Sentry®

Claims reporting guide

Please use the following information when reporting claims:

Client/customer name: United Methodist Homes of NJ

Account number: A0275963

Report accidents or injuries immediately, even if you don't have all the information. When you immediately notify us, it helps us determine the severity of the claim, deliver timely claim benefits, and reduce claim costs.

You can report a claim anytime—24 hours a day, 365 days a year.
See reverse side for questions you can expect from us when reporting a claim.

CLAIMS REPORTING—ALL LINES OF COVERAGE

Phone: 800-473-6879

Fax: 800-999-4642

Online*: Log in to sentry.com

Email: claimsmail@sentry.com

Mail:
Sentry Claims Service
P.O. Box 8032—for workers' compensation
P.O. Box 8026—for all other departments
Stevens Point, WI 54481

*Available at no cost, but pre-registration is required

90-2259 3118060 9/15/23

Questions you can expect during an injury report or accident interview

WC Workers' compensation **A** Auto **GL** General liability **P** Property

WC	A	GL	P	
				Caller information
■	■	■	■	Name
■	■	■	■	Title
■	■	■	■	Phone number
■	■	■	■	Preferred contact time
				Primary contact information
■	■	■	■	Name
■	■	■	■	Title
■	■	■	■	Phone number
				Employer information
■	■	■	■	Name
■	■	■	■	Address
■	■	■	■	Phone number
■	■	■	■	Reporting location name
■	■	■	■	Reporting location address
■	■	■	■	Reporting location phone number
■				Federal ID number
■	■	■		Location code
■				Employer notification date
■				Employee death
■	■	■	■	Policy number
■	■	■	■	Policy expiration date
				Employment information
■				Hire date
■				Hire state
■				Hourly wage rate
■				Average hours worked per day
■				Average days worked per week
■				Last day worked
■				Continued salary
■				Other compensation earned
■				Date returned to work
				Accident information
■	■	■	■	Accident date
■	■	■	■	Full name
■	■	■		Gender
■	■	■	■	Social Security number
■				Birth date

WC	A	GL	P	
				Accident information (continued)
■				Marital status
■				Number of dependents
■				Occupation
■	■	■	■	Phone number
■	■	■		Accident time
■		■	■	Accident location
■	■	■	■	Accident description
■				Witnesses
■				Class code
■	■	■		Injury description
				Medical information
■		■		Physician or clinic name
■		■		Physician or clinic address
■		■		Physician or clinic phone number
				Auto and property
	■			Police report
	■			Violations or citations
	■			Driver name and address
	■			Driver license number and state
	■			Driver phone number
	■			Driver birth date
	■			Insured name and address
	■			Insured phone number
	■			Vehicle identification number
	■			Vehicle plate number and state
	■			Vehicle year/make/model/body
	■			Vehicle purpose
	■			Passengers
	■			Driver relation to injured
	■		■	Damage and point of impact
	■		■	Claimant insurance information
	■		■	Damage amount estimate
				General liability
		■	■	Premises owner
		■	■	Owner address
		■		Manufacturer name
		■		Manufacturer address
		■		Manufacturer phone
		■		Product type

Sentry Insurance Co.
Reporting Guide

Workers' Compensation

Date: ____/____/____

INSURANCE INFORMATION

Carrier (Insurance Company): Sentry Insurance | Policy No.: A0275963

EMPLOYER INFORMATION

Employer Name: United Methodist Homes of New Jersey

Federal Tax ID No.: | Location No.:

Address: | City: | State: | ZIP:

Phone No.: | Fax No.:

Preparer's Name First: | Last:

Preparer's Title: | Phone No.:

Physical Location (if different):

Address: | City: | State: | ZIP:

EMPLOYEE INFORMATION

Employee's Name First: | Middle: | Last:

Address: | City: | State: | ZIP:

Employee ID No.: | Employee Occupation: | SSN: - - | Phone No.:

Date of Birth: / / | Marital Status: | Sex: Female ☐ Male ☐ | Number of Dependents: Under 18 Other

Department: | Date of Hire: / / | State of Hire:

Wage Rate: $ Per | Average Hours Per Day: | Average Days Per Week:

Paid in full for date of injury? ☐ Yes ☐ No | Did salary continue? ☐ Yes ☐ No

INCIDENT INFORMATION

Address where incident occurred: | City: | State: | ZIP:

Filing State: | On employer's premises? ☐ Yes ☐ No

Did employee lose one or more days of work? ☐ Yes ☐ No | Injury Date: / / | Time of Injury: ☐ AM ☐ PM

Time work began on day of injury: ☐ AM ☐ PM | If lost time, last day worked: / / | Date returned to work: / /

Date employer was notified: / / | Name of person notified:

Fatality? ☐ Yes ☐ No | If yes, date of death: / /

Were safeguards or safety equipment provided? ☐ Yes ☐ No | If so, was employee using them? ☐ Yes ☐ No

Type of Injury: | Part of Body:

Describe what happened in detail (employee's activity, objects involved, how injury occurred, etc.):

WITNESSES

Witness Name: | Phone No.:

Witness Name: | Phone No.:

MEDICAL TREATMENT

Did Employee Go To …Clinic/Physician? Name: | Phone No.:

Address: | City: | State: | ZIP:

…Hospital? Name: | Phone No.:

Address: | City: | State: | ZIP:

Type of Treatment: ☐ ER ☐ First Aid ☐ Hospital ☐ In-House ☐ None ☐ Unknown ☐ Outpatient

Any reason to believe this was not work related? ☐ Yes ☐ No ☐ Unknown