

Mississippi Housing Authorities Risk Management, Inc.

Claims Reporting Procedures 12/1/2011 to 12/1/2012



Arthur J. Gallagher Risk Management Services, Inc.

750 Woodlands Parkway, Suite 200
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INTRODUCTION

This Claims Reporting Procedures manual has been prepared to give you a “hands-on tool” for reporting possible claims and known accidents under your existing property and casualty insurance program. Prompt and complete information is extremely valuable in providing speedy and equitable claims adjustment. Any assistance which you render in this regard will be beneficial to both you and to the injured party.



Gallagher Bassett Services, Inc.
All Claims Except for Workers' Compensation

MHARM, Inc. contracts with **Gallagher Bassett Services, Inc. (GBS)**, located in Birmingham, AL, for most of the claim reporting and handling of your insurance program. Mr. Mark Petty is the person to contact to file a claim and the telephone number is 205-986-0566. Claims may also be faxed to 866-552-5441. In the event that Mr. Petty cannot be reached, please contact Doug Pederson at the number below.

CLAIMS SERVICE TEAM

Name	Title	Phone	Fax
Mark Petty Mark_petty@gbtpa.com	Adjuster	205-986-0566	866-552-5441
Douglas Pedersen Douglas_pederson@gbtpa.com	Liability Claims Supervisor	800-843-9999 ext 3229	877-729-3793

While every possible situation cannot be anticipated, it is expected that these procedures will enable you to handle most situations. Since your insurance program is serviced by Arthur J. Gallagher Risk Management Services, Inc., please feel free to contact any of the Client Service Team directly, should you feel a need to do so.

A brief description of coverage is included on the following pages. While every effort has been made to make this as complete and accurate as possible, it does not contain a full restatement of the contracts. In the event of any conflict or omission, the terms of the actual contract of insurance shall be paramount in every instance.



Arthur J. Gallagher Risk Management Services, Inc.

Your *Account Manager* is the **primary contact** for servicing the policies and programs placed through Arthur J. Gallagher Risk Management Services, Inc. You can talk directly with your Account Manager from 8:30 a.m. to 5:00 p.m. (Monday-Friday) by calling her directly or by dialing the main switchboard number: 800-960-4992 ext 3121.

BROKERAGE SERVICE TEAM

Name	Title	Phone Number	Fax Number
Philip Rutledge	<i>Broker</i>	<i>601-863-3152</i>	<i>601-812-6212</i>
Laura Young	<i>Account Manager</i>	<i>601-863-3121</i>	<i>601-812-6204</i>
Linda Bograd	<i>Account Associate</i>	<i>601-863-3129</i>	<i>601-812-6205</i>
Brandi Carter	<i>Claims Representative Arthur J Gallagher</i>	<i>601-863-3130</i>	<i>601-812-6231</i>

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REAL AND PERSONAL PROPERTY/TRANSIT

Company: Primary: Axis Surplus Insurance Company
Policy No.: EAF75632310

COVERAGE: All Risk of direct physical loss or damage provided for losses to buildings, contents, stock, machinery, equipment, valuable papers, account receivables, furniture and fixtures, extra expense and goods in transit subject to policy terms, conditions and exclusions.

INSTRUCTIONS: Take immediate necessary action to minimize damage and prevent further damage, i.e. (call fire department, return sprinkler system, alarm systems, etc. to normal service conditions, etc.), then follow these steps:

1. Contact by telephone, email or facsimile, Mark Petty, Claims Adjuster at Gallagher Bassett. If you are unable to reach someone at GAB, proceed to step #2.
2. Contact by telephone or facsimile, Brandi Carter, Claims Representative, at Arthur J. Gallagher Risk Management Services, Inc., or any other member of the Client Service Team.



