VenSure
Employer Services

Claims Reporting Procedures

Vensure Employer Services, 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 Vensure will work with our insurance carriers to properly investigate questionable claims. Any employee 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 Vensure 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

1. **Employer's Report of Injury:** To be completed by a representative of the company and faxed or emailed to Vensure within 24 hours of an injury or illness.

2. **Supervisor's Report of Injury:** All supervisors must have access and know the procedures for completing this form and submitting it to the right person.

3. **Employee's Report of Injury:** All injuries, no matter how minor the injury, must be reported by the employee to their respective supervisor using this form.

The Report of Injury forms must be completed immediately and sent to Vensure via email or fax. Our email address is: claims@vensure.com and our fax number is: 480-289-6220.

If you have any questions or concerns, please feel free to call Vensure's Claims department or Loss Control.

Claims email address:	claims@vensure.com
Claims fax:	480-289-6220
Claims department:	480-993-2650 option 7 (for Workers' Compensation)
Loss control:	480-993-2650 extension 1313 or 1360

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Reset Form

IMPORTANT
To be completed by Employer

Employer's Report of Injury

Complete and fax or email this report within 24 hours from the time of accident.

4140 E. Baseline Rd., Suite 201 • Mesa, AZ 85206 • Phone: (480) 993-2650 • Fax (480) 289-6220 • Toll-Free 1-800-383-5403

The clients designated supervisor must notify Vensure (on this form) of every injury or disease suffered by an employee, arising out of and in the course of employment.

Please fill out this form by clicking on the fields and typing the appropriate information on each line.

Employee

Last Name: _____ First Name: _____ M.I. ____ SSN: _____

Street Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Date of Birth: _____ Department: _____

History of Claims

Does Employee have any previous Work Comp Claims? ☐ No ☐ Yes If "Yes", please provide details below such as date of claim and type of injury. _____

Employer

Current Employer: Vensure Employer Services, Inc. Company Name: _____ Date of Hire: _____

Company Information

Office Address: _____ Suite: _____ City: _____ St: _____ Zip: _____

Phone: _____ Fax: _____ Nature of Business: _____

Accident

Date of Injury: _____ Hour of Injury: _____ AM ☐ PM ☐ Date Employer Notified: _____

Last Day Worked: _____ Date Returned to Work: _____ Class Code: _____

Employees Occupation (Job Title) When Injured: _____ Department: _____

Can a light duty position be accomodated? ☐ No ☐ Yes

Nature of Injury: _____ Part of body injured:_____ On Company Premises? ☐ No ☐ Yes

Was claimaint working at your company's client location? ☐ No ☐ Yes

Name/Address/Location of Accident: _____

Was the employee paid for the day of injury? ☐ No ☐ Yes Time employee began work: _____ ☐ AM ☐ PM

Hospital or Clinic Name: _____ Phone: _____ City: _____ St: ____ Zip: _____

If validity of Claim is Doubted, State Reason: _____

Cause of Accident

How Did Accident Happen? _____

Specify Machine, Tool, Substance, or Object most closely connected with Accident: _____

What was Employee doing when Accident occurred? _____

If another person not in Company Employ
caused the Accident, give name and Address: _____

Please fax completed form to (480) 289-6220 or email to claims@vensure.com

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Supervisor's Report of Injury

Please complete and submit within 24 hours no matter how minor the injury.

Company: _____

Injured Employee: _____

Date of Injury: _____ Time of Injury: _____ ☐ AM ☐ PM

Injury reported to: _____ Date reported: _____

Was the employee paid for a full days work? ☐ No ☐ Yes

Did the employee lose at least one full day of work after the injury? ☐ No ☐ Yes

Date last worked: _____ Time: _____ ☐ AM ☐ PM

Has the employee returned to work? ☐ No ☐ Yes Date: _____

Was the employee performing assigned duties? ☐ No ☐ Yes

Location where the injury occured: _____

What was the employee doing when injured? _____

How did the injury occur? _____

Object or substance that injured the employee? _____

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 any other company? ☐ No ☐ Yes

What (if any) safety procedures were violated? _____

Is the employee an officer, partner or relative of the employer? ☐ No ☐ Yes

Please include any additional comments you feel are important on the other side.

Supervisor Name (print): _____ Date: _____

Supervisor Signature: _____

Please fax completed form to (480) 289-6220 or email to claims@vensure.com

VENSURE
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Reset Form

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: _____

Please fax completed form to (480) 289-6220 or email to claims@vensure.com