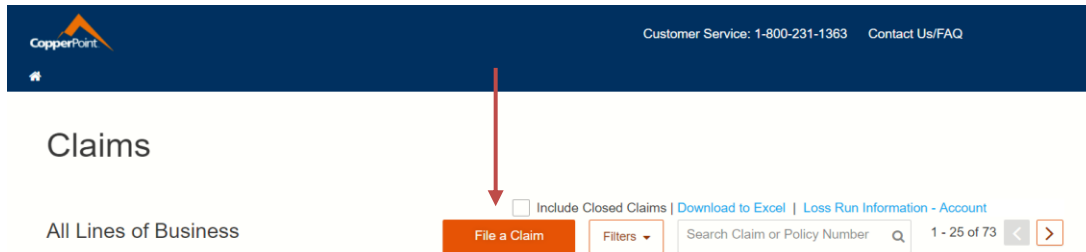


FILING A CLAIM

To file a new notice of loss, log in to the claims portal and select the File a Claim button from the homepage.




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

Use the calendar icon throughout the submission to find date/time

Date of loss?

When did loss occur? * 

Against which policy are you submitting a claim?

POLICY #	TYPE	EFFECTIVE	EXPIRES
 1000640		January 31, 2018	January 1, 2019

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 claims 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.

Have you completed an [Employer’s First Report of Injury?](#) *

Yes	No
-----	----

 Upload Document

 Web Document.pdf
Date Uploaded 11/5/18

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 on screen.

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.

Use the calendar icon throughout the submission to find date/time

Describe what happened

Date you were notified *

10/30/2018 06:30 AM	
---------------------	---

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:

Lost time from work? * Yes No

Work Status

Work Status *

Start Date * 

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 *

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. A claim number will be generated, along with contact information of the assigned adjuster.

Click on the Adjuster Name to send an email about the claim



You have successfully submitted this claim.

Claim Number: 100000250

Adjuster Name: [Donna Escobedo](#)

Adjuster Phone: 1 602-631-2931

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 *

Body Part *

Side

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 

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"/>	Witness ▼	<input type="text"/>	

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