COVID-19 FIRST REPORT
(Non-Hospitalization Claims Only)

Insured: _____ Assoc. Member No: (If applicable): _____
Policy number & Policy period: _____ SIR: _____
Date of Loss: _____ Accident State: _____
Claim #: _____
Claimant(s): _____ DOB: _____ Marital Status: _____
NCCI Job Class Code: _____ Job Description: _____

Has a COVID-19 test come back positive? ☐ **Yes** ☐ **No**

This Claim: ☐ Has been investigated and found compensable. *Additional information may be requested separately.

☐ Has been investigated and is denied.

☐ Currently remains under investigation.

Additional Pertinent Information: _____

_____

_____

_____

_____

Please attach the Employer's First Report of Injury and all pertinent file material.

Form completed by: _____ Date completed: _____
Company: _____ Address: _____
Phone: _____ Fax: _____ Email: _____

Safety National Casualty Corporation
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