ECM CLAIM REPORTING KIT

(ECM Client Name),

Detailed below you will find a quick summary of your primary insurance carriers and claim reporting contact information. This may not be a complete list of your coverages. If you have questions about coverages not included on this list, please contact your ECM representative. When you call the insurance company with the claims information, they will generally complete the forms that we have provided in this kit for you. Having the forms allows you to know what information they will be requesting. At the time you report any loss, be prepared to furnish the following information:

- Date and time of loss
- Location/Condition
- Complete description of loss
- Names, addresses and phone number of drivers, persons injured or owners/managers of damaged property
- Vehicle description (year, make, model, VIN); Property location (full address); or Equipment description (model/serial #)
- Any witnesses (including names, addresses, phone number)
- The nature of the injuries or damages

POLICY TYPE	*POLICY TERM*	*POLICY #*	*CARRIER*
Business Auto	**7/1/2020** **7/1/2021**	**46CSES528**	***Hartford Insurance Company** **Phone: 800-327-3636** **Email: lossconnect@thehartford.com**
Work Comp (all states except TX)	**7/1/2020** **7/1/2021**	**46WEAD1**	***Hartford Insurance Company** **Phone: 800-327-3636** **Email: lossconnect@thehartford.com**
Property	**3/1/2021** **3/1/2022**	**CPP 1079201**	**Zurich** Phone: 800-987-3373 Fax: 877-962-2567 Email: usz_carecenter@zurichna.com
General Liability/ Liquor	**7/1/2020** **7/1/2021**	**46CS52890**	***Hartford Insurance Company** **Phone: 800-327-3636** **Email: lossconnect@thehartford.com**

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Cyber	**8/16/2020** **8/16/2021**	**D953266**	**Contact your ECM claims advocate**
Crime	**8/16/2020** **8/16/2021**	**8248151**	**Contact your ECM claims advocate**
Directors and Officers, Employment Practices Liability, Fiduciary	**8/16/2020** **8/16/2021**	**MAP3000122**	**Contact your ECM claims advocate**

If you have any questions, please contact your ECM claims team:

Addie Whitten whitten@ecmins.com 704-594-1578

Megan Anderson anderson@ecmins.com 704-594-2062

Wanda Pegues pegues@ecmins.com 704-227-3129

If this is a catastrophic loss or fatality, please contact a member of your ECM Team in addition to immediately reporting it to the carrier.

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WORKERS' COMPENSATION CLAIM INSTRUCTIONS

ALL ACCIDENTS AND INCIDENTS INVOLVING AN EMPLOYEE MUST BE IMMEDIATELY INVESTIGATED, DOCUMENTED AND REPORTED.

WHEN AN EMPLOYEE INJURY OCCURS:

- In the event of a medical emergency, involving life threatening injuries, call 911 immediately
  - Secure the scene to prevent further exposure and calm the employee.
  - Contact HR and the Department manager
  - Contact the injured employee's family or emergency contact.
- For non-emergencies: Arrange for immediate, proper and efficient medical care for the employee.
  - Provide caring, non-judgmental response to injured worker
  - Arrange for employee transport to the medical provider
- Thoroughly ***investigate*** every incident
  - Secure the scene and preserve any evidence
  - Document the scene through photos, sketches or written descriptions.
  - Interview all witnesses and secure a written statement
  - Document information you hear
  - Document evidence of non-work-injury
  - Document any facts that contradict the injured workers version
- Have employee complete Part 2 of the investigative report in their own words. Ensure it is complete and they sign and date the document
- Immediately report the claim
- Maintain contact with your injured employee during the recovery process.
- Treat every injury and illness as legitimate

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PART 1: EMPLOYER'S FIRST REPORT OF INJURY

Employer:		Policy Number:
Address:		
Phone Number:		Facsimile Number:
Employer Contact:		Employer Contact Phone Number and email:
Employee's Name:		
Social Security Number:	Date of Birth:	Sex: Male ☐ Female ☐
Race/Ethnic Identification (per/for DWC-7) White ☐ African-American ☐ Hispanic ☐ Asian ☐ Other ☐		
Employee's Address:		
City:	State & Zip:	Home Phone:
Job Title:	Date of Hire:	Department:
Date of Injury:	Date Reported by Employee:	
Location of Injury (check one): Primary Business location ☐ Off site location ☐ during travel ☐		
Description of Accident:		
Losing time from work? Yes ☐ or No ☐		Date lost time began:
Time Employee began work:		
Time of Injury: A.M.☐ or P.M. ☐		Rate of Pay $ Hourly ☐ or Salary ☐
Avg # of Hours Worked per Week:		Speaks English: Yes ☐ or No ☐ Preferred Language:
Medical Attention provided away from worksite required: (if so, name of Physician or Medical Facility and phone number:		
Was the Employee treated in an Emergency Room? Yes ☐ or No ☐ Was Employee hospitalized overnight as an In-Patient? Yes ☐ or No ☐		

ECM CLAIM REPORTING KIT

Signed/Completed by:	Position/Title:	Date:

PART 2: EMPLOYEE STATEMENT AND INFORMATION

(TO BE COMPLETED BY THE EMPLOYEE)

Employee's Name:	
Date of Birth:	Social Security Number:
Street Address:	
State & Zip:	Home Phone:
Email Address:	Job Position/Title:
Date of Hire:	Department:
Direct Supervisor:	Normal Work Schedule (Days of the Week):
Average Hours Worked Per Week:	Rate of Pay:
ACCIDENT DETAILS	
How were you injured?	
What job were you performing at the time of the accident?	
List the exact Injuries you sustained and to what part of your body. List **all** injuries.	
Who did you report this injury to?	When did you report it (Date and Time):

Were there any witnesses to this event? If so, please list their names.