AUTOMOBILE LIABILITY AND PHYSICAL DAMAGE

Company: Travelers Indemnity Company
Policy No.: 9158P942

COVERAGE: **Liability:** Legal liability for Bodily Injury or Property Damage to third parties or their property, arising out of the ownership, maintenance and use of owned, non-owned or hired automobiles, subject to policy terms and conditions.

Physical Damage: Direct physical loss or damage caused by collision or upset, including comprehensive coverage to owned or leased vehicles (where applicable) subject to deductibles, policy terms and conditions.

INSTRUCTIONS: Take immediate necessary action to minimize damage and prevent further damage, then follow these steps:

1. Stop and investigate.
2. Secure necessary medical aid.
3. Report accident to police.
4. Never admit liability for an accident.
5. Obtain names, addresses and tag #'s of all witnesses.
6. Complete any necessary local or state accident reports.
7. Contact by telephone or facsimile, Mark Petty, Claims Adjuster at Gallagher Bassett Services. If you are unable to reach someone at Gallagher Bassett, proceed to step #8.
8. Contact by telephone or facsimile, Brandi Carter, Claims Representative at Arthur J. Gallagher Risk Management Services, Inc., or any other member of the Client Service Team.
9. If a legal suit is delivered or a letter of intent to sue is given, send this immediately to Gallagher Bassett and to Arthur J. Gallagher Risk Management Services, Inc. in care of Brandi Carter, Claims Representative. See contact information on pages 2 and 3.



COMPREHENSIVE CRIME (EMPLOYEE THEFT)

Company: Travelers Indemnity Company
Policy No.: 560M3285

COVERAGE: Coverage is provided for losses resulting from employee dishonesty, depositors forgery, credit card forgery, money orders and counterfeit currency. Coverage is also provided for losses, including burglary and robbery both inside and outside premises, subject to policy terms, conditions and exclusions.

INSTRUCTIONS: Take immediate necessary action to prevent further losses, then follow these steps:

1. Immediately institute claim reporting procedures as outlined in the policy. After this has been initiated, by telephone or facsimile, contact Mark Petty, Claims Adjuster at Gallagher Bassett Services. If you are unable to reach someone at Gallagher Bassett, proceed to step #2.
2. Contact by telephone or facsimile, Brandi Carter, Claims Representative at Arthur J. Gallagher Risk Management Services, Inc., or any other member of the Client Service Team.
3. Contact the local authorities to report any criminal activity of loss.



COMMERCIAL GENERAL LIABILITY

Company: Travelers Indemnity Company
Policy No.: GP06302498

COVERAGE: Legal Liability for injury to or death of members of the public (except by automobile) and damage to their property subject to policy terms, conditions and exclusions. (Includes Product Liability),

INSTRUCTIONS: If bodily injury, we suggest that the injured party see his/her physician immediately. Note any circumstances which may have a bearing on legal liability, then:

1. Contact by Telephone or facsimile, Mark Petty, Adjuster at Gallagher Bassett Services. If you are unable to reach someone at Gallagher Bassett, proceed to step #2
2. Contact by telephone or facsimile, Brandi Carter, Claims Representative at Arthur J. Gallagher Risk Management Services, Inc., or any other member of the Client Service Team.
3. Obtain names and addresses of all witnesses.
4. Never admit liability for an occurrence or claim.
5. If a legal suit is delivered or a letter of intent to sue is given, send this immediately to Arthur J. Gallagher Risk Management Services, Inc. in care of Brandi Carter, Claims Representative and to Mark Petty, Claims Adjuster at Gallagher Bassett.



WORKERS' COMPENSATION

Company: Tower Insurance Company of New York

COVERAGE: Employee related injuries

INSTRUCTIONS: See Tower Claim Reporting instruction sheet attached as well as a copy of the MS First Report of Injury form to be used for all claims. All Workers Comp claims are to reported directly to Tower Insurance Company by fax, email, phone or mail. Please direct all providers to send bills for reported claims to the following address:

Tower Group Companies
Claims Department
P. O. Box 907
Paramus, NJ 07653-0907





Reporting Work Related Accidents

The timely reporting of work related accidents is critical in helping to reduce the overall costs associated with these claims. Please remember to notify us immediately in the event that one of your employees is injured at work or claims to be ill due to conditions on the job. By doing so we can work together to help control claim costs. It is very important to include contact numbers for the employee and the employer when submitting a First Report of Injury. We recommend you list both landline and cell phone numbers.

