



ASSOCIATED
CLAIMS
ADMINISTRATORS

Dear Employer:

Associated Claims Administrators (ACA) will be administering your Worker's Compensation claims on behalf of National Liability & Fire Insurance Company and in partnership with North American Risk Services (NARS).

ACA and NARS professionals are experienced in Worker's Compensation Law. Please feel free to call our office with any questions you may have regarding your Worker's Compensation concerns.

Early involvement in a claim is important. It is not only cost effective for you, but it also can help the injured employee get proper medical care and return to work as soon as possible. We look forward to working with to accomplish these goals.

You, the employer, are a vital part of making this happen. Listed below are some things you can do:

1. Report all work-related injuries as soon as you are aware of them.
2. You may report all work-related injuries by email at claims@acaworkcomp.com, fax to **1-800-988-4722**, or call **1-800-388-6268** for assistance reporting a claim.

After reporting your claim, you can contact NARS at **1-800-315-6090** for further assistance with your claim including:

1. Refer all medical authorization requests to NARS.
2. Communicate with your employee and NARS throughout the claim.
3. Have some light duty work available for restricted duty.
4. Advise NARS when the employee returns to work.

Please keep copies of the attached forms to have on hand if needed. Fillable forms can also be downloaded at <https://aiamga.com/workers-compensation/states-covered/>.

We look forward to a long and pleasant working relationship with you and your employees.

Please call anytime between 8:00am and 5:00pm Central Time, Monday through Friday if you have any questions regarding Worker's Compensation claims procedures.

Best regards,

Associated Claims Administrators

First Report of Injury

Virginia Workers' Compensation Commission
333 E. Franklin St. Richmond Virginia 23219
1-877-664-2566



Reason for filing: _____
VWC Jurisdiction Claim #: _____
(If assigned) _____
Claim Administrator File#: _____

SEE INSTRUCTIONS ON REVERSE SIDE

www.vwc.state.va.us

Employer		
Employer's Legal Name		Federal Employer Identification Number (FEIN)
Employer's Mailing Address		
Name/FEIN of Entity on Policy		Nature of Business
Name and Address of Insurer or Self-Insurer for this Claim		Policy Number
Time and Place of Accident		
Location where accident occurred	Date of injury	Hour of injury ☐ a.m. ☐ p.m.
Date injury or illness reported	If fatal, give date of death	If fatal, give marital status
	If fatal, give number of dependent children	☐ Single ☐ Divorced ☐ Married ☐ Widowed
Injured Worker		
Name of Injured Worker	Phone Number	Injured Worker ID Number
Injured Worker's mailing address		Type of ID ☐ Social Security No. ☐ Employment Visa ☐ Green Card ☐ Passport No. ☐ Unknown
Occupation at time of injury or illness	Date of birth	Sex ☐ Male ☐ Female
Nature and Cause of Accident		
Machine, tool, or object causing injury or illness		
Describe fully how injury or illness occurred		
Describe nature of injury, occupational disease, or illness, including body parts affected		
Signatures		
Submitter (name, signature, title)	Date	Phone number
Submitter's Address		

First Report of Injury

Filing Instructions

The Virginia Workers' Compensation Act requires that **ALL** injuries occurring in the course of employment be reported to the Commission pursuant to Va. Code §65.2-900.

Employer

The employer is responsible for accurately completing all sections of this form when an employee is injured. It should be typed or legibly printed, signed, and dated by the preparer. Send the original form to the claim administrator for the insurance company who provided insurance coverage on the date of the occurrence. The claim administrator will report this information to the Commission. Contact your workers' compensation insurance provider for additional information.

Claim Administrator

Claim administrators who are EDI enabled will use the information contained on the paper form and submit electronic data to the Commission.

Claim administrators who are NOT EDI enabled must immediately file the completed form with the Commission. Please note: EDI is mandatory no later than June 30, 2009, after which time paper reports will no longer be accepted. Until you are in EDI production, mail the completed form to the Virginia Workers' Compensation Commission, 333 E. Franklin St., Richmond, VA 23219. At the top of the form, use a numerical code (1-7) to indicate the reason for filing the form for accidents meeting one of the filing criterion.* If none of the criteria apply, you must still report the accident, but may use either Form 45A or this form to do so. (Leave "reason for filing" blank in such a case.)

For questions or assistance in completing the form, please contact the Commission toll-free at 877-664-2566.

*Criteria for filing are: (1) lost time exceeds seven days; (2) medical expenses exceed \$1,000.00; (3) compensability is denied; (4) issues are disputed; (5) accident resulted in death; (6) permanent disability or disfigurement may be involved; and (7) a specific request is made by the Virginia Workers' Compensation Commission.

ASSOCIATED CLAIMS ADMINISTRATORS

P.O. Box 230848

Montgomery, AL 36123-0848

334-271-6767 (main)

1-800-388-6268 (toll free)

1-800-988-4722 (fax)

WAGE STATEMENT

CLAIMANT: _____ DATE OF INJURY: _____

A. The following table shows the wages earned by _____ employed as a
_____ during the period stated.

	MONTH	DAY	YEAR	GROSS WAGES		MONTH	DAY	YEAR	GROSS WAGES		MONTH	DAY	YEAR	GROSS WAGES
1					19					37				
2					20					38				
3					21					39				
4					22					40				
5					23					41				
6					24					42				
7					25					43				
8					26					44				
9					27					45				
10					28					46				
11					29					47				
12					30					48				
13					31					49				
14					32					50				
15					33					51				
16					34					52				
17					35					TOTAL				
18					36					GRAND TOTAL				

I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT STATEMENT.

_____, TITLE _____

DATE: _____