

## Broadspire Workers' Compensation Reporting Form

To report the injury the Department Supervisor must be prepared to answer the questions listed below  
Before contacting Broadspire at 800-753-6737

Once form is completed you may fax to 800-245-9927 or Email to nol@ choosebroadspire.com

Is this an Emergency Claim:  Yes  No      Reported by: \_\_\_\_\_      **✓ Request:**  
Business Phone: (\_\_\_\_) \_\_\_\_\_      Title: \_\_\_\_\_      Fax Confirmation with Claim #  
to (405) \_\_\_\_\_ \_\_\_\_\_  
Date of Accident (mm/dd/yy): \_\_\_\_\_      Time of Accident (hh:mm am/pm): \_\_\_\_\_

### A. Employer Information

Parent Company Name: Oklahoma State University      Department: \_\_\_\_\_  
Address: 106 Whitehurst      City: Stillwater      State: OK      Zip: 74078      County: Payne  
Business Phone (405) 744-5449      Fax: (405) 744-8345      E-mail: \_\_\_\_\_  
Location Code: (Division/Dept) \_\_\_\_\_ (example: AA C1015)      Nature of Business: University  
Class Code: (Office/Clerical: OFC or Other: OTH) \_\_\_\_\_

### B. Insured Contact Information

Are You the Contact Person:  Yes  No  
**If No**, Enter Contact Name: \_\_\_\_\_      Title: \_\_\_\_\_  
Contact Phone (\_\_\_\_) \_\_\_\_\_      E-mail: \_\_\_\_\_

### C. Loss Location Information

Did Accident Occur on the Insured Premises:  Yes  No  
If No, Enter Physical Address: \_\_\_\_\_      City: \_\_\_\_\_      State: \_\_ Zip: \_\_\_\_\_      County: \_\_\_\_\_

### D. Employee Information

CWID: \_\_\_\_\_      Employee Name: \_\_\_\_\_      Birthday: \_\_\_\_\_      Age: \_\_  
Address: \_\_\_\_\_      City: \_\_\_\_\_      State: \_\_ Zip: \_\_\_\_\_      County: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_      Business Phone: (\_\_\_\_) \_\_\_\_\_      Sex:  Female  Male  
Number of Dependents: \_\_      Marital Status: \_\_\_\_\_  
Regular Occupation: \_\_\_\_\_      Regular Department: \_\_\_\_\_      Class Code: \_\_\_\_\_  
Date of Hire: \_\_\_\_\_      Hire County: \_\_\_\_\_      Hire State: \_\_  
Employment Status:  Full Time  Part Time      Pay Type:  Monthly  Bi-Weekly  
Gross Wages (hourly/monthly): \_\_\_\_\_      Hours per Day: \_\_ Days per Week: \_\_      Hours per Week: \_\_  
**Supervisor Name:** \_\_\_\_\_      **Business Phone:** (\_\_\_\_) \_\_\_\_\_

### E. Loss Information

Employee Start Time: \_\_\_\_\_      Date Employer Notified: \_\_\_\_\_      Questionable Case:  Yes  No  
Description of Accident: \_\_\_\_\_  
Removed by Ambulance:  Yes  No  Unknown  
Any Stitches/Surgery Required:  Yes  No  Unknown  
Was a Fatality Involved:  Yes  No      (If Yes) Provide Date: \_\_\_\_\_





**Supervisor will complete the Name & Claim Number assigned by Broadspire on the Card below.**

**WORKERS' COMPENSATION**

Employee Name: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Employer: Oklahoma State University

Please mail all inquires and bills to:

Broadspire Services, Inc.                      800-890-8975, ext 221  
PO Box 10900                                      405-387-3960 Fax  
Overland Park, KS 66225-0900  
ATTN: Lisa Colbert