How to File a Claim

Portal Instruction Guide – Policyholders

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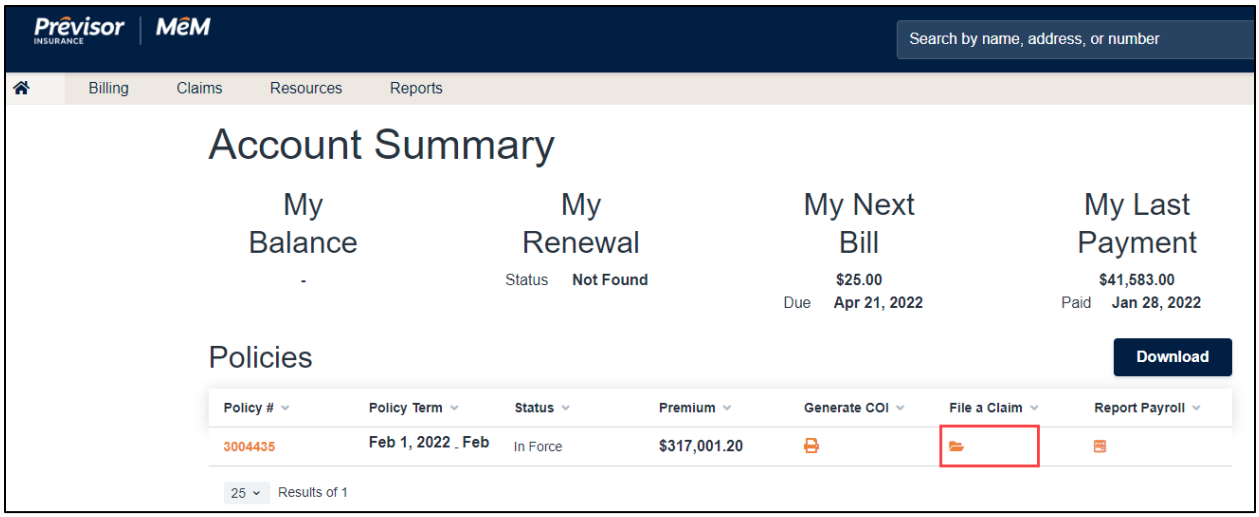
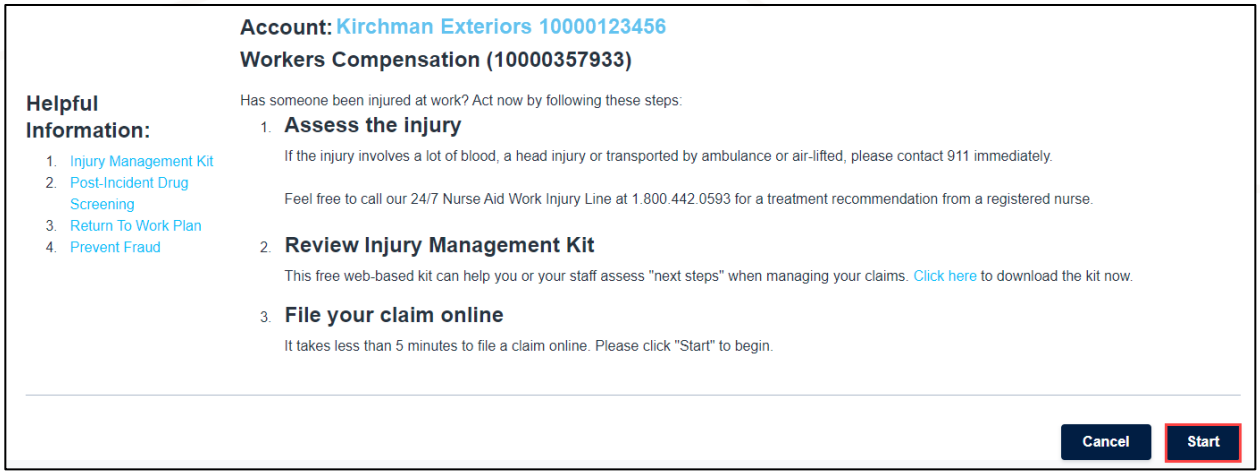
File a Claim

1. On the home screen, select the **Orange File a Claim Envelope**.



2. Select **Start**.



Basic Information

1. Select the **Radio Button** next to the **Policy Number** for which the claim should be filed.
2. Enter the **Date/Time When Did the Incident/Injury Occur** or select the **Calendar Icon** to select the date and time.

