THE FOURSQUARE CHURCH

HOW TO FILE
AN INSURANCE CLAIM

Workers' Compensation Insurance

To report a claim under your workers' compensation insurance please call the administrator, Gallagher Bassett 24 hours a day, 7 days a week at 833.813.5580, Option 3. It is imperative that all workers' compensation claims be reported immediately. Delays in reporting can subject the church/school to fines and penalties imposed by their respective states.

You will be asked to provide the following information regarding your workers' compensation claim:

- Foursquare Client Number: 005053
- Church legal name (not the slogan name)
- Church code number
- Name, address and phone number of the injured worker
- Social Security number of the injured worker
- Age, gender, marital status and number of dependents
- Date of hire; length of time in current position
- Current wage information
- When/where and how the injury occurred
- Date the injury was reported to you
- Type of injury
- Body part(s) injured
- Name of any witnesses
- Name and address of physician and/or hospital
- Estimated amount of time employee will lose due to injury
- Any reason(s) to question this injury

Revised October 2022

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Foursquare Workers' Compensation Loss Notice
Email claim form to: tnwclaims@tnwinc.com

Legal Church/School/Camp Name ______________________________ Today's Date __________
Church Code ______________ Fein # ______________________ Client Number 005053

Employee Information

Employee Name (First/Last): ____________________________________
Street Address: ______________________ City: ______________ State: ________
Work Phone: ______________________ Ext. ______________________
Cell Phone: ____________________________________
Email: ____________________________________
SSN: ______________________ DOB: ______________________
Marital Status: Married/Single/Divorced: ______________________
Spouse's Name: ____________________________________
Number of Dependents: ____________________________________

Employment

Occupation: ____________________________________
Date of Hire: ____________________________________
Date Terminated (if applicable): ______________________
Employment Status (Full Time/Part-Time): ______________________
Wages/Hourly Rate and # of hours per week): ______________________

Supervisor Information

Name of Supervisor/Manager: ______________________
Work Phone: ______________________ Ext. ______________
Email: ____________________________________

Incident Information

Exact Date of Injury: ______________________
Exact Time of Injury: ______________________
Exact Location or site where injury occurred: ______________________
Specific Description of Injury: ______________________
Injured Body Parts: ______________________
Witnesses: Y __________ N __________
Name (First/Last): ______________________
Phone: ______________________
Employer Notified: ______________ Date: ______________ Time: __________

Medical Provider

Was treatment sought? Y ______________ N __________
Hospital/Clinic Name where treatment was sought: ______________________
Address: ______________________ City: ______________ State: __________
Phone: ______________________ Ext. ` ______________
Doctor's Name: ______________________

Lost Time

Date last worked: ______________________
Return to Work Date: ______________________