Reporting a work related accident can be done by fax, email, phone or mail. Simply complete the attached First Report of Injury form and forward to us in any manner as noted below.

BY FAX

To report a claim by fax:

Fax the completed First Report of Injury Form to our 1st Report fax line at 1-888-291-6262.

BY EMAIL

To report a claim by email - Please email the completed First Report of Injury Form to reportaloss@twgrp.com.

BY PHONE

To report a claim by phone - Call 1-888-856-5522.

BY MAIL

To report a claim by mail - Please forward the completed First Report of Injury Form to:

Tower Group Companies
Claims Department
P.O. Box 907
Paramus, NJ 07653-0907

If at any time you have questions about the reporting process or how to complete the First Report of Injury Form, please feel free to contact our claims department at 1(888) 856-5522.

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
SIC CODE	EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION # PHONE #

CARRIER/CLAIMS ADMINISTRATOR		
CARRIER (NAME, ADDRESS & PHONE NO)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
	TO	
CHECK IF APPROPRIATE		
<input type="checkbox"/> SELF INSURANCE		
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
NAME (LAST, FIRST, MIDDLE)					
ADDRESS (INCL ZIP)		SEX	MARITAL STATUS		OCCUPATION/JOB TITLE
		<input type="checkbox"/> MALE (M) <input type="checkbox"/> FEMALE (F) <input type="checkbox"/> UNKNOWN (U)	<input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U) <input type="checkbox"/> MARRIED (M) <input type="checkbox"/> SEPARATED (S) <input type="checkbox"/> UNKNOWN (K)	EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE		
RATE PER:	DAY	MONTH	#DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY?	YES NO
	WEEK	OTHER:		DID SALARY CONTINUE?	YES NO

OCCURRENCE/TREATMENT							
TIME EMPLOYEE BEGAN WORK	AM PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM PM	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?		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED CODE			
<input type="checkbox"/> YES <input type="checkbox"/> NO							
COUNTY 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 ACCIDENT OR ILLNESS 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 OBJECTS 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
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT
			NO MEDICAL TREATMENT (0) <input type="checkbox"/>
			MINOR: BY EMPLOYER (1) <input type="checkbox"/>
			MINOR CLINIC/HOSP (2) <input type="checkbox"/>
			EMERGENCY CARE(3) <input type="checkbox"/>
			HOSPITALIZED > 24 HRS (4) <input type="checkbox"/>
			FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) <input type="checkbox"/>
WITNESSES (NAME & PHONE #)	DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE
			PHONE NUMBER

WORKERS' COMPENSATION - FIRST REPORT OF INJURY EMPLOYER'S INSTRUCTIONS

EMPLOYER (NAME & ADDRESS INCL ZIP) - The name and address of the entity employing or statutorily responsible for the employee.

IC CODE - The code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

EMPLOYER FEIN - Employer's Federal Employer Identification Number.

CARRIER/ADMINISTRATOR CLAIM NUMBER - Carrier's claim or file number.

REPORT PURPOSE CODE - A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

JURISDICTION - State in which you are filing the claim (Mississippi).

JURISDICTION CLAIM NUMBER - Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

INSURED REPORT NUMBER - The number, if any, used by the employer to identify the claim.

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) - The name and address of the employer's facility where the employee was employed at the time of injury, if different from above.

LOCATION #/ PHONE # - The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

CARRIER (NAME, ADDRESS & PHONE NO) - The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

POLICY PERIOD - The date that the contract/policy under which the claim occurred began and expired.

