To Report Workers' Compensation Claims

www.berkleynet.com

Fax: 866.275.6320

Call Toll-Free 800.435.1127

Email:Claims@berkleynet.com

Promptly Report all Claims: www.berkleynet.com; Email: Claims@berkleynet.com; Fax 866.275.6320; Call 800.435.1127;

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKERS'S COMPENSATION LAW

WCC Form 2
Rev. 9/2006

STATE OF ALABAMA

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Ombudsman 1-800-528-5166

CLAIM REFERENCE

1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name 5. Physical Address 1 6. Physical Address 2 7. City 8. State 9. Zip	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS 10. Mailing Address 1 11. Mailing Address 2 or Telephone Number 12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number	17. NAICS

INSURER / FILING OFFICE

18. Insurer Name 19. Insurer Federal ID Number 20. Type Insurer ☐ Insurance Co. Ins Co # ☐ Self-Insurer SI # ☐ Group Fund GF #	21. Filing Office Name 21a. Service Co. # 22. Mailing Address 1 23. Mailing Address 2 or Telephone Number 24. City 25. State 26. Zip 27. Filing Office Federal ID Number

EMPLOYEE / WAGES

28. First Name 29. Middle Name 30. Last Name 31 Last Name Suffix (ie. Jr., Sr., III)	32. Employee ID Number 33. Type Employee ID Number SSN ☐ Passport Number ☐ Green Card ☐ Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1 35. Mailing Address 2 36. City 37. State 38. Zip 39. Phone	40. Gender Male ☐ Female ☐	41. Date of Birth 42.Nbr of Dependents

43. Marital Status Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐	44. Date Hired
45. Occupation Description	46. Number of Days Worked Per Week
47. Wages $ 48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐	49. Received Full Pay For Day of Injury? Yes ☐ No ☐ 50. Did Salary Continue? Yes ☐ No ☐

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE 56. Site Address 57. City 58. State 59. Zip 60. County	61. Injury Occurred on Employer's Premises? Yes ☐ No ☐ 62. Date Employer Notified

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// DIR.ALABAMA.GOV/WC

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

67. Initial Treatment No Medical Treatment ☐ First Aid By Employer ☐ Minor Clinic / Hospital ☐ Emergency Room ☐ Hospitalized > 24 Hours ☐ Major medical/Lost time ☐ Hospitalized Overnight ☐	68. Name of Treatment Facility 69. Address 70. City 71. State 72. Zip

73. Name of Physician or Other Health Care Professional	74. Has Injured Returned to Work Yes ☐ No ☐	If so, 75. Date 76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name 79. Last Name 80. Title	81. Preparer's Telephone Number

STATE OF ALABAMA
WORKERS' COMPENSATION INFORMATION

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE CARRIER_____

TELEPHONE NUMBER_____

ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS' COMPENSATION LAW INCLUDING MEDIATION SERVICE.
FOR INFORMATION CALL:
1-800-528-5166
Alabama Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131

CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED
IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

FORM WCC#1 10/12