NOTE: The date defaults to today's date, click the calendar icon to select a previous date.

NOTE: If the time is unknown enter the time as 12:00 PM.

NOTE: Once a policy is selected, the associated business name, insurance agent, and selected policy number populates on the screen.

3. Enter the **Date You Were Notified of the Occurrence** or select the **Calendar Icon** to select the date and time.

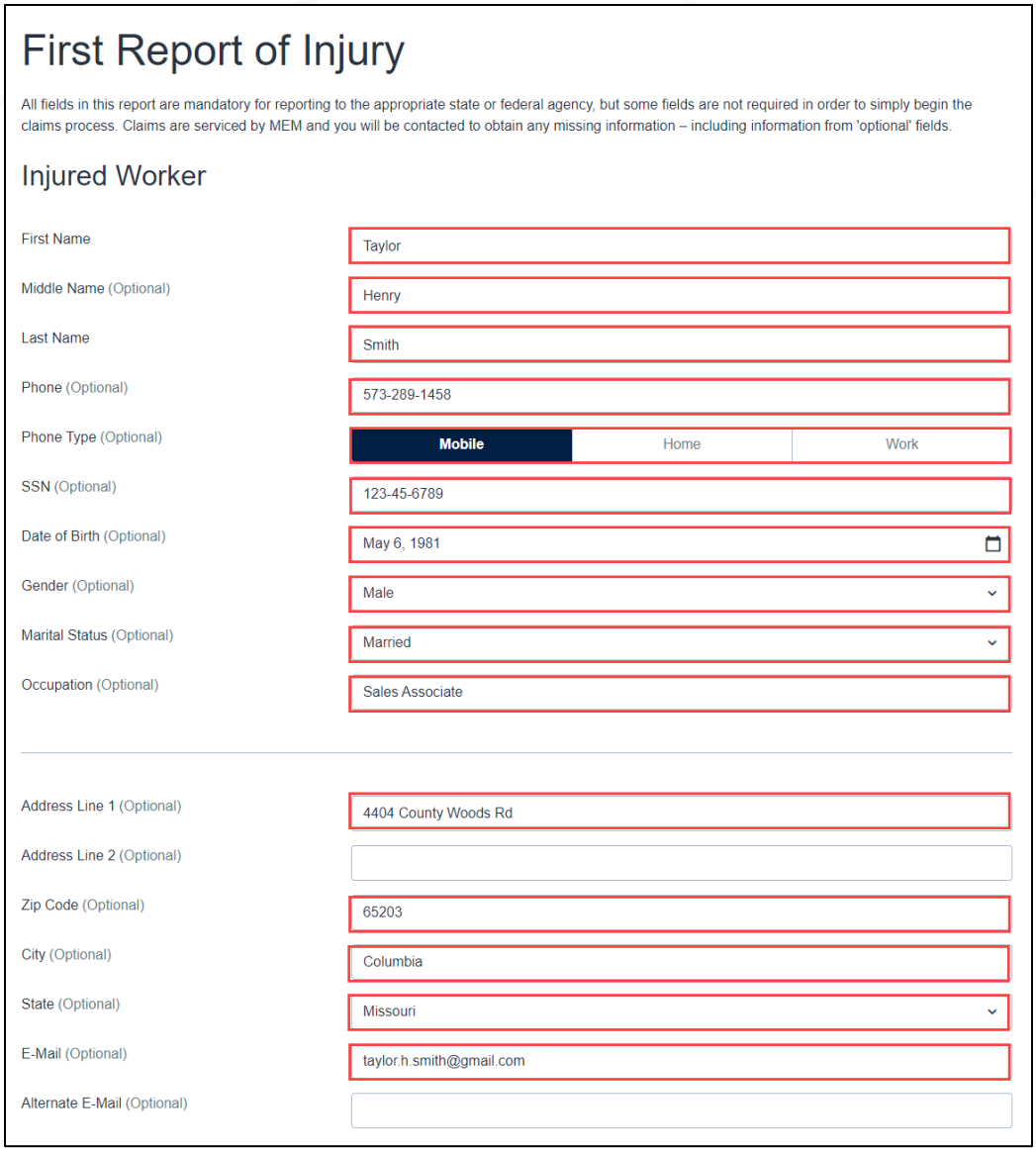
4. Select **Next**.

General Claim Information

1. To add a contact, enter the required **First Name** and **Last Name**.

2. Enter any known **Optional Information** on the injured party **(Phone, Phone Type, SSN, Date of Birth, Gender, Marital Status, Occupation, Address, Zip Code, City, State,** and **E-Mail)**.

