the broker to ensure that premium is paid and coverage is in effect. The loss information request is sent to the motor carrier unless the broker wishes to complete after verifying with the motor carriers.

CLAIM FORMS

- A letter is sent to the insured with the claims forms. The letter explains the information that we require for settlement history or proof of income if they are going to be disabled past the waiting period. If a claim forms are sent by mail, a return envelope is enclosed. These claim forms can be faxed or emailed to the insured and returned by fax or email if requested.

If we have not received the claim form within 30 days, another medical form is sent to the insured with a letter stating that we cannot process their claim without it. If 30 more days elapse, a final request is sent. After 30 more days, the insured is notified that they will be responsible for the bills and the medical providers are notified.

CLAIM PROCESSING

- The loss information request, premium verification, and claim form(s) must be in our file before any benefits can be paid. In some instances, medical records must be received before a claim can be considered.

Telephonic Claim Reporting

Toll-free Claims Reporting Quick Reference Sheet for Occupational Accident Claims

(833) 226-3371

To report your occupational accident claim quickly and efficiently, please have the following information ready when you call your toll-free claims reporting service. This is a general listing for your quick reference. Additional information may be requested based on state requirements. Thank you for your prompt claims reporting!



CLIENT INFORMATION

- Insured Name and DBA (doing business as name)
- Owner/Operator Address

CLAIMANT INFORMATION

- Owner Operator name
- Social security number
- Address and home phone number
- Date of lease
- Income Verification

ACCIDENT INFORMATION

- Exact date and time of injury
- Exact location or site code where injury occurred
- Specific description of injury (i.e., employee slipped and fell on wet floor in warehouse)
- Name and address of claimant's physician
- Name and address of hospital

Please send completed form to:
 GB/CMC
 Post Office Box 419797
 Kansas City, MO 64141
 Telephone: 1-833-226-3371
 Fax: 1-866-486-5243

OCCUPATIONAL ACCIDENT PLAN CLAIM FORM / WRITTEN PROOF OF LOSS

PLEASE COMPLETE ONE CLAIM FORM PER ACCIDENT

CMC

Section A

1. Claimant Information	Contracting Company	Unit# (if applicable)				
	Claimant's Information	Last Name	First Name	Initial	Social Security No. - -	
		Home Address			Birth Date	Month / Day / Year
		City	State	Zip	Telephone No. - -	

2. Other Insurance	Complete if you are covered under any other insurance plan	Other Plan Name Insurance Company Name and Address City	Identification Policy No. State
			Zip

3. Physician Information	Name and Address of Physicians	Family Physician
		Current Treating Physician

4. Accident Details	Give Complete Accident Details	Is claim due to an Accident? <input type="checkbox"/> or an Illness? <input type="checkbox"/> If "accident" where did the accident occur?	Accident Date of
		Describe Accident - What happened?	Describe All Injuries:

Section B

1. Disability Information	Complete only if you have been disabled by a physician	1. Have you ever had a similar injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", when?
		2. Describe the duties of your job?
		3. What was your last day worked?
		4. When did you first treat with a physician?
		5. On what date did you return to any job duties of an occupation?

2. Must be signed and date by Claimant	Read and complete authorization to release medical and insurance information.	To any physician, medical practitioner, hospital, clinic or other medically related facility or provider of medical services or supplies, and any group policyholder or insurer, I authorized you to release to GB or its representatives any and all information you may have about the mental and physical history, condition and treatment and insurance coverage for the Claimant named in Section B above. I further authorize any company to release any driving or business records to GB. I understand the information obtained by GB will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by GB to any person or organization EXCEPT to reinsuring companies, Medical Information Bureau, Inc. Group Policyholder, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required as I may further authorize. For the purpose of disclosing information, I understand this authorization is given in connection with a claim for medical benefits, disability or life insurance benefits. I understand that it is valid for the duration of the claim. A photocopy of this authorization shall be as valid as the original.
		Claimant's Signature _____ Date _____ <small>Month / Day / Year</small>

I hereby certify the above statements are true and correct, to the best of my knowledge.

 Signature Date

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

IF UNABLE TO WORK, THIS SECTION IS TO BE COMPLETED BY YOUR TREATING PHYSICIAN

**OCCUPATIONAL ACCIDENT PLAN
INITIAL ATTENDING PHYSICIAN'S STATEMENT
SECTION C**

Patient's Name: _____ Date of Birth: _____

Height: _____ Weight: _____

1 **Objective** Diagnosis _____

2 Is claim for accident or sickness? Accident Sickness

3 If accident, do you have any knowledge as to how accident occurred? (If Yes, please describe). Yes No

4 When did symptoms first appear or accident happen? Date _____, 20__

5 When did patient first consult you for this condition? Date _____, 20__

6 Has patient ever had same or similar condition? (If yes, state when and describe) Yes No

7 Hospital name and dates confined: _____ from _____, 20__ to _____, 20__

8 Nature of surgical procedure, if any (Describe fully).
Date surgery performed? _____, 20__
Where performed? _____
If in hospital, inpatient outpatient

9 Give dates of treatment: Office _____
Hospital _____

10 Is patient still under your care for this condition? If discharged, give date. Yes No

11 List the dates the patient will be totally disabled? (Unable to do one or more duties of their own occupation) Disabled from _____, 20__ to _____, 20__

12 Is condition due to injury arising out of patient's work? (If yes, please describe): Yes No

13 Are you this patient's family physician? (If no, please list the family physician's name and address) Yes No
Name: _____
Address: _____

14 PROGNOSIS (Including expected return to work date):

Date _____, 20__ Signed _____
Attending Physician

Phone #: _____ Social Security or Tax ID Number: _____

Street Address _____ City or Town _____ State _____ Zip Code _____

If you have questions, or the insured has a question, please contact our office, the following people can assist you:

BRENDA CULLINAN	816-216-5200	BRANCH MANAGER
HARRY DAWSON	816-216-5201	SUPERVISOR
ILDA MIRANDA	816-216-5205	SUPERVISOR
JAY ANDERSON	816-216-5202	CLAIMS LEAD
TISHA JOHNSON	816-216-5207	SR. RESOLUTION MANAGER

We **GUIDE** those suffering a loss to the best outcomes
for their health and financial wellbeing.

We **GUARD** our clients' assets as the trusted stewards of their claims
and risk management programs.

We **GO BEYOND** expectations in the continuous pursuit of a better way.



The 2850 Golf Road, Rolling Meadows, IL 60008-4050 (630) 773-3800 |
www.gallagherbassett.com

Gallagher Bassett is the premier provider of global claims services, dedicated to exceptional customer service and demonstrably superior outcomes. GB helps people, teams and businesses overcome adversity and loss through the guiding expertise of over 5,000 claims professionals, all committed to going beyond expectations in the continuous pursuit of a better way.

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