



CLAIMS KIT

Contacting Us:

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1-888-249-0035

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**Bret Dixon Insurance
PO Box 205
Bethalto, IL 62010-0205**

Bret Dixon Insurance

What To Do If You Have a Claim

USING ACCIDENT OR INCIDENT REPORTS

With most 2nd and 3rd Party Claims, you won't find out about a claim being filed against you until several months after the date of the incident. By this time, you aren't likely to remember anything about the event and it makes it harder for your insurance company to defend you. This is why keeping Incident Reports on every out-of-the-ordinary event, no matter how minor, is strongly recommended. The information you gather at the time can be invaluable months later when you've forgotten about the incident.

When you should complete an incident report:

- Any time you refuse service to a patron
- At any time the establishment becomes aware of any incident that could cause a rise in liability
- Any accident that results in injury to a patron or employee
- Any time that a law enforcement agency is notified to arrest or remove a patron or employee
- Any time an ambulance is required to assist a patron or employee
- Any time an employee makes physical contact with a patron in the course of their duties
- At the request of management, with the intent to conduct an investigation into an incident concerning employee or patron behavior
- Internal incidents that resulted in physical contact between two or more employees

Where You can find an Incident Report:

- You should have two copies of incident reports in the front pocket of your policies
- You can submit an Incident Report to us through our website, www.bretdixonins.com. Look on the Client Resources page.
- Call us and we will fax or email you a copy

Important Info to Record:

- Date & Time
- Employees on duty
- Any witnesses and their contact information
- A description of the events
- Summaries of any calls to law enforcement or medical assistance
- How much the person(s) involved had been served

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What To Do If You Have a Claim

PROPERTY CLAIMS

Damage to your building and/or contents.

- 1) If anyone was inside the premises and is injured, get them medical assistance immediately.
- 2) As soon as feasible, call us at 1-888-249-0035 to report the claim.
- 3) We will need some information from you to complete the Property Loss Notice and turn in your claim.
- 4) In the event of a **Total Loss**: We will report the claim immediately, but there is little you can do at this point.
- 5) **Partial Losses**: We will report the claim immediately. As there are probably unsafe conditions, prevent patrons from entering. You must attempt to prevent any further losses from being incurred, i.e. boarding up a broken door or window, or moving furniture and items out from under leaking roofs to prevent water damage.
- 6) An adjuster will be assigned as soon as possible and will be contacting you directly.
- 7) Documenting any property damage will make settling your claim easier on the adjuster. A \$5 disposable camera is a great asset. Take pictures of the damage before you start securing the premises and turn the camera over to the adjuster.
- 8) Begin to gather receipts or invoices for any damaged or destroyed property. If your building suffered structural damage, begin scheduling a couple of contractors to give you bids on the cost to repair or replace the damage.

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What To Do If You Have a Claim

GENERAL LIABILITY CLAIMS

Injuries to your patrons.

- 1) See if the injured person(s) need medical assistance and call 9-1-1 immediately if they do.
- 2) Have one of your employees complete an incident report, even if the person did not appear injured or refused treatment. You can submit an Incident Report to us online at www.bretdixonins.com, under the Client Resources section. There should also be hard copies of this form in the front pocket of your policies. Get the name and contact info of the injured person(s), names of witnesses and their phone numbers, employees on duty at the time and pertinent detail about what happened, and send that information to us.
- 3) At this immediate time, there is nothing more you can do. If you receive medical bills or correspondence from the patron's attorney at a later date, immediately forward them to us so that we may forward them to your carrier to begin defending you.
- 4) NEVER DISCUSS THE SITUATION WITH ANYONE OTHER THAN A CLAIMS ADJUSTER FROM YOUR INSURANCE COMPANY.

LIQUOR LIABILITY CLAIMS

Injuries to third parties caused by one of your patrons.

- 1) You usually won't find out about one of these until you are served a notice to appear months after the incident happened. Forward any legal paperwork over to us to forward to your insurance carrier.
- 2) If you had an Incident Report on the event that you have not previously submitted to us, send it to us at this time also.
- 3) The carrier will assign an adjuster, who may need to contact you about any video surveillance or records you have of patrons in your establishment on the date of occurrence.

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What To Do If You Have a Claim

WORK COMP CLAIMS

Injuries to your employees

- 1) Get the employee First Aid or professional medical help if needed. When an employee injured your first priority is to get them the appropriate medical treatment.
 - a. In an emergency, call 911 or arrange transportation to a medical facility.
 - b. In case of a work-related injury or illness requiring non-emergency services (i.e., back pain, sprained ankle, etc.) follow the Claims Reporting Instructions below.
- 2) As soon as feasible, call us at 1-888-249-0035 to report the claim.
- 3) We will have to complete a form called a "First Report of Injury." Filing this form is not an admission of liability on your part. How to get a First Report of Injury form:
 - a. If you can track down your policies there should be a blank form in with your Work Comp policy.
 - b. You can complete the form over the phone with us
 - c. We can also fax or email you a copy to complete on your own.
- 4) Completing the First Report
 - a. Gather the facts. In non-emergencies, you can interview the employee first and their co-workers second. If they've gone for medical treatment, talk to any co-workers who might have seen what happened. You'll need to know the time, place and cause of injury.
 - b. You will need some personal information about the injured employee. You may have to check their Human Resources or Personnel File. We'll need their full name and social security number. If you can't get a hold of all their information right away, that's ok, we want to get the claim turned in as quickly as possible. Not everything is needed at once to file the claim.
- 5) With the First Report completed, we can turn the claim into your Work Comp carrier.

