To report a claim, please call: (844) 430 – 0811 or email: ADOIClaims@tnwinc.com

*Note: Any question with an asterisk (\*) is required information.*

|  |
| --- |
| Client Information |
| GB Client Number | 000059 |
| Client Name | Archdiocese of Indianapolis |
| VDN Number | 2228377 |
| Date and Time of Accident |
| \*Incident Date | Enter date. | Incident Time | Enter time.  |
| \*Employer Notified Date | Enter date. |
| Client Location |
| \*Location Code | Enter Location Code. |
| \*Client Name | Enter Client Name. |
| Street Address | Enter Street Address. |
| City | Enter City. | \*State | Choose State. | ZIP | Enter ZIP. |
| Phone Number | Enter phone #. |  |
| Submitter/Preparer Information |
| Name | Enter Name. |
| Title | Enter Title. |
| Phone Number | Enter Phone #. |
| Email Address | Enter Email. |
| Claimant Information |
| \*Social Security Number | Enter SSN. |
| \*First Name | Enter First Name. | Middle Initial | Enter Initial. |
| \*Last Name | Enter Last Name. |  |
| Home Phone | Enter Phone #. | Work Phone | Enter Phone #. |
| Street Address | Enter Street Address. |
| City | Enter City. | State | Choose State. | ZIP | Enter ZIP. |
| Email Address | Enter Email. | Cell Phone | Enter Phone #. |
| Date of Birth | Enter date. | Marital Status |  | Choose... |
| Gender | Choose... |
| Employment |
| Occupation | Enter text. |
| Employment Status | Enter text. |
| \*Date Hired | Enter date. |
| Wages |
| Amount | Enter amount. |
| Frequency | Enter frequency (hourly, salary, etc.) |
| Incident Information |
| \*Detailed Description of Incident | Enter Description. |
| Part and side of Body | Enter Part and side of Body. |
| Injury Type | Enter Injury Type. |
| Cause of Injury | Enter Cause of Injury. |
| Date Last Worked | Enter date. | Date Returned to Work | Enter date. |
| Date of Death (if applicable) | Enter date. |
| Medical Provider *(Only if medical treatment rendered)* |
| Hospital/Clinic Name | Enter text. |
| Street Address | Enter Street Address. |
| City | Enter City. | State | Choose State. | ZIP | Enter ZIP. |
| Phone Number | Enter Phone #. |
| Doctor Name | Enter Name. |
| Street Address | Enter Street Address. |
| City | Enter City. | State | Choose State. | ZIP | Enter ZIP. |
| Phone Number | Enter Phone #. |
| GB Questions |
| \*Was outside medical treatment provided for the injured worker? | Enter text. |
| \*Will the injured worker lose time from work other than the day of injury? | Enter text. |
| \*For which state are payroll taxes withheld for the employee? | Choose State. |
| Accident Location *(Enter SAME, if same as reporting location)* |
| Location Name | Enter Location Name. |
| Street Address | Enter Street Address. |
| City | Enter City. | \*State | Choose State. | ZIP | Enter ZIP. |
| Client Premises? | Choose... |
| Contact Information |
| \*First and Last Name | Enter Name. |
| \*Phone | Enter Phone #. |
| Additional Dissemination Information |
| Who should receive an email confirmation for this loss? | Enter text. |
| Email Address | Enter Email. |
| Notes/Additional Comments *(ie, if there were witnesses or if this is for report only)* |
| Additional Remarks | Enter text. |
|  |
| NOTE: Please advise if this was a vehicle accident, should an Auto Loss be entered from this loss information? | Choose... |
|  |