



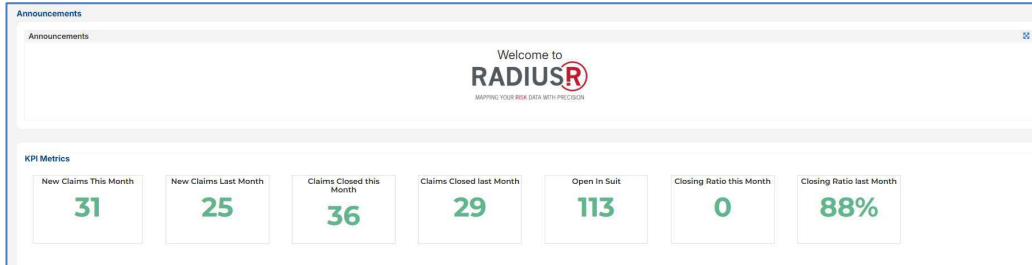
RADIUS[®]

RMIS Solution User Guide

April 2026
Version 1.0

Dashboard

The Client Level dashboard will provide a brief overview of your program with Lodestar Claims & Risk Service, Inc. and links to specific claims.



Announcements

There is an area for announcements at the top of the screen where we will notify you of system enhancements, scheduled maintenance, or upcoming events and webinars.

KPI Metrics

This section contains statistics on new claims reported, closed claims, claims in suit, and closing ratio.

My Tasks, Recent Claim, and Watch List

Click the claim number link in any section to view the claim details.

My Diary – Lists your tasks/diary items

Recent Claims – Lists the 10 most recently filed claims

Watch List – Claims you have flagged as favorites

Drafts that were entered by me – Lists draft claims that you have not yet submitted

My tasks, recent claims and watch list

My Diary

Due Date	Claim Number	Claimant	Loss Date	Client	Description
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Recent Claims

Claim Number	Claimant	Accident Date	Status	Report Date	Client
W004623098	Test Claimant	07/07/2025	Closed	07/10/2025	Test Account Name 1
W004622854	Test Claimant	07/07/2025	Open	07/10/2025	Test Account Name 1
L004621034-1	Test Claimant	06/13/2025	Open	07/07/2025	Test Account Name 1
W004620613	Test Claimant	07/05/2025	Open	07/07/2025	Test Account Name 1
W004620035	Test Claimant	07/03/2025	Closed	07/03/2025	Test Account Name 1
W004620012	Test Claimant	07/02/2025	Closed	07/03/2025	Test Account Name 1
W004619535	Test Claimant	07/02/2025	Open	07/02/2025	Test Account Name 1
W004619333	Test Claimant	06/27/2025	Open	07/02/2025	Test Account Name 1
L004616893-1	Test Claimant	06/20/2025	Open	06/27/2025	Test Account Name 1
W004616822	Test Claimant	06/22/2025	Open	06/27/2025	Test Account Name 1

Watch List

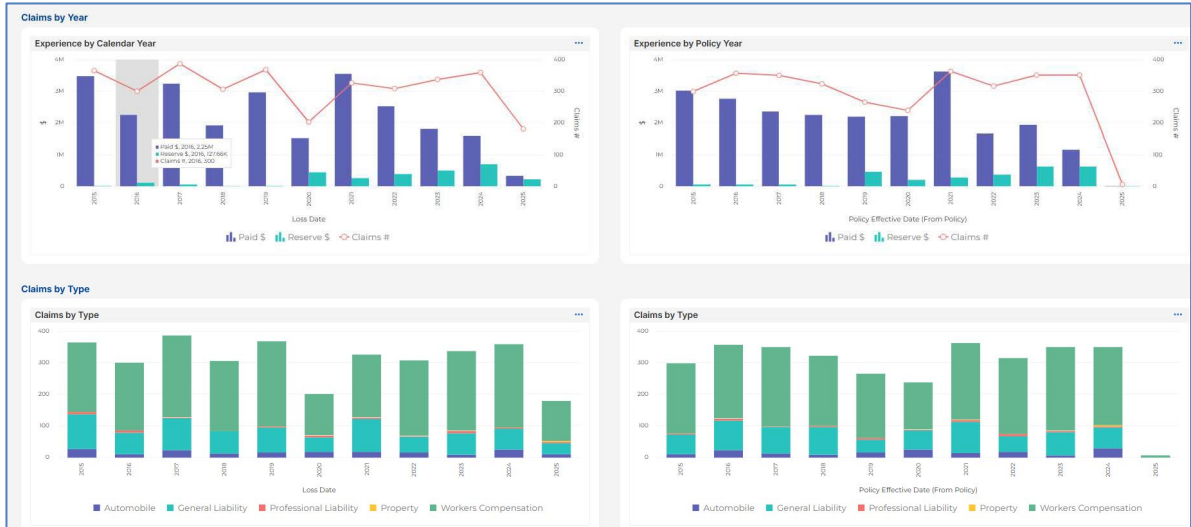
Claim Number	Claimant	Loss Date	Client
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