FORM 45: Employers First Report of Injury or Illness

PLEASE TYPE OR PRINT

Filing of this report does not affect your liability under the Workers' Compensation Act and is not incriminatory in any sense.

| | | | | | | | |
|----------|---|---|--|--|--|---|--|
| A | *45 | ILLINOIS UNEMPLOYMENT COMPENSATION NUMBER | DATE OF REPORT | MONTH | DAY | YEAR | CASE OR FILE NUMBER |
| B | EMPLOYER'S NAME | | | EMPLOYER'S FEIN NUMBER | | | IS THIS A LOST WORKDAY-CASE? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C | DOING BUSINESS UNDER THE NAME OF | | | | | | CITY, STATE / ZIP CODE |
| D | MAILING ADDRESS | | | | | | CITY, STATE / ZIP CODE |
| E | EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS | | | | | | |
| F | NATURE OF BUSINESS OR SERVICE | | | SIC CODE | TOTAL NUMBER OF EMPLOYEES AT THE LOCATION WHERE ILLNESS OR INJURY OCCURRED | | |
| G | NAME OF WORKERS' COMPEN. INSURANCE CARRIER | | POLICY NUMBER: UNIT NUMBER: | | SELF INSURED YES <input type="checkbox"/> NO <input type="checkbox"/> | | COUNTY WHERE INJURY OCCURRED |
| H | EMPLOYEE'S NAME (LAST, FIRST, MIDDLE) | | | | | SOCIAL SECURITY NUMBER | |
| I | HOME ADDRESS | | | | | | CITY, STATE / ZIP CODE |
| J | MALE <input type="checkbox"/> | FEMALE <input type="checkbox"/> | MARRIED <input type="checkbox"/> | SINGLE <input type="checkbox"/> | WIDOW(ER) <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | BIRTH DATE MONTH DAY YEAR / NUMBER OF DEPENDENT CHILDREN UNDER 18 AT TIME OF INJURY OR ILLNESS |
| K | DATE AND TIME OF THE INJURY OR EXPOSURE | | EMPLOYEE'S AVERAGE WEEKLY EARNINGS | | \$ | | LAST DAY EMPLOYEE WORKED MONTH DAY YEAR |
| L | JOB TITLE OR OCCUPATION | | | DEPARTMENT NORMALLY ASSIGNED | | | |
| M | ADDRESS OF LOCATION WHERE INJURY OR EXPOSURE OCCURRED | | | | | | CITY, STATE / ZIP CODE |
| N | DID EMPLOYEE DIE AS A RESULT OF THE INJURY OR ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | EMPLOYEE DIED AS A RESULT OF THE INJURY OR ILLNESS, GIVE DATE OF DEATH | | | MONTH DAY YEAR |
| O | WAS THE INJURY OR EXPOSURE ON THE EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO | | DID THIS INCIDENT RESULT IN: <input type="checkbox"/> OCCUPATIONAL DISEASE | | | WAS EMPLOYEE GIVEN INDUSTRIAL COMMISSION HANDBOOK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| P | NATURE OF THE INJURY | | | | | | |
| Q | PART OF THE BODY AFFECTED (BE SPECIFIC) | | | | | | |
| R | WHAT TASK WAS EMPLOYEE PERFORMING WHEN ILLNESS OCCURRED? | | | | | | |
| S | OBJECT OR SUBSTANCE RESPONSIBLE FOR INJURY OR ILLNESS (SOURCE) | | | | | | |
| T | HOW DID ACCIDENT OR ILLNESS OCCUR (TYPE)? | | | | | | |
| U | WHAT HAZARDOUS CONDITIONS, METHODS OR LACK OF PROTECTIVE DEVICES CONTRIBUTED? | | | | | | |
| V | WHAT UNSAFE ACT BY A PERSON CAUSED OR CONTRIBUTED TO THE INJURY OR ILLNESS? | | | | | | |
| W | HAVE MEDICAL SERVICES BEEN RENDERED TO THE EMPLOYEE? <input type="checkbox"/> YES <input type="checkbox"/> NO | | IS OR HAS THE EMPLOYEE BEEN HOSPITALIZED? | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| X | NAME AND ADDRESS OF PHYSICIAN | | | | | | CITY, STATE / ZIP CODE |
| Y | NAME AND ADDRESS OF HOSPITAL | | | | | | CITY, STATE / ZIP CODE |
| Z | REPORT PREPARED BY: (NAME - PRINT OR TYPE) | | SIGNATURE | | | TITLE AND TELEPHONE NUMBER | |

ACCIDENT REPORTING DEPT., ILLINOIS INDUSTRIAL COMMISSION, 100 West Randolph Street. Chicago, Illinois 60601
 NOTE: DISCLOSURE OF THIS INFORMATION TO THE INDUSTRIAL COMMISSION IS MANDATORY UNDER IL. REV. STAT CH. 48, §1386
 FAILURE TO PROVIDE ANY INFORMATION COULD RESULT IN PROSECUTION. APPROVED BY FORMS MANAGEMENT.

Bret Dixon Insurance

A Division of Maverick Insurance Services, Inc.

Toll Free
888-249-0035

www.bretdixonins.com

Fax
(888) 349-0035

Illinois

Indiana

Iowa

Missouri

Establishment: _____

Incident Occurred: On Premises: _____ Off Premises: _____

Date: _____ Time: _____

Name of Injured Patron: _____

Patron's Address: _____

Patron's Phone # : _____

What Happened?

Action Taken:

Hospital Needed? _____ Was Patron Intoxicated? _____ Was Patron Alone? _____

If not, name(s) of associates:

Witnesses & Phone #s: _____

Server on Duty: _____ Manager on Duty: _____

Agent Notified: _____

This form can also be submitted electronically at www.bretdixonins.com