To report a claim, please call: (844) 430 – 0811 or email: [ADOIClaims@tnwinc.com](mailto:ADOIClaims@tnwinc.com)

*Note: Any question with an asterisk (\*) is required information.*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client Information | | | | | | | | | | | | | |
| GB Client Number | | | 000059 | | | | | | | | | | |
| Client Name | | | Archdiocese of Indianapolis | | | | | | | | | | |
| VDN Number | | | 2228377 | | | | | | | | | | |
| Date and Time of Accident | | | | | | | | | | | | | |
| \*Incident Date | | | Enter date. | | | | | Incident Time | | | | Enter time. | |
| \*Employer Notified Date | | | Enter date. | | | | | | | | | | |
| Client Location | | | | | | | | | | | | | |
| \*Location Code | | | Enter Location Code. | | | | | | | | | | |
| \*Client Name | | | Enter Client Name. | | | | | | | | | | |
| Street Address | | | Enter Street Address. | | | | | | | | | | |
| City | Enter City. | | \*State | | Choose State. | | | | ZIP | | | Enter ZIP. | |
| Phone Number | Enter phone #. | | | | | | | | | |  | | |
| Submitter/Preparer Information | | | | | | | | | | | | | |
| Name | | | Enter Name. | | | | | | | | | | |
| Title | | | Enter Title. | | | | | | | | | | |
| Phone Number | | | Enter Phone #. | | | | | | | | | | |
| Email Address | | | Enter Email. | | | | | | | | | | |
| Claimant Information | | | | | | | | | | | | | |
| \*Social Security Number | | | Enter SSN. | | | | | | | | | | |
| \*First Name | | | Enter First Name. | | | | | Middle Initial | | | | | Enter Initial. |
| \*Last Name | | | Enter Last Name. | | | | |  | | | | | |
| Home Phone | | | Enter Phone #. | | | | | Work Phone | | | | | Enter Phone #. |
| Street Address | | | Enter Street Address. | | | | | | | | | | |
| City | Enter City. | | State | | Choose State. | | | ZIP | | | | | Enter ZIP. |
| Email Address | Enter Email. | | | | | | | Cell Phone | | | | | Enter Phone #. |
| Date of Birth | Enter date. | | | | | Marital Status | |  | | | | | Choose... |
| Gender | Choose... | | | | | | | | | | | | |
| Employment | | | |
| Occupation | | | Enter text. | | | | | | | | | | |
| Employment Status | | | Enter text. | | | | | | | | | | |
| \*Date Hired | | | Enter date. | | | | | | | | | | |
| Wages | | | |
| Amount | | | Enter amount. | | | | | | | | | | |
| Frequency | | | Enter frequency (hourly, salary, etc.) | | | | | | | | | | |
| Incident Information | | | | | | | | | | | | | |
| \*Detailed Description of Incident | | | Enter Description. | | | | | | | | | | |
| Part and side of Body | | | Enter Part and side of Body. | | | | | | | | | | |
| Injury Type | | | Enter Injury Type. | | | | | | | | | | |
| Cause of Injury | | | Enter Cause of Injury. | | | | | | | | | | |
| Date Last Worked | | | Enter date. | | | | Date Returned to Work | | | | | | Enter date. |
| Date of Death (if applicable) | | | Enter date. | | | | | | | | | | |
| Medical Provider *(Only if medical treatment rendered)* | | | | | | | | | | | | | |
| Hospital/Clinic Name | | | Enter text. | | | | | | | | | | |
| Street Address | | | Enter Street Address. | | | | | | | | | | |
| City | Enter City. | | State | | Choose State. | | | ZIP | | | | | Enter ZIP. |
| Phone Number | | Enter Phone #. | | | | | | | | | | | |
| Doctor Name | | Enter Name. | | | | | | | | | | | |
| Street Address | | Enter Street Address. | | | | | | | | | | | |
| City | Enter City. | | State | | Choose State. | | | ZIP | | | | | Enter ZIP. |
| Phone Number | | Enter Phone #. | | | | | | | | | | | |
| GB Questions | | | |
| \*Was outside medical treatment provided for the injured worker? | | | | | | | | Enter text. | | | | | |
| \*Will the injured worker lose time from work other than the day of injury? | | | | | | | | Enter text. | | | | | |
| \*For which state are payroll taxes withheld for the employee? | | | | | | | | Choose State. | | | | | |
| Accident Location *(Enter SAME, if same as reporting location)* | | | | | | | | | | | | | |
| Location Name | | | Enter Location Name. | | | | | | | | | | |
| Street Address | | | Enter Street Address. | | | | | | | | | | |
| City | Enter City. | | \*State | | Choose State. | | | | | ZIP | | Enter ZIP. | |
| Client Premises? | | | Choose... | | | | | | | | | | |
| Contact Information | | | |
| \*First and Last Name | | | Enter Name. | | | | | | | | | | |
| \*Phone | | | Enter Phone #. | | | | | | | | | | |
| Additional Dissemination Information | | | | | | | | | | | | | |
| Who should receive an email confirmation for this loss? | | | Enter text. | | | | | | | | | | |
| Email Address | | | Enter Email. | | | | | | | | | | |
| Notes/Additional Comments *(ie, if there were witnesses or if this is for report only)* | | | | | | | | | | | | | |
| Additional Remarks | | | Enter text. | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| NOTE: Please advise if this was a vehicle accident, should an Auto Loss be entered from this loss information? | | | | | | | | | | | Choose... | | |
|  | | | | | | | | | | | | | |