Form continues on following page

PART 2: EMPLOYEE STATEMENT AND INFORMATION (CONTINUED)

On the diagram to the right, please circle the parts of your body where you are experiencing paid due to this injury.		
Print Name:	**Signature:**	**Date:**

I certify that by executing and signing this document that this is a true and accurate report of the circumstances which occurred on the date of my injury/accident listed above.

PART 3: SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Employee's Name:	Social Security Number:	Date of Birth:
Employee's Job Position/Title:	Date of Hire:	
Employee's Direct Supervisor:		
Date of Accident:	Time of Accident:	On Insured's premises: Yes ☐ or No ☐
To Whom did the Employee report the Accident to?		
When was the Accident Reported? (Include Date and Time):		
Actual location of accident (physical location on Insured's premises or address if accident off site):		
List any/all witnesses to accident:		
Name:	Address:	Phone:
Name:	Address:	Phone:
Name:	Address:	Phone:
Was Employee taken for Medical Care? Yes ☐ or No ☐	Taken by: Employer ☐ or On his own ☐	
Did the Employee lose time from work? Yes ☐ or No ☐	Date Returned to Work:	
Describe the Accident Details as they were first reported to you:		

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Name of Medical Provider (include Address/Phone if possible):		
Signed/Completed by:	Position/Title:	Date:

PART 4: WITNESS STATEMENT

Name of Witness:	Date of Incident:
Name of Injured employee:	
Address:	Telephone Number:
Same Employer as injured employee? Yes ☐ or No ☐	
If not, employed by:	Employer's telephone number:
Are you related to the injured employee? Yes ☐ or No ☐	If "YES", how?
Please state the date and time of the injury:	
Did you actually see this injury happen? Yes ☐ or No ☐ If "NO", how do you know about it?	
How near to the injured employee were you at the time of the injury?	
Please explain in detail what you know about this incident:	
Did this employee ever talk with you about getting hurt on the job? Yes ☐ or No ☐ If "YES", what was the date and time this conversation took place? What did the employee say?	
Do you know of any other injury, accident, or illness this employee has had? Yes ☐ or No ☐ If "YES", please explain:	
Give the names of any other persons who might know about this accident/ injury:	
Additional comments:	

To the best of my knowledge, this statement is true and correct.	
Signature of Witness:	Date Signed:

ECM CLAIM REPORTING KIT

Auto Claim Instructions

1. Contact police.
2. Obtain information about other people involved in the accident or anyone who may have witnessed the accident. If possible, take a photo of their drivers' license and insurance ID card.
   - Name
   - Address
   - Phone number
   - Insurance carrier
   - Policy number
   - Etc.
3. Take photos of the accident site, if possible.
4. Have the vehicle towed to a repair facility if it cannot be driven.
5. If the vehicle is drivable:
   - Obtain an estimate for repair.
6. The claim adjuster will review the estimate and may send an appraiser to see the vehicle.
7. The claims adjuster will deal directly with the claimant or his/her attorney. Do not deal with the claimant yourself. Please refer all inquiries to the assigned adjuster.
8. Expect to be contacted by the claims adjuster within two working days.
   - If the damage significantly affects your continuing operations, we will request that the insurance carrier expedite your claim.
   - Please let us know immediately if your circumstances change and this loss will have a greater impact on your business than originally anticipated.

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AUTOMOBILE CLAIM FORM

INSURED NAME:		
BRANCH Name & Number:		
LOSS INFORMATION	**Date of Loss:**	
Location of accident:		
City:	State:	
Police Department Involved:	Ticket Issued? Yes ☐ No ☐	
Description of Accident:		
INSURED VEHICLE		
Owner of insured vehicle:		
Year:	Make:	Model:
V.I.N.:	Plate:	
Extent of Damages:		
Present Location:		
Driver:		
Date of Birth:	License #:	State:
OTHER VEHICLE		
Year:	Make:	Model:
Extent of Damages:		
Owner:	Phone #:	
Driver (if different from owner):		
Address:		
City:	State:	Zip:
OTHER DRIVERS INSURANCE INFORMATION		
Company name:	Policy #:	
Agent Name:	Phone #:	

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INJURED		
Name:	Phone #:	
Address:		
City:	State:	Zip:
Extent of Injury:		