   NOTE: All fields are mandatory for reporting to the appropriate state or federal agency, but some fields are not required to simply begin the claims process. Claims are serviced by MEM and policyholders will be contacted to obtain any missing information – including information from 'optional' fields.



First Report of Injury

All fields in this report are mandatory for reporting to the appropriate state or federal agency, but some fields are not required in order to simply begin the claims process. Claims are serviced by MEM and you will be contacted to obtain any missing information – including information from 'optional' fields.

Injured Worker

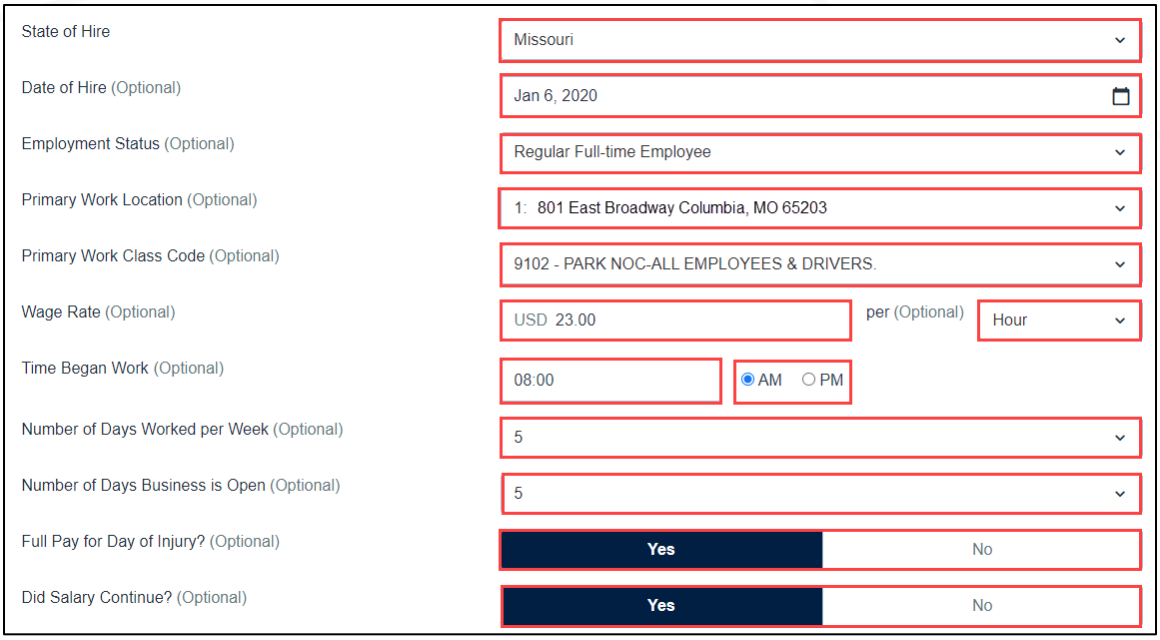
First Name: Taylor
Middle Name (Optional): Henry
Last Name: Smith
Phone (Optional): 573-289-1458
Phone Type (Optional): Mobile | Home | Work
SSN (Optional): 123-45-6789
Date of Birth (Optional): May 6, 1981
Gender (Optional): Male
Marital Status (Optional): Married
Occupation (Optional): Sales Associate

Address Line 1 (Optional): 4404 County Woods Rd
Address Line 2 (Optional):
Zip Code (Optional): 65203
City (Optional): Columbia
State (Optional): Missouri
E-Mail (Optional): taylor.h.smith@gmail.com
Alternate E-Mail (Optional):

3. Select the **State of Hire** from the pre-populated list of states for which the policy provides coverage.
4. Enter or select any known **Optional Information** on the injured party **(Date of Hire, Employment Status, Primary Work Location, Primary Work Class Code, Wage Rate, Time Work Began, Number of Days Worked Per Week, Number of Days the Business is Open, Full Pay for Day of Injury, Did Salary Continue)**.

   NOTE: Primary Work Location and **Primary Work Class Code** will pre-populate based on the associated location and class code on the policy. If one of these values does not pertain to the claim, select another value from the dropdown in each field.

NOTE: Please enter as much information as possible, as MEM will call to collect additional information, if needed.

