**COVID-19 FIRST REPORT**

***(Non-Hospitalization Claims Only)***

**­Insured:**  Assoc. Member No: (If applicable):

 

 

**No**

 

**Yes**

 

**Has a COVID-19 test come back positive?**

Policy number & Policy period:

SIR:

Date of Loss:

Accident State:

Claim #:

**Claimant(s):**

Marital Status:

DOB:

Job Description:

NCCI Job Class Code:

**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: