RISK MANAGEMENT
RISK FINANCE AND INSURANCE SERVICES
333 S. Beaudry Ave.
Los Angeles, CA 90017

Worker's Compensation

Direct Claim Reporting Information

LAUSD OCIP V

Call-in: 844-713-5516

Email: LAUSDOCIP.ClaimStart@esis.com

CC: ocip@lausd.net

RISK MANAGEMENT
RISK FINANCE AND INSURANCE SERVICES
333 S. Beaudry Ave.
Los Angeles, CA 90017

Workers' Compensation Claim Checklist

LAUSD OCIP V

☐ Claim Form

☐ Copy of Payroll Records (Last 12 Months)

☐ Copy of Current Work Status

☐ Is the Employee Losing Time from Work?
If yes, provide the 1st day of lost time: _____

☐ Modified Work Provided
If yes, please specify: _____

☐ Employee Statement

Worker's Compensation Claim

LAUSD OCIP V

Phone: 844-713-5516

Email: lausdocip.claimstart@esis.com
CC: ocip@lausd.net

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:	