

# Claim Reporting Web Form Instructions



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## REPORT A CLAIM

START FORM



**Click the button to get started.**

Browser Requirements: IE 9 or higher,  
Mozilla Firefox, Google Chrome, Safari

### DIRECTIONS

To report a claim, click on the button above. The web form will take approximately 15-20 minutes – please make sure you have adequate time before starting the process as you will not be able to return to the form at a later time.

Before you begin, please have all essential details available (Claimant SSN, birthdate, hire date, etc.) and document attachments (Post-offer Medical Questionnaire, medical notes, witness statements, etc.). **DO NOT CLICK THE BROWSER BACK BUTTON** - you will have the opportunity to review and edit your entries before submitting the form.

If you have any questions, please contact us at [info@synergyinsurance.net](mailto:info@synergyinsurance.net) or 1-866-710-0908.

Internet Explorer users: This form requires IE 9 or higher.

**\*If you have any difficulty with completing the form, please call (704) 927-3274 for assistance.**

## Step 1: Employer Information

Employer Name \*

Employer Address \*

City \*

State \*

Zip \*

Is the accident address different from employer address? \*

Yes

Policy Number

Employer Contact name \*

Employer Contact Email Address \*

Employer Contact Phone \*

Submit & Continue to Step 2 >

← Enter Employer Information in Step 1.

*Fields marked with \* denotes required fields.*

## Step 2: Claimant Information

Last Name \*

← Enter Claimant Information in Step 2.

First Name \*

Middle Name

Address \*

City \*

State \*

Zip \*

County \*

Home Phone  
  
e.g. 7048675309

Work Phone  
  
e.g. 7048675309

Email Address

Date of Birth \*  
  
e.g. 11/26/1982

Social Security Number \*  
  
e.g. 123456789

Gender \*

Smoker \*

Marital Status

Number of Dependents

Weight (approximate in lbs.)

How satisfied is claimant with their job? \*

Height  
Feet   
Inches

Submit & Continue to Step 3 >

### Step 3: Accident Information

Date of Injury \*

Time of Injury \*

Date the Employee reported injury to Employer \*

Did more than one day pass between date of injury and date injury was reported to the Employer?

Whom was the claim reported to? \*

Body part injured? \*

Diagnosis of injury \*

Cause of injury \*

Accident Description \*  
  
1000 characters remaining

On employer's premises? \*

Are there any witnesses? \*

Please attach photo or video of accident scene  
 No file selected.

← Enter Accident Information in Step 3.

*In this section, you will be able to upload witness statements, as well as any photo or video from the accident scene.*

## Step 4: Employment Information

Supervisor name \*

Supervisor phone number \*

Describe claimant occupation and job duties: \*

Attach detailed job description:  
 No file selected.

Class Code \*

Date of Hire (Leave blank if unsure)

Employment Status \*

Number days worked per week \*

Number of hours worked per day \*

Shift

Is Employee paid salary or by the hour? \*

What is their rate and hours worked per week? \*

What is their yearly salary? \*

← Enter Employment Information in Step 4.

*In this section, you will be able to upload a job description.*

## Step 5: Subrogation

Are there any other contributing parties that may have caused the accident? \*

Do you have a police Report? \*

← Enter Subrogation Information in Step 5.

*In this section, you will be able to upload a police report (if applicable).*

## Step 6: Medical Treatment

Type of treatment received: \*

← Enter Medical Treatment Information in Step 6.

## Step 7: Return to Work Information

Was the employee paid for the date of injury in full? \*

Has the employee been out of work? \*

← Enter Return to Work Information in Step 7.

Are there any light duty restrictions given by the doctor? \*

## Step 8: Additional Questions

Do you have any reason to question the injury or accident? \*

← Enter Additional Information in Step 8.

Was a Post-Offer Medical Questionnaire completed? \*

Was a Post-Accident drug screening completed? \*

Do you know of any prior or ongoing medical conditions? \*

Has the employee ever injured this body part in the past? \*

Do you know of any concurrent employment? \*

Was there a safety violation? \*

Do you know of any prior workers' compensation claims the employee has filed? \*

← Click this button to review all information entered.

## Review and Submit

### Step 1 - Employer Information Edit

Employer Name

Employer Address

Accident Address (reference to above)

Policy Number

Employer Contact Name

Employer Contact Email

Employer Contact Phone

Review all entered information on this page.

To edit a section, click the "Edit" button in the appropriate section, enter corrected information, and click the "Save & Review" button at the bottom of the page to return to the Review & Submit page.

If you would like a copy of this detailed claim submission for your records, please **PRINT** this page before submitting the claim to Synergy.

For a detailed copy for your records, **PRINT** page before hitting the "Submit" button

Submit Completed Form 

Click this button to submit the First Report of Injury to Synergy Coverage Solutions.

After the First Report of Injury form has been successfully received by Synergy Coverage Solutions, you will receive the below message. *\*If you did not receive the message below, your First Report of Injury Form has **NOT** been submitted to Synergy Coverage Solutions.*



First Report of Injury Form

Step 10 of 10

Your First Report of Injury submission for Tom Smith, Date of Injury 4/1/2015 10:30 AM, has been successfully received.

Following submission, the injured employee should expect to receive a Claims packet via mail including the assigned claim number and any necessary forms to fill out and return for completion of the claims investigation. The employer will also receive the assigned claim number and any necessary claims information via email.

Should you have any questions or concerns, please contact our Claims department at 1-866-710-0908 or [claims@synergyinsurance.net](mailto:claims@synergyinsurance.net). For more information regarding the Claims process, please visit [www.synergyinsurance.net](http://www.synergyinsurance.net).

Thank you for submitting the First Report of Injury for Tom Smith, Date of Injury 4/1/2015 10:30 AM, Employer: Test Company.