

**St. Joseph Real Estate Services Corp.  
St. Luke Benefit and Insurance Services Corp.**

**Claim Reporting Instructions**

July 1, 2023 to July 1, 2024

Immediate, direct reporting of claims ensures that insurance adjusters are promptly notified of losses, enabling them to initiate appropriate investigation and timely resolution of your claim. Insurance adjusters have the capacity to receive reports of claims on a "24/7" basis. Therefore, while other claim reporting options are available to you, we encourage Direct Reporting of claims while providing you with Aon's support to ensure proper handling and resolution of catastrophic losses, and coverage issues.

**The forms you are to use for claims (Attached here and available on the Diocese web site)**

- **2023 Work Comp – Filing a Claim**
- **2023 When to call Aon - GL Property claim reporting**
- **2023 Incident Report Form - Property Auto GL**

Discard any prior versions of the Claim Reporting Instructions and Incident Report Forms.

Policy numbers change from year to year.

Complete the appropriate form and submit per the information below.

**Property, Liability and Crime Claims**

**Insurance Carrier:** Catholic Mutual Group (CMG)  
**Policy Number:** 8878  
**Policy Term:** 07/01/2023 to 07/01/2024

- Complete the Incident Report Form
- Submit form to CMG per below and send a copy to Aon at [laura.erdmann@aon.com](mailto:laura.erdmann@aon.com)

E-mail to: [reportclaim@catholicmutual.org](mailto:reportclaim@catholicmutual.org)

Phone: 1-800-228-6108 Ext. 2410

**Auto Claims**

**Insurance Carrier:** Church Mutual Insurance Company  
**Policy Number:** 0500232-09-422879  
**Policy Term:** 07/01/2023 to 07/01/2024

- Complete the Incident Report Form
- Submit form to Church Mutual per below and send a copy to Aon at [laura.erdmann@aon.com](mailto:laura.erdmann@aon.com)

E-mail to: [claimsintake@churchmutual.com](mailto:claimsintake@churchmutual.com)

Phone: 1-800-554-2642 Option 2

## **Workers' Compensation**

**Insurance Carrier:** Christian Brothers  
**Policy Number:** 2200001  
**Policy Term:** 07/01/2023 to 07/01/2024

- All claims should be filed with Gallagher Bassett Services. Gallagher Bassett Services are the administrators for claims on behalf of Christian Brothers. When calling in a claim provide the policy number plus your location number.
- Phone 1-877-735-2270
- Fax: 1-800-748-6159

### **When An Employee is Injured At Work Immediately:**

- Administer first aid.
- Accompany/assist injured employee to a medical provider.
- Notify family.
- Report an accident immediately to Gallagher Bassett Services

### **When Reporting**

#### **Make sure to include accident information, such as:**

- Time/date of injury
- Cause of accident/injury
- Nature of injury (sprain, fracture, etc.)
- Body part involved
- Witnesses
- To whom injury was reported
- Location code/beneficiary number

### **You Can Assist The Claim Handling Process by:**

- Making yourself and witnesses available to the Gallagher Bassett Services claim professional.
- In case of lost time, have job description readily available and the injured employee information, including wage information.
- Continue to reinforce your concern and the organization's concern for the injured employee. Intermittently touch base with the injured employee using a "wellness approach".

## **When to Call Aon**

All claims are to be filed directly with the carrier. If at any time you feel uncomfortable with a particular claim situation, please contact your Aon claims representative. Clients frequently seek our assistance and expertise when claims involve catastrophic losses, questionable liability issues, contract language issues, or claims involving questionable coverage. Some examples:

- Losses involving serious injury or death
- Major fire and other property losses
- Losses of a “sensitive” nature requiring confidential and discreet handling
- Losses requiring assistance in “crisis management”
- Situations where you are being asked to defend and/or indemnify another party due to contract language
- Situations involving additional insured coverage you provide to another party
- Questions as to which type of policy to report a claim under (e.g., auto versus general liability)
- Dissatisfaction with insurance company claims representative or their response time

## **Things You Should Know – Helpful Hints**

- In the event of property damage, you are responsible for protecting the property from further damage after the initial loss.
- Your policy allows you to make emergency repairs to protect your property from further damage. Keep all pertinent documentation.
- Discuss your claim only with those persons who properly identify themselves as your claims representative, your counsel or fire and law enforcement officers.

## **Other Considerations**

Clearly identify to the insurance claims representative who in your organization will make final decisions during the adjustment process.

If you have contractors you prefer, or repair facilities you wish to use, please make them known to the claims representative.

The insurance company is entitled to inspect and appraise the damage. If they are aware of your repair preference, joint inspections can assist in arriving at agreed repair or replacement figures.

# Incident Report Form 7/1/2023-2024

## St Joseph Real Estate Services Corporation

To Report an Automobile Claim 24/7:

Call 1-800-554-2642 Option 2

**Auto Policy Number:**

**0500232-09-422879**

Other Claims:

Call 800-228-6108

**Property / Liability / Crime Policy Number:**

**8878**

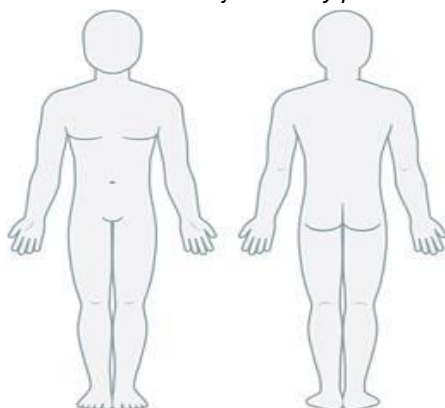
**Complete applicable boxes as they correspond to you claim.**

Parish/School: Name & Complete Mailing Address		Phone:	
		Fax:	
		E-mail:	
Contact:		Title:	
Date/Time of Incident:		Specific Location:	
Injured Party: Name/Address/Age: (include parent or guardian name if a minor)			
Phone Number:		Alternate Number:	
Injured Party: Parishioner <input type="checkbox"/> Volunteer <input type="checkbox"/> Vendor <input type="checkbox"/> General Public <input type="checkbox"/> Other <input type="checkbox"/> Please check the most applicable description as it relates to the incident.			
Medical or First Aid Offered? Yes <input type="checkbox"/> No <input type="checkbox"/>	Accepted or Refused		Transported by Ambulance:
Description of Accident or Damage:			
Were Photographs Taken? – Suggested for property losses over \$5,000, vehicle accidents and liability claim that may have premises factors involved:			
Public Authority Contacted: Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of Authority:		Incident Report Number:
Auto Claim Information:	Vehicle Involved - Year:		Make/Model:
Witnesses: Name/Address/Phone:			
Additional Comments/Information: (If additional space is required, please use reverse side or an additional page)			
Date:		Completed By:	
<p style="text-align: center;">Please complete and report immediately with as much information as available at the time of loss.          Submit this report directly to Catholic Mutual Group. Preference for submission:          E-mail: <a href="mailto:reportclaim@catholicmutual.org">reportclaim@catholicmutual.org</a> or fax: 402-551-2943 or  <b>Auto 1-800-554-2642 Option2, All Other: 800-228-6108</b>          Also submit a <b>copy</b> to Aon Risk Solutions: Laura Erdmann: <a href="mailto:laura.erdmann@aon.com">laura.erdmann@aon.com</a> or fax 920-431-6352.  <b>RETAIN A COPY IN YOUR PERMANENT FILE</b></p>			

## Manager's Report of Incident/Injury

- ☒ Ensure injured employee receives appropriate medical care. If necessary, call 911.
- ☐ Secure the scene for investigative purposes, e.g. limit access, secure and save equipment/materials involved.
- ☐ Complete necessary paperwork, e.g. Report claim to insurance carrier and Employee Relations Manager (920-272-8216).
- ☐ Submit Manager's Report of Incident/Injury to Employee Relations Manager, [nbraam@gbdioc.org](mailto:nbraam@gbdioc.org) within 24 hours of incident.

