ESIS®

LAUSD OCIP V

Claim Reporting

Direct Claim Reporting Information

ESIS®

LAUSD OCIP V

Call-in: 844-621-9183

Email: lausdocipvclaims@tnwinc.com.

VDN: 3165563

Claim Handling Office Directory for LAUSD OCIP V

ESIS®

Phone: 844-621-9183
Fax: 470-219-6712
Email: lausdocipvclaims@tnwinc.com.
Navex Client VDN Number: 3165563

Service Office Physical Address	Mailing Address	VP Claims	Claim Supervisor	Claim Representative	Claim Representative
Workers' Compensation					
Southern California Claims Office 9200 Oakdale Avenue, 8th Floor Chatsworth, CA 91311 800 654-5374 (tel)	P.O Box 6569 Scranton, PA 18505	Kimberly Gerber 818-454-8788 kimberly.gerber@esis.com	Sean Drury 818-248-3664 sean.drury@esis.com	Nancy Flores 818-428-3782 nancy.flores@esis.com	Secondary rep TBD
General Liability					
Dallas Claims Office *2001 Bryan Street, Suite 3600* *Dallas, TX 75201* *800 250-1645 (tel)*	P.O Box 5129 Scranton, PA 18505	Anthony Pullen 214-754-8578 anthony.pullen@esis.com	Diane Bibb 214-721-6237 diane.bibb@esis.com	Assigned within the team based on claim type and complexity.	

Partnership Services Contacts	
Lynne Soza Senior Partnership Leader M 713-829-3545 Lynne.Soza@esis.com	Michael Byrne VP, Partnership Services M 215-485-2646 Michael.Byrne@esis.com

ESIS®

New Claim Report

LOB: Worker's Comp

VDN: 3165563

Account Name:
LAUSD OCIP V

ESIS®

Worker's Compensation Claim

VDN: 3165563

LAUSD OCIP V

Phone: 844-621-9183 **Email: lausdocipvclaims@tnwinc.com.**

Entity Name					
Contract Number		6K62			
Location Code					
Date Reported to Employer					
Date of Loss/Injury					
Loss Address		Address 2:			
Loss City		Loss State		Loss Zip Code	

Incident Reported By		Title	
Phone			

Loss Description	

Was the accident / injury witnessed?			☐ Yes ☐ No
Witness Name:		Phone #:	
Witness Name:		Phone #:	

Claimant Information			
SSN		Job Title	
First Name		Middle Initial	
Last Name		Address 2	
City		State	Zip Code
Home Phone		Work Phone	
Gender		Date of Birth	
Marital Status		Date of Death	
# of Dependents		Status	☐ Active ☐ Retired ☐ Seasonal ☐ Temporary ☐ Terminated
PT/FT	☐ Part-Time ☐ Full-Time	Date of Hire	
		Termination Date	
Wage Amount		Frequency	☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Bi-Monthly ☐ Semi-Monthly ☐ Monthly ☐ Annually ☐ Unknown

Worker's Compensation Claim

Supervisor Name		Supervisor Title	
Supervisor Phone		Ext	
Will miss work beyond date of injury?	☐Yes ☐No ☐Unknown	Date Last Worked	
Returned to Work Date		Salary Continued	☐Yes ☐No ☐Unknown
Received Full Wages?	☐Yes ☐No ☐Unknown	Contact Name (for this report)	
Contact Phone Number		Ext	

Complete if Medical Treatment Provided					
Hospital/Clinic Name		Doctor Name			
Address		Address cont'd			
Hospital/Clinic Phone #		Doctor Phone #			
City		State		Zip Code	
Transportation Type	☐ 3rd Party ☐Air ☐Ambulance ☐Drove Self ☐Unknown ☐None				

Supplemental Questions	
1. Initial Medical Treatment	☐ No Treatment ☐Minor: By Employer ☐Minor: Clinic/Hospital ☐Emergency Care ☐ Hospitalized > 24 Hours ☐ Major: Clinic/Hospital ☐ Unknown
2. Employee Email Address:	
3. Employee Department:	
Notes/Additional Comments:	