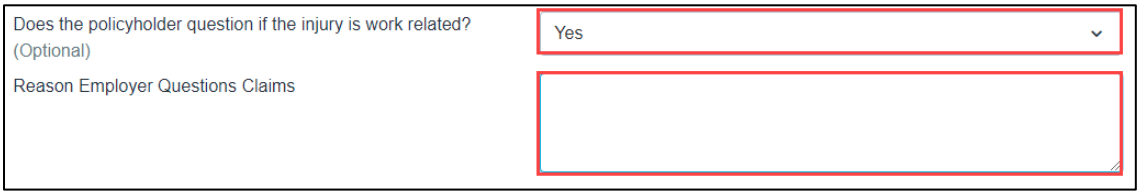


5. Select the **Injury Cause/Source**.
6. Input brief **Incident Details**.
7. Enter or select any known **Optional Information** regarding what happened **(Incident Description, Were Safeguards or Safety Equipment Provided, Were Safeguards or Safety Equipment Used, Was There a Mechanical Defect That Caused the Loss, Were Safety Rules Violated, Are the Use of Drugs or Alcohol Suspected, Does the Policyholder Question if the Injury is Work Related),** if applicable.

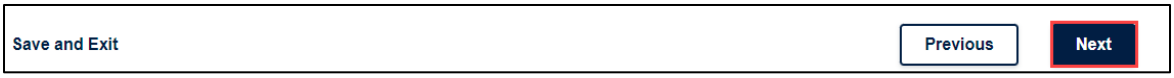
   NOTE: Please enter as much information as possible, as MEM will call to collect additional information, if needed.

   NOTE: The **Incident Description** box can be used to elaborate on the story or situation around the incident; however, please know any information included in the box may be admissible in the event this case is addressed in a courtroom.

8. *If the policyholder questions if the injury is work related*, input a **Reason Employer Questions Claim**.