PROPERTY CLAIM INSTRUCTIONS

Damage to YOUR property

1. Protect property from further damage.
    - Cover the property if it is exposed to the elements.
    - Make temporary repairs, if reasonable and necessary, to protect the property from further damage.
    - Maintain a record of all expenses incurred.
    - Separate damaged from undamaged personal property.
2. Take photos of damage (if possible).
3. Prepare an inventory of damaged personal property.
    - List quantity, description, and value.
    - Attach bills, receipts, estimates, and related documents.
4. Retain damaged property until a claims adjuster approves its disposal (unless a danger to safety exists).
    - The adjuster may need to inspect the property.
    - The insurance company may be able to salvage the damaged property.
5. Notify police in the case of theft.
6. Expect to be contacted by the claims adjuster within two working days. Please call your IMA representative if you have not been contacted within that timeframe.
    - If the damage significantly affects your continuing operations, we will request that the insurance carrier expedite your claim.
    - Please let us know immediately if your circumstances change and this loss will have a greater impact on your business than originally anticipated.
7. Be prepared to provide additional information as requested by the claims adjuster.

PROPERTY CLAIM FORM (YOUR PROPERTY)

INSURED NAME:	
BRANCH Name & Number:	
Policy Number:	
INSURED CONTACT	Name and Phone:
Address of insured:	
City:	State:
Additional Insured contacts:	
LOSS	
Date of Loss:	
Location of Loss:	
Kind of Loss:	
Description of Loss & Damage	
Police or Fire Dept to which reported:	
Probable amount of entire loss:	
Mortgagee:	
REPORTED BY	

ECM CLAIM REPORTING KIT

Name	
Title:	Date of report:
Contact:	

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General/Product Liability Claim Instructions

1. Investigate the loss when reported and notify your manager of the loss. Provide all documents, correspondence, or lawsuit papers you have that relate to this incident.
2. Provide names and addresses of any witnesses to the incident, or of employees who may be able to provide details on the product or location involved in the incident.
3. If a product is involved and you have the product, save it for inspection by the claims adjuster or insurance carrier expert.
4. The claims adjuster will deal directly with the claimant or his/her attorney. Do not deal with the claimant yourself. Please refer all inquiries to your insurance broker.
5. Expect to be contacted by the claims adjuster within two working days. Contact your ECM representative if you have not been contacted by the claim adjuster.
    - Advise the adjuster if this claim significantly affects your continuing operations.
    - Advise the adjuster immediately if your circumstances change and this loss will have a greater impact on your business than originally anticipated.

GENERAL/PRODUCT LIABILITY CLAIM FORM

INSURED NAME:		
BRANCH Name & Number:		
LOSS INFORMATION		**Date of Loss:**
Location:		
City:	State:	Zip:
Description of Alleged Incident:		
If Product involved, identify the product:		
INJURED		
Name:		Phone #:
Address:		
City:	State:	Zip:
Extent of Injury:		
PROPERTY DAMAGE		
Name:		Phone #:
Address:		
City:	State:	Zip:
Type of Damage:		
Extent of Damage:		
INJURED		
Name:		Phone #:
Address:		
City:	State:	Zip:
LAWSUIT FILED? Yes □ No □		

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County and state where filed:	
Date of service:	
Name of Person Filing Report:	
Email:	Phone #:
Date of Report:	

IMPORTANT REPORTING INFORMATION

EMPLOYMENT PRACTICES LIABILITY CLAIMS

Employment Practices Liability (EPL) insurance policies are generally written on a **claims-made** basis. It is **CRITICAL** to report potential claims immediately. Any delay in reporting incidents may preclude coverage on the basis of late reporting.

In addition, many policies also require the claim to be **reported** during the policy period. This type of policy is generally referred to as a **claims-made and reported** policy.

The insuring agreement, definitions and notice requirements vary by carrier and policy. There is no standard" language". It is important to review the insuring agreement, notice requirements and terms and conditions of your **claims** made policy to avoid potential notice issues with the carrier.

EPL policies are triggered by an alleged "wrongful act" committed by the insured. This may include any actual or alleged Discrimination, Retaliation, Sexual Harassment, Workplace Harassment, Wrongful Termination, breach of Employment Agreement, violation of the Family Medical Leave Act, employment-related misrepresentation, defamation including libel or slander, or invasion of privacy.

As a result, these can be emotionally charged claims and somewhat personal in nature. However, to avoid late reporting of claims, it is **CRUCIAL** to report any **potential** claim immediately. Whether a claim is covered or not by the insurance policy is only determined **after** a claim has been reported to the insurance carrier.

To report an EPL claim, contact your ECM representative.

IMPORTANT INFORMATION

DEFENSE OBLIGATIONS AND CONSENT TO SETTLE

Defense obligations under EPL policies vary as well. Dependent upon your policy, you may not have the right to select counsel. Prior to incurring any defense costs on claims, be sure to call your ECM representative to discuss the defense obligations under your policy.

Most policies contain a settlement condition requiring the insured to obtain consent to settle from their insurance carrier prior to committing to settlement or entering into negotiations.