AmTrust North America

An AmTrust Financial Company

Provide 24/7 Toll-Free Claim Reporting

For ALL States
Phone: (866) 272-9267
Fax: (775) 908-3724 or (877) 669-9140
Email: Amtrustclaims@qrm-inc.com
Online: www.amtrustfinancial.com (Must Register)

Information Required for All Claims reported.

1. Name of the insured and policy number
2. Date, Time & Place of Accident
3. Description of accident or incident
4. Name, phone and/or e-mail of person making the report

Additional Information Required for Specific Claim Types

A. For Workers' Compensation
   1. ***MUST have the injured employee's social security number as it is required by law***
   2. Description of injury

B. For Property Claims
   1. Physical address of the loss
   2. If more than one building on property must have specific building(s) involved
   3. Type of loss, i.e., Fire, Theft, etc.
   4. Description of loss or damage

C. For Motor Vehicle (Auto) Claims
   1. Name, address and contact information of ***ALL*** parties involved.
   2. Make, model and VIN of the insured vehicle
   3. Make, model of all other vehicles involved
   4. Current location of all vehicles
   5. Name and contact information ***for each driver and all passengers***
   6. Name and contact information any known witnesses

D. For General Liability Claims
   1. Physical address of where the loss occurred
   2. Name, address and contact information for all persons claiming injury or damage
   3. Name and contact information any known witnesses

ACORD ™ WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
Brevard Alzheimer's Foundation, Inc 4676 N. Wickham Road Melbourne, FL 32935	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		

SIC CODE	EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	LOCATION #
	593369526		PHONE # COUNTY

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Wesco Insurance Company 800 Superior Avenue East, 21st Floor Cleveland, OH 44114	6/1/2022 TO 6/1/2023 CHECK IF APPROPRIATE ☐ SELF INSURANCE	To Report a Claim By Phone: 1-866-272-9267 To Report a Claim By Fax: 1-877-669-9140 To Report a Claim My Email: amtrustclaims@qrm-inc.com

CARRIER FEIN	POLICY / SELF INSURED NUMBER	ADMINISTRATOR FEIN
85-0165753	WWC3590361	

AGENT NAME & CODE NUMBER

Brown & Brown of Florida, Inc. - Daytona -# 13437

EMPLOYEE / WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS ☐ UNMARRIED (SNGL/DIV) ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION / JOB TITLE EMPLOYMENT STATUS	
PHONE HOME WORK	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER: ☐DAY ☐MONTH ☐WEEK ☐OTHER:	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE ☐ YES ☐ NO

OCCURRENCE / TREATMENT

TIME EMPLOYEE BEGAN WORK	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME / PHONE NUMBER	TYPE OF INJURY / ILLNESS	PART OF BODY AFFECTED
DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY / ILLNESS CODE	PART OF BODY AFFECTED

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECT OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

	HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT ☐ NO MEDICAL TREATMENT ☐ MINOR BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HRS ☐ FUTURE MAJOR MED/LOST TIME ANTICIPATED
WITNESS (NAME & PHONE)		

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

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