



OcCLINK

SIMPLIFYING OCCUPATIONAL INJURIES

Company Information

Name of Company

Address

City

State

Zip Code

Contact Information

First Name

Last Name

Title

Phone

Fax

E-Mail

Historical Information

Claims Information

	Most Recent					
	Year 1		Year 2		Year 3	
Premium						
	<i>Indem</i>	<i>Med</i>	<i>Indem</i>	<i>Med</i>	<i>Indem</i>	<i>Med</i>
# of Claims						
# Litigated						

Reports Needed

- 1) Loss Ratio Reports for three years, including average claim age
- 2) Loss History Report
- 3) Claim Stratification Report & Ratio of Indemnity to Medical
- 4) Frequency & Severity Report
- 5) First Aid Claims Frequency & Number

Current Information

<i>Class of Operation</i>	<i>Code Number</i>	<i># of Employees</i>	<i>Last Years Payroll</i>	<i>This Years Payroll</i>
Total				

Claim Services & Costs (If Self Funded, please complete the following)

<i>Service</i>	<i>Name of Program</i>	<i>Managing Entity</i>	<i>Cost</i>
Program Management			
Reinsurance or Excess Coverage			
Utilization Review			
Bill Review			
Medical Case Management			
Legal (including 132a)			
Investigation			
Temporary Disability			
Permanent Disability			
Medical Provider Network (MPN)			

Third Party Claims Administrator (Check if Self-Administered)

Name of Company

Address

City State Zip Code

Loss Prevention Service

Name of Company

Address

City State Zip Code