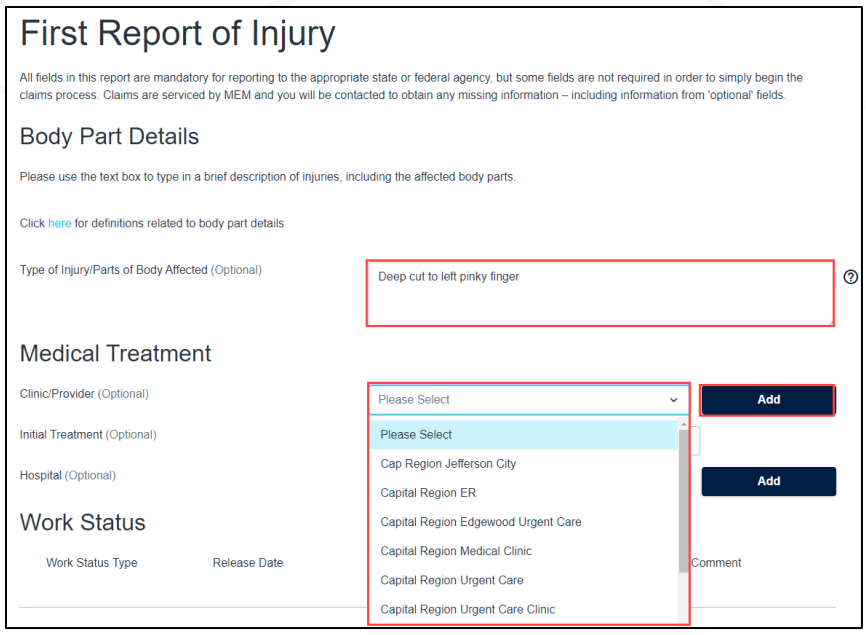


9. Select **Next**.



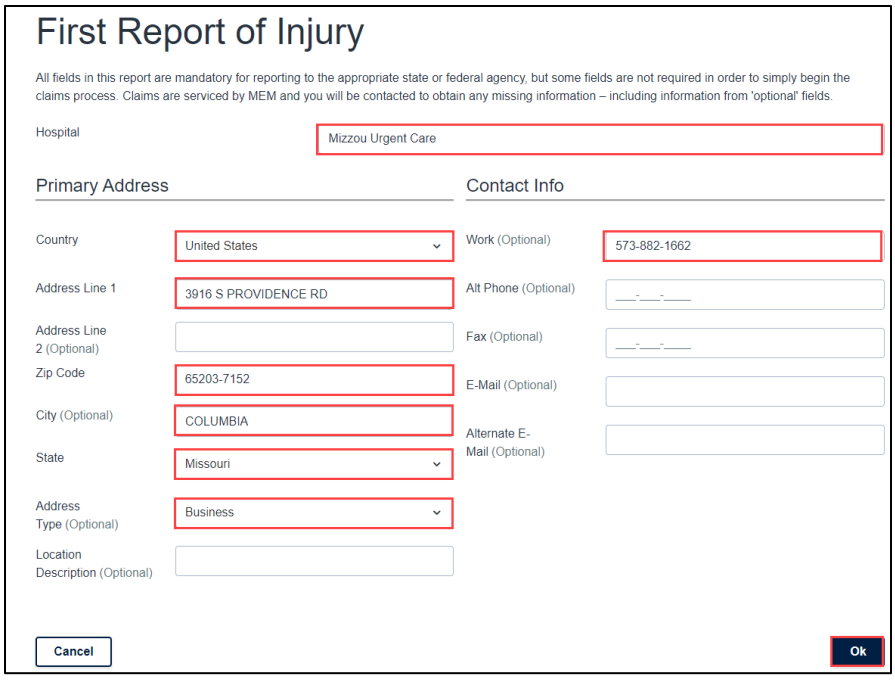
Injury Details

1. Enter **Type of Injury/Parts of Body Affected**.
2. *If the injured worker received treatment for their injury*, select any known **Optional Fields** regarding medical treatment **(Clinic/Provider, Initial Treatment,** and/or **Hospital**.)



NOTE: Please enter as much information as possible, as MEM will call to collect additional information, if needed.

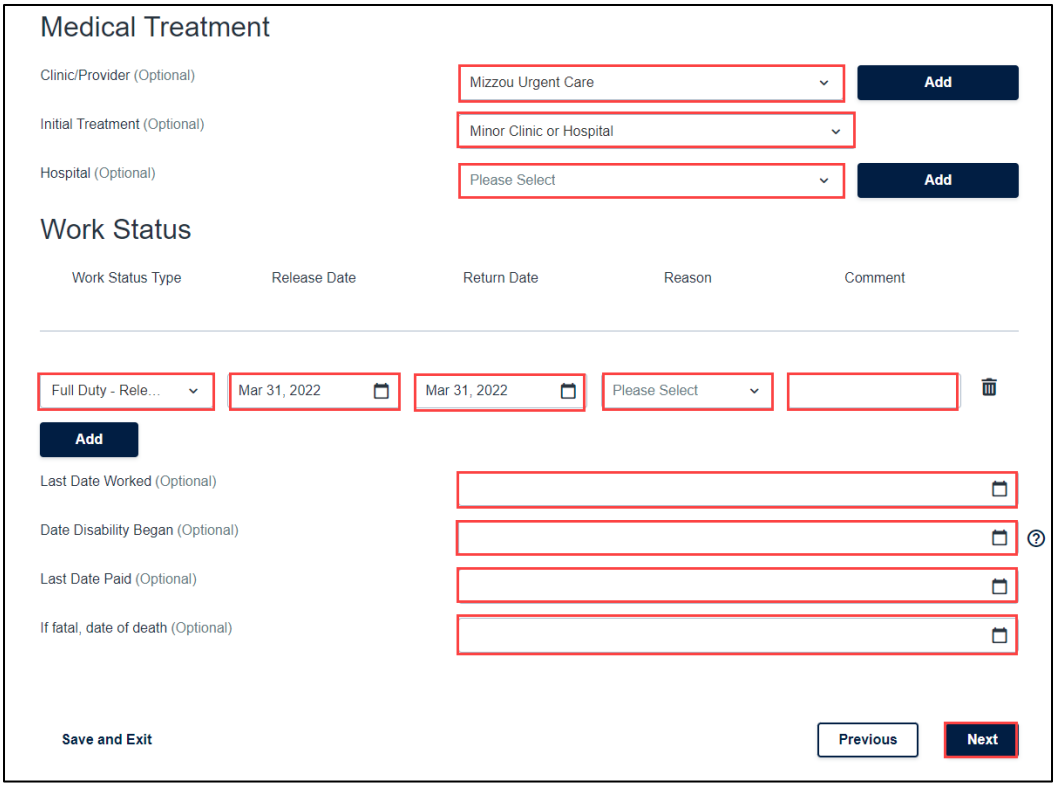
3. *If the treatment provided is not listed in the drop down*, select **Add**.
4. Enter the **Hospital Name**.
5. Enter any known Optional Fields regarding the provider (**Country, Address, Zip Code, City, State, Phone, Fax, Email)**.
6. Select **Ok**.



