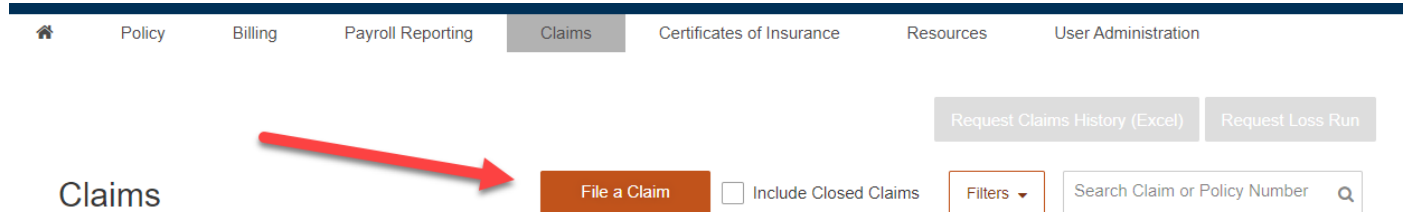


Filing a Claim

Last Updated February 1, 2022

To file a new notice of loss on a workers' compensation policy, select the File a Claim button from the Claims page.



By default, the system will populate today's date and the policies in effect at the time of loss. You may adjust the date and time by clicking on the calendar icon:

New Claim

To expedite your experience, complete an [Employer's Report of Injury](#) (select Resource: Claims Kit for your state) prior to this online submission. This system will not produce a completed Employer's Report of Injury for submission to the state.

Date of loss?

When did loss occur?

08/30/2021

Use the calendar icon through the submission to find date



If there is another claim in the system within 72 hours of the time entered, a warning message for possible duplicate will appear. You may check your open claims on the home screen or ignore the message to continue.



First Report of Injury – Completed Previously

The system will now ask if an Employer’s First Report of Injury has been completed. If yes, the system will allow the user to upload the document and complete a minimized set of questions. [Completing an Employer’s First Report of Injury before submitting the claim online will expedite the reporting process.](#) A link is provided to the state form.

If the report has been completed, answer “Yes” and click the Upload Document button.

Claim Information

Select Policy

What

Injury

Where

Additional Information

Contact Details

Summary

New Claim

Have you completed an [Employer’s First Report of Injury](#) (select Resource: Claims Kit for your state)? *

Yes

No

* please upload the document

Upload Document

Valid document types are PDF, JPG, WAV, BMP, PNG.

Once uploaded, your document will be renamed “Web Document” and will be acknowledged by a blue icon onscreen. Please note that date/time formats must be followed exactly as the default. To prevent error, use the calendar icon to select the appropriate date, rather than overwriting the text provided.

Describe what happened

Date you were notified *

08/27/2021

Use the calendar icon throughout the submission to find date



Continue to enter information about the incident and click the Next button to continue. Questions with an orange asterisk require a response.

Injury Details

Do you doubt the validity of the injury/illness?
*

Yes

No

Lost time from work? *

Yes

No

Medical Treatment

Did injured worker seek medical attention? *

Yes

No

Cancel

Instructions

Previous

Next

Some responses will require additional information:

Work Status

Work Status *

Working - No Restrictions

Start Date *

MM/DD/YYYY

Comments

You may select a location of the business listed on the policy or create a new one:

Where did this happen?

Injury Location *

City *

ZIP Code *

State *

-- Enter New Location --

-- Enter New Location --

6432 E Dale Ln, Cave Creek, 85331, AZ

1069 N Lakepoint Way, flagstaff, 86004, AZ

1108 E Meadowmoor Dr, Pueblo West, 81007, CO

1111 E Dale Ln, Cave Creek, 85327, AZ

-- Choose State --

Additional information related to the incident can be uploaded to the file. Once uploaded, a document cannot be deleted.

After entering all information, a summary screen will appear with primary information that was input (name of injured worker, date of injury, injury location, and description of event). A claim number will be generated, along with contact information of the assigned adjuster.



You have successfully submitted this claim.

Claim Summary			
Injured Worker:	Demo InjuredWorker	Claim Number:	1000035543
Date of Injury/Loss:	08/26/2021	Adjuster Name:	Shelli Tickle
Injury Location:	1234 California St, Los Angeles, CA 90001	Adjuster Phone:	1 818-575-8579
Description of how the injury/illness occurred:	Employee was testing and ended breaking his test.		

Your CopperPoint team thanks you for your business. You can expect to receive a call from your adjuster concerning this claim within 2 business days.

Back to Homepage

Print Confirmation



First Report of Injury – Not Completed

A loss may be reported without first completing an Employer's First Report of Injury.

There will be similar screens, plus areas to describe the injury and provide additional demographic information about the injured employee.

A section for affected body part(s) is also added. In this section, enter detailed information about each body part:

Affected Body Part(s)

Add Body Part

Body Part #1

Area of Body *

-- Select Area of Body --

Body Part *

-- Select Body Part --

Side

-- Select Side --

Dominant

-- Select Dominant --

If medical care was provided, complete these fields:

Medical Treatment

Did injured worker seek medical attention? *

Yes

No

Facility or Doctor's Name where treatment sought

Facility or Doctor's Address where treatment sought. Include address, city, state, zip

Phone Number of Facility or Doctor who provided treatment

__-__-__

Examination Date

MM/DD/YYYY



There is also a section to provide optional witness information:

Witnesses or Other Involved Parties

Add Party ▾

FIRST NAME *	LAST NAME *	INVOLVEMENT	PHONE NUMBER	REMOVE
<input type="text"/>	<input type="text"/>	<div>Witness ▾</div>	<input type="text"/>	

The summary page will provide the same information, and the report is complete.