**CONFIDENTIAL**

SECTION A – Employee/Volunteer Information			
1. Name:			
2. Employment Status:		3. If a Temporary Worker:	
4. Job Title:			
SECTION B – Manager Information			
5. Name:			
6. Employment Status:		7. Job Title:	
SECTION C – Incident/Injury Information			
8. Type of Incident:		9. If Injury:	
		10. If Other:	
11. Date of Incident:		12. Time of Incident:	AM <input type="checkbox"/> PM <input type="checkbox"/>
13. Date Reported:		14. Time Reported:	AM <input type="checkbox"/> PM <input type="checkbox"/>
15. Type of Location:		16. If Other:	
17. Name of Location:		18. Location #	
19. Describe the Incident/Injury:	(Please detail events leading to and following the incident/injury)		
20. Describe objects, equipment, movement or unsafe act or condition resulting in the Incident/Injury:			
SECTION D – Medical Treatment Information			
21. Describe the injury:	(Have employee mark and initial injured body parts on diagram below)		
			
22. Did employee refuse medical treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes:	Have employee initial: _____
23. Has employee returned to work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes:	Date
24. Will employee miss time from work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes:	Specify

## SECTION E – Incident/Injury Investigation

*NOTE: Attach all witness statements to this report.*

<b>25. Name of Witnesses:</b>	First Name		Last Name	
	Phone No.:		Email:	
	First Name		Last Name	
	Phone No.:		Email:	
<b>26. Causation:</b>	<i>(Check all factors contributing to incident/injury)</i>			
	<input type="checkbox"/> Slip, Trip, Fall	<input type="checkbox"/> Improper guarding	<input type="checkbox"/> Improper instruction	
	<input type="checkbox"/> Improper attire	<input type="checkbox"/> Improper maintenance	<input type="checkbox"/> Improper Tool/Tool Use	
	<input type="checkbox"/> Defective equipment	<input type="checkbox"/> Uneven ground	<input type="checkbox"/> Not following procedure	
	<input type="checkbox"/> Unsafe process	<input type="checkbox"/> Distraction/haste	<input type="checkbox"/> Wet floors	
	<input type="checkbox"/> Weather related	<input type="checkbox"/> Failure to lock/tag out	<input type="checkbox"/> Failure to secure	
	<input type="checkbox"/> Lack of proper PPE	<input type="checkbox"/> Ergonomics Issue	<input type="checkbox"/> Operating w/o authority	
	<input type="checkbox"/> Poor housekeeping	<input type="checkbox"/> Inoperative safety device	<input type="checkbox"/> Unsafe position	
	<input type="checkbox"/> Tight working area	<input type="checkbox"/> Poor ventilation	<input type="checkbox"/> Chemical hazard or spill	
	<input type="checkbox"/> Electrical hazard	<input type="checkbox"/> Poor lighting	<input type="checkbox"/> Lack of training/skills	
	<input type="checkbox"/> Unaware of surroundings	<input type="checkbox"/> Horseplay	<input type="checkbox"/> Animal or Insect	
	<input type="checkbox"/> Other factors:	Please Specify		
	<b>27. Personal Protective Equipment (PPE) used at time of Incident/Injury:</b>	<i>(Check all that apply)</i>		
<input type="checkbox"/> Foot protection		<input type="checkbox"/> Face/eye protection	<input type="checkbox"/> Hand protection	
<input type="checkbox"/> Hearing protection		<input type="checkbox"/> Fall protection	<input type="checkbox"/> Respiratory protection	
<input type="checkbox"/> None				
<b>28. What action(s) do you plan to implement to prevent this type of Incident/Injury from reoccurring?</b>				
<b>29. Have you instructed the employee/volunteer on how to avoid the reoccurrence? How?</b>				
<b>30. Was a safety rule/policy violated? If so, has the employee/volunteer been disciplined/coached?</b>				
<b>31. Manager's Signature:</b>			<b>Date:</b>	
<b>32. Employee's Signature:</b>			<b>Date:</b>	