7. *If the injured worker has returned to work*, input any **Optional Fields** regarding work status **(Work Status Type**, **Release Date**, **Return Date**, **Reason** and **Comments)**.
8. Select **Add** if multiple work statuses need to be added.
9. Input any known **Optional Fields** regarding work status **(Last Date Worked, Date Disability Began, Last Date Paid, Date of Death)**, if applicable.

   NOTE: Date Disability Began is defined as the first day on which the employee originally lost time from work due to the occupational injury or disease or as otherwise defined by jurisdiction.

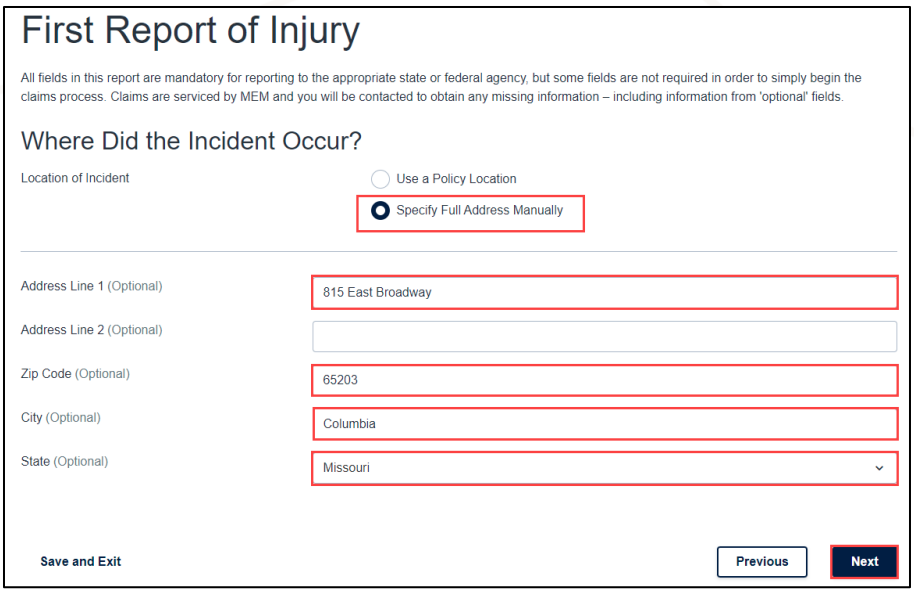
   NOTE: Please enter as much information as possible, as MEM will call to collect additional information, if needed.
10. Select **Next**.



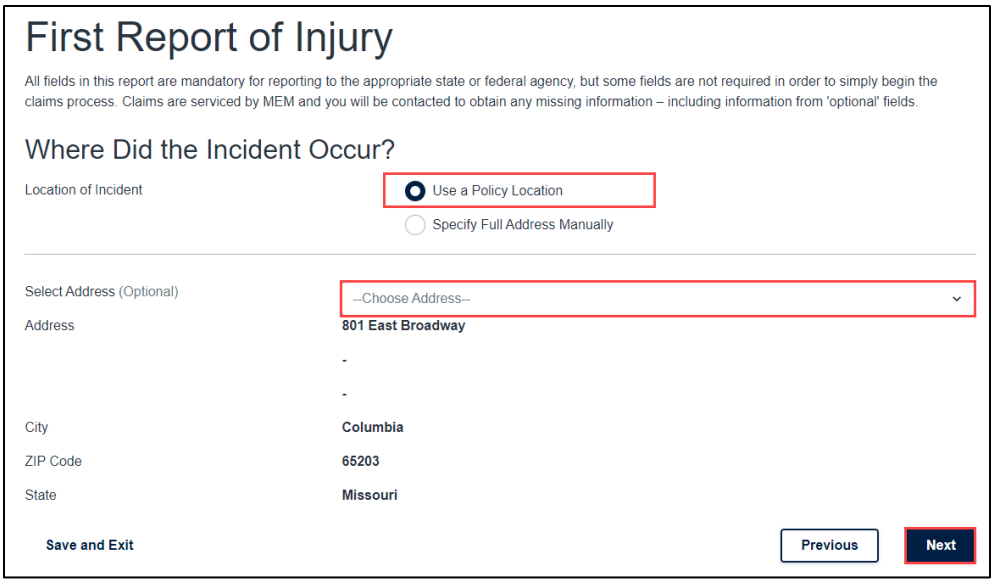
Where

1. Select the **Use a Policy Location** or **Specify Full Address Manually** radio button for Location of Incident.

   NOTE: If a policy location is selected, the address details will automatically populate in the form below. If the policy has multiple known locations associated to the policy, use the drop-down to make the appropriate selection.



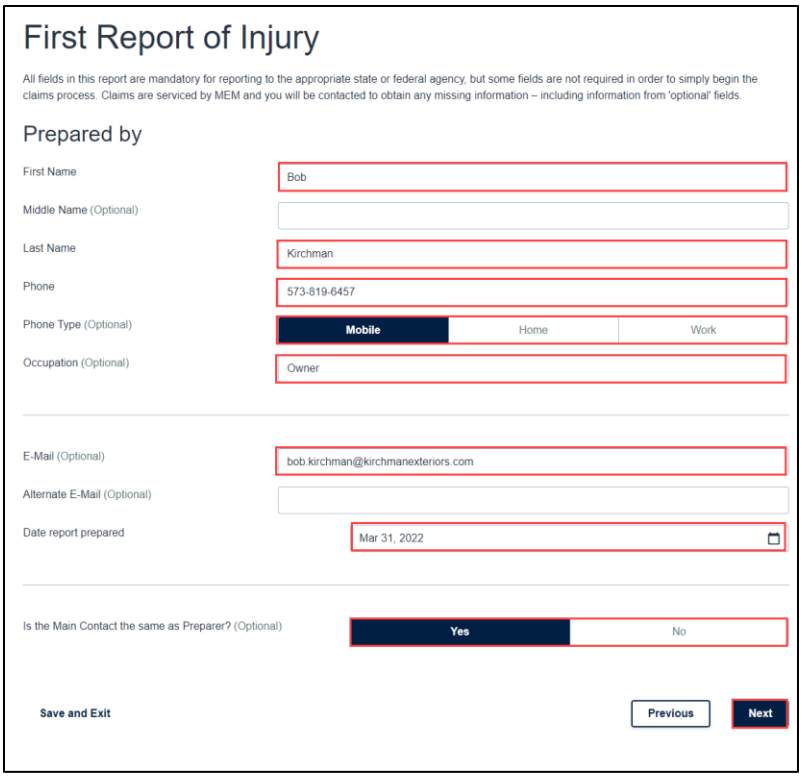
2. *If the Specify Full Address Manually radio button is selected*, input **Address, City, Zip Code and State.**
3. Select **Next**.



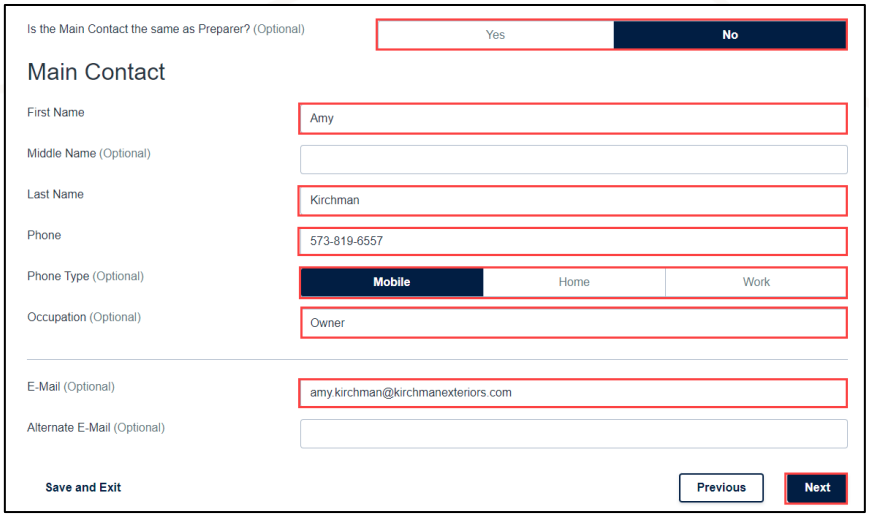
Contact Details

1. Enter the **First Name**, **Last Name** and **Phone Number** for the prepared by individual.
2. Input any known **Optional Fields** regarding the preparer **(Phone Number Type, Occupation, Email)**.
3. Select the **Date Report Prepared**.

   NOTE: The date reported field will default to today's date. To enter another date type in an alternate date or click the calendar icon to select a date.
4. *If the Main Contact is same as the Preparer*, select **Next** and skip to the Additional Information section.

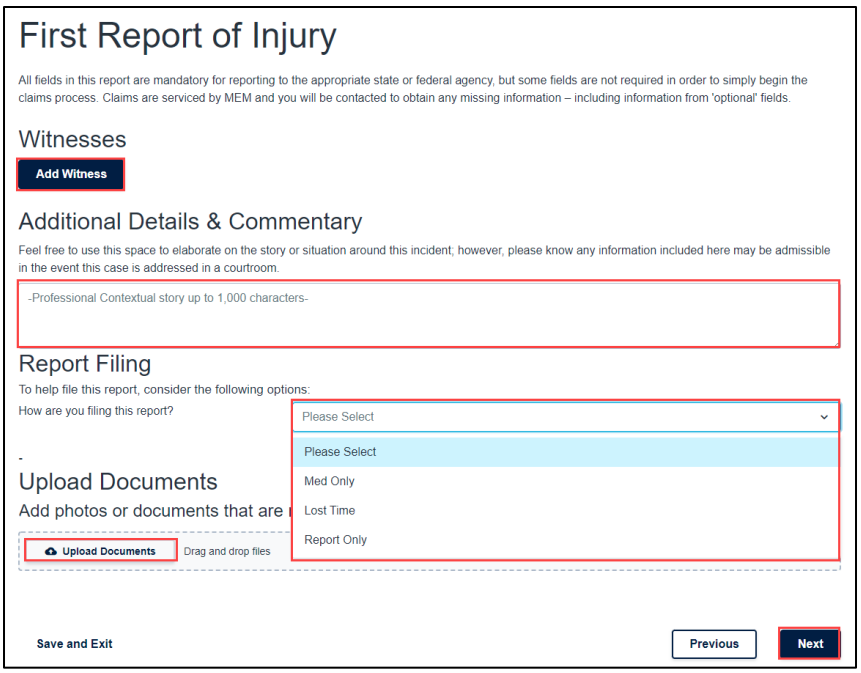


5. *If the Main Contact is **NOT** the same as the Preparer*, select **No**.
6. Enter the **First Name**, **Last Name** and **Phone Number** for the main contact.
7. Input any known **Optional Fields** regarding the preparer **(Phone Number Type, Occupation, Email)**.
8. Select **Next**.



Additional Information

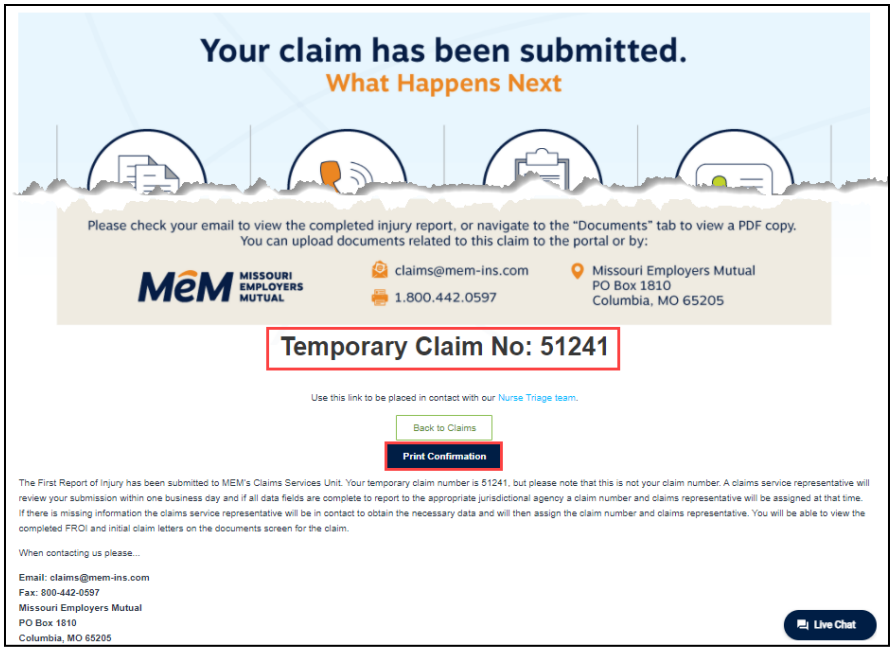
1. Complete any of the following **Optional Fields** regarding the claim **(Add Witness**, **Additional Details & Commentary)**.
2. Select a **Report Filing**.
3. Select **Upload Documents** to upload any pictures, files, written testimonials, or other documentation to be included with the claim report.
4. Select **Next**.



Summary

1. Review the **Summary** information for accuracy.
2. Select **Submit Claim**.

3. A **Temporary Claim Number** is assigned.
4. *If desired*, select **Print Confirmation**.



Where to Get Help

If your questions were not addressed within this document, please contact **MEM Customer Care** at customercare@mem-ins.com or by phone at 1.800.442.0593.