PIE INSURANCE

How to respond to a workplace injury:

For life-threatening medical emergencies, call 911.

For non-life-threatening injuries, call the 24/7 Nurse Line at (844) 581-0828 to report the incident and get your employee the right care

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Workers' comp claims
You can file your first report of injury for a workers' comp claim in three simple ways:
Call the 24/7 claim intake line within 24 hours of the incident: **(844) 581-0828**

Submit the claim information online here

Email the claims team within 24 hours of he incident: **claims@pieinsurance.com**

- **In your email, please include the following:**
- The name of your business
- The policy number
- Reporting party's contact information (name. phone, email)
- The name, phone, and email address of the injured employee
- Date of the injury or accident
- A description of the injury or accident

Thank you.

WORKER'S COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Worker's Compensation Act of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The worker's compensation insurance carrier or the administrator for

_____ is: _Pie Insurance___
(name of company) (name of insurance carrier or administrator)

_____Pie Insurance_____
(name of carrier/administrator)

_____
(mailing address)

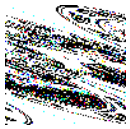
_____PO Box 30018, Salt Lake City, UT 84130-0018_____
(city, state, zip)

_____(844) 581-028_____
(telephone number)

_____claims@pieinsurance.com_____
(contact person)

For more information about rights or procedures under the Indiana Worker's Compensation system, call or write:

Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667



INDIANA WORKER'S COMPENSATION
FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

Please return completed form electronically by an approved EDI process.

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex ☐ Male ☐ Female ☐ Unknown	Occupation / Job title	NCCI class code
Name (*last, first, middle*)		Marital status ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown	Date hired / State of hire	Employee status
Address (*number and street, city, state, ZIP code)*			Hrs / Day / Days / Wk / Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued
Telephone number (include area		Number of dependents	Wage $ Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other	

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number
Address of employer (*number and street, city, state, ZIP code*)	Location number / Telephone number	Employer's location address (*if different)*	
	Carrier / Administrator claim number	OSHA log number	Report purpose code
Actual location of accident / exposure (*if not on employer's premises*)			

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate ☐ Self Insurance
Address of claims administrator (*number and street, city, state, ZIP code*)	☐ Insurance Carrier ☐ Third Party Admin.	Policy / Self-insured number
Telephone number		Policy period From To
Name of agent	Code number	

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp.	Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined	Date employer notified	Type of injury / exposure	Type code
Last work date	Time workday began	Date disability began	Part of body	Part code
RTW date	Date of death	Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No	Name of contact	Telephone number
Department or location where accident / exposure occurred			All equipment, materials, or chemicals involved in accident	
Specific activity engaged in during accident / exposure			Work process employee engaged in during accident / exposure	
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.				Cause of injury code
Name of physician / health care provider				
Hospital or offsite treatment (*name and address*)				INITIAL TREATMENT ☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor: Clinic / Hospital ☐ Emergency Care ☐ Hospitalized > 24 Hours ☐ Future Major Medical / Lost Time Anticipated
Name of witness	Telephone number	Date administrator notified		
Date prepared	Name of preparer	Title	Telephone number	

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).

NOTICIA DE COMPENSACION PARA TRABAJADORES

A su empleador le es requerido proveer pagos de beneficios bajo el Acta de Compensación para Trabajadores del Estado de Indiana.

Cualquier empleado que sea lesionado mientras esté trabajando debe reportar el accidente laboral inmediatamente a su supervisor, empleador o representante designado.

La compañía de seguro de compensación del trabajador o el administrador de la compañía _____ es:
(nombre de la compañía)

Pie Insurance
(nombre de la compañía de seguro/administrador)

Pie Insurance
(dirección)

PO Box 30018, Salt Lake City, UT 84130-0018
(ciudad, estado, código postal)

(844) 581-0828
(número de teléfono)

claims@pieinsurance.com
(persona de contacto)

Para más información acerca de sus derechos o los procedimientos bajo el sistema de compensación para trabajadores de Indiana, llame o escriba a:

Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667