CHECK IF APPROPRIATE (SELF-INSURANCE) - An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

CLAIMS ADMINISTRATOR - The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

CARRIER FEIN - Carrier's Federal Employer Identification Number.

POLICY/ SELF-INSURED NUMBER - The number assigned by the carrier to the insurance contract/policy for the employer; or any similar number assigned to a self-insured employer.

ADMINISTRATOR FEIN - Federal Employer Identification Number of Administrator.

AGENT NAME & CODE NUMBER - The name of the insurance agent and the agent's code number if known. This information should be found in the insurance policy.

NAME (LAST, FIRST MIDDLE) - Employee's legally recognized name.

ADDRESS - The mailing address used by the employee.

PHONE - A telephone number where the employee can be reached.

DATE OF BIRTH - The date the employee was born.

SOCIAL SECURITY NUMBER - A number assigned by the Social Security Administration used to identify the employee.

DATE HIRED - The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

STATE OF HIRE - State where employee was hired.

SEX - The code which indicates the sex of the employee.

MARITAL STATUS - The code which indicates the marital status of the employee.

OCCUPATION/JOB TITLE - This is the primary occupation of the employee at the time of the accident or exposure.

EMPLOYMENT STATUS - Indicate the employee's work status. The valid choices are: Full-time, Part-Time, Not Employed, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-Time, Apprenticeship Part-Time, Volunteer, Seasonal, or Piece Worker.

NCCI CLASS CODE - A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE.

RATE - The reported employee's wage rate at the time of injury.

DAYS WORKED/ WEEK - The number of days worked by the employee in a week.

FULL PAY FOR DAY OF INJURY - State whether employee was paid his full wages on the injury date.

DID SALARY CONTINUE - State whether employee's salary was continued by the employer in lieu of compensation benefits.

TIME EMPLOYEE BEGAN WORK - The time employee began work on date of injury.

DATE OF INJURY/ILLNESS - The date employee was injured.

TIME OF OCCURRENCE - The time employee was injured.

LAST WORK DATE - The date employee last worked following the injury.

DATE EMPLOYER NOTIFIED - The date on which the employer was notified of the injury.

DATE DISABILITY BEGAN - The date on which employee began losing time.

CONTACT NAME/PHONE NUMBER - Name and phone number of employer representative to be contacted for further information.

TYPE OF INJURY/ILLNESS - Briefly describe the nature of the injury or illness. (e.g., Lacerations to the forearm).

PART OF BODY AFFECTED - Indicate the part of body affected by the injury/illness, (e.g., Right Forearm, lower back).

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES - Mark yes or no as applicable.

TYPE OF INJURY/ILLNESS CODE - The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

PART OF BODY AFFECTED CODE - The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - The county where the injury occurred. If the injury did not occur in Mississippi, put "out of state".

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED - List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint. Enter "NA" for not applicable if no equipment, materials, or chemicals were being used.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED - Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g., walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL - Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

CAUSE OF INJURY CODE - The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

DATE RETURN(ED) TO WORK - Enter the date following the most recent disability period on which the employee returned to work.

IF FATAL, GIVE DATE OF DEATH - Date of death of employee.

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED/WERE THEY USED - Check applicable "yes" or "no" box.

PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS) - The name and address of the physician or health care professional providing initial treatment.

HOSPITAL (NAME AND ADDRESS) - The name and address of the hospital where employee was treated (if applicable).

INITIAL TREATMENT - Check applicable choices.

WITNESSES (NAME & PHONE #) - The name(s) and phone number(s) of any one who witnessed the accident.

DATE ADMINISTRATOR NOTIFIED - The date the carrier or claims administrator processing the claim received notice of the injury.

DATE PREPARED - The date this report was prepared.

PREPARER'S NAME & TITLE - The name and title of the person who prepared this report.

PHONE NUMBER - The phone number of the person who prepared this report.