OLD REPUBLIC

Old Republic Residual Markets

Claim Report Form

Instructions

Complete the form as thoroughly as you can with the information you have. Do not delay reporting due to lack of information. Email the completed form to ORMARKS@Lodestar.com or fax it to 888-329-2721.

Employee SSN: _____

Employee Full Name: _____

Employee Sex: ☐ Male ☐ Female

Employee Birthdate: _____

Employee Phone Number: _____

Employee Email Address: _____

Employee Mailing Address: _____

Employee Marital Status: ☐ Married ☐ Unmarried

Employee Number of Dependents: _____

Employee Job Title/Occupation: _____

Employee Date of Hire: _____

Employee Number of Hours Worked Per Day: _____

Employee Number of Days Worked Per Week: _____

Employee Rate of Pay: $_____Hourly $_____Weekly $_____Monthly $_____Annually

Employer Legal Name: _____

Employer Doing-Business-As Name (if any): _____

Employer Mailing Address: _____

Employer Contact Name & Phone Number: _____

Employer FEIN: _____

Policyholder Name: _____

Policy Number: _____

Time Employee Began Work on Date of Injury: _____

Date of Employee Injury: _____

Date of Death (if fatal injury): _____

Time of Injury: _____

Location of Injury (including address): _____

Description of Accident: _____

_____

_____

Nature of Injury (e.g., fracture, sprain, laceration, etc.): _____

Parts of Body Injured: _____

Extent of Medical Treatment: _____

Name of Treating Physician: _____

Name & Address of Treating Hospital or Medical Facility: _____

_____

Tools/Equipment Involved in Accident (if any): _____

Names & Phone Numbers of Any Witnesses: _____

Date Employer Notified of Injury: _____

Is Injured Worker Losing Any Time From Work? ☐ Yes ☐ No

First Date of Any Lost Time: _____

Date Employer Notified of Lost Time: _____

Return-to-Work Date (if applicable): _____

Name, Phone Number & Email Address of Person Completing This Form: _____

_____

_____

Any Additional Comments or Information You Feel May Be Helpful: _____

_____

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