Associated Claims Administrators

Dear Employer:

Associated Claims Administrators (ACA) will be administering your Workers' Compensation claims on behalf of National Liability & Fire Insurance Company and in partnership with North American Risk Services (NARS).

ACA and NARS professionals are experienced in Workers' Compensation Law. Please feel free to call our office with any questions you may have regarding your Workers' Compensation concerns.

Early involvement in a claim is important. It is not only cost effective for you, but it also can help the injured employee get proper medical care and return to work as soon as possible. We look forward to working with you to accomplish these goals.

You, the employer, are a vital part of making this happen and listed below are some things you can do:

- Report all work related injuries as soon as you are aware of them. Our toll-free fax number is 1-800-988-4722.
- You may report all work-related injuries by email at claims@acaworkcomp.com, or call 1-800-388-6268 for assistance reporting a claim.

After reporting your claim, you can contact NARS at 1-800-315-6090 for further assistance with your claim including:

- Refer all medical authorization requests to NARS.
- Communicate with your employee and NARS throughout the claim.
- Have some light duty work available for restricted duty.
- Advise NARS when the employee returns to work.

Please keep copies of the attached forms to have on hand if needed.

We look forward to a long and pleasant working relationship with you and your employees.

Please call anytime between 7:00am and 5:00pm Central Time, Monday through Friday if you have any questions regarding Workers' Compensation claims procedures.

Thank you.

Sincerely,

Associated Claims Administrators

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCLUDING ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION # (IF AVAILABLE)

INDUSTRY CODE | EMPLOYER FEIN | PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE #)

POLICY PERIOD TO

CHECK IF APPROPRIATE: SELF-INSURANCE ☐

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE #)

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SEC. # (IF THERE IS ONE) | DATE HIRED | STATE OF HIRE: LOUISIANA

ADDRESS (INCLUDING ZIP)

SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN

MARITAL STATUS: ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE # | # OF DEPENDENTS | NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK: ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE: ☐ CANNOT BE DETERMINED ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL. | CAUSE OF INJURY CODE

DATE RETURNED TO WORK | IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH-CARE PROVIDER (NAME & ADDRESS) | HOSPITAL OR OFF-SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT:
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR: BY EMPLOYER
- ☐ MINOR: CLINIC/HOSPITAL
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED > 24 HOURS
- ☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

WITNESS(ES) NAME(S) & PHONE #(S)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER