Filing a Claim
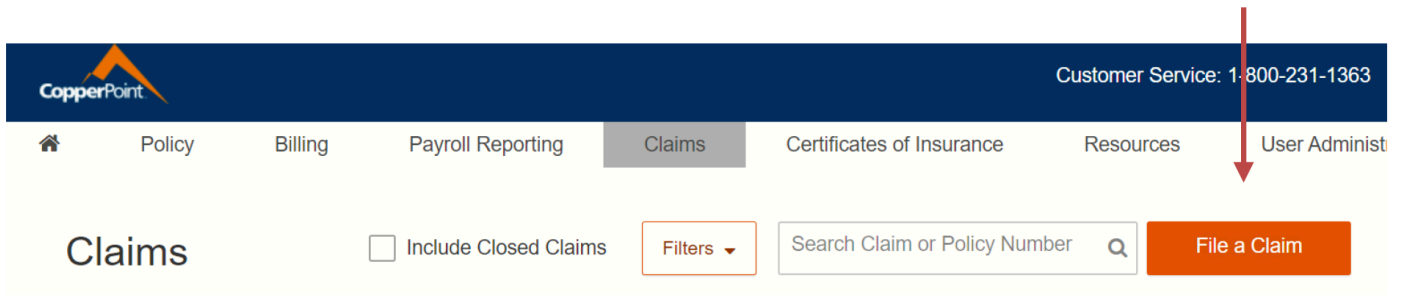
To file a new notice of loss on a workers' compensation policy, select the File a Claim button from the Claims page.

By default, the system will populate today's date and the policies in effect at the time of loss. You may adjust the date and time by clicking on the calendar icon:

Use the calendar icon throughout the submission to find date/time

If there is another claim in the system within 72 hours of the time entered, a warning message for possible duplicate will appear. You may check your open claims on the home screen or ignore the message to continue.

FIRST REPORT OF INJURY – COMPLETED PREVIOUSLY

The system will now ask if an Employer's First Report of Injury has been completed. If yes, the system will allow the user to upload the document and complete a minimized set of questions. Completing an Employer's First Report of Injury before submitting the claims online will expedite the reporting process. A link is provided to the state form.

If the report has been completed, answer "Yes" and click the Upload Document button. If a report is uploaded, CopperPoint will notify the state authority as part of the claim management process.

Have you completed an Employer's First Report of Injury? *   **Yes**   No

⬆ Upload Document

📄 Web Document.pdf
Date Uploaded
11/5/18

Valid document types are PDF,JPG, WAV, BMP, PNG.

Once uploaded, your document will be renamed "Web Document" and will be acknowledged by a blue icon on screen.

Please note that date/time formats must be followed exactly as the default. To prevent error, use the calendar icon to select the appropriate date, rather than overwriting the text provided.

Use the calendar icon throughout the submission to find date/time

Describe what happened

Date you were notified *   10/30/2018 06:30 AM   📅

Continue to enter information about the incident and click the Next button to continue. Questions with an orange asterisk require a response.

Injury Details

Do you doubt the validity of the injury/illness? *	Yes / **No**
Lost time from work? *	Yes / **No**

Medical Treatment

Did injured worker seek medical attention? *	Yes / **No**

Cancel   Instructions   Previous   **Next**

Some responses will require additional information:

Work Status

Work Status *	Working - No Restrictions ▾
Start Date *	MM/DD/YYYY
Comments	

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You may select a location of the business listed on the policy or create a new one:

Where did this happen?

Injury Location *	-- Enter New Location --
	-- Enter New Location --
	6432 E Dale Ln, Cave Creek, 85331, AZ
City *	1069 N Lakepoint Way, flagstaff, 86004, AZ
	1108 E Meadowmoor Dr, Pueblo West, 81007, CO
	1111 E Dale Ln, Cave Creek, 85327, AZ
ZIP Code *	
State *	-- Choose State --

Additional information related to the incident can be uploaded to the file. Once uploaded, a document cannot be deleted.

After entering all information, a summary screen will appear with primary information that was input (name of injured worker, date of injury, injury location, and description of event). A claim number will be generated, along with contact information of the assigned adjuster.

Click on the Adjuster Name to send an email about the claim

You have successfully submitted this claim.

Claim Summary

Injured Worker:	First Last		Claim Number:	1000007037
Date of Injury/Loss:	10/01/2019		Adjuster Name:	Joyce Castillo
Injury Location:	123 S Oak St, Chandler, AZ 85768		Adjuster Phone:	1 602-631-2963
Description of how the injury/illness occurred:	Describe how injury occurred			

Your CopperPoint team thanks you for your business. You can expect to receive a call from your adjuster concerning this claim within 2 business days.

Back to Homepage

Print Confirmation

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FIRST REPORT OF INJURY – NOT COMPLETED

A loss may be reported without first completing an Employer's First Report of Injury.

There will be similar screens, plus areas to describe the injury and provide additional demographic information about the injured employee.

A section for affected body part(s) is also added. In this section, enter detailed information about each body part:

Affected Body Part(s)

Add Body Part

Body Part #1

Area of Body *   -- Select Area of Body --

Body Part *   -- Select Body Part --

Side   -- Select Side --

Dominant   -- Select Dominant --

If medical care was provided, complete these fields:

Medical Treatment

Did injured worker seek medical attention? *   [**Yes**] [No]

Facility or Doctor's Name where treatment sought

Facility or Doctor's Address where treatment sought. Include address, city, state, zip

Phone Number of Facility or Doctor who provided treatment
___-___-____

Examination Date
MM/DD/YYYY hh:mm AM

There is also a section to provide optional witness information:

Witnesses or Other Involved Parties

[Add Party ▾]

FIRST NAME *	LAST NAME *	INVOLVEMENT	PHONE NUMBER	REMOVE
		Witness ▾	___-___-____	🗑

The summary page will provide the same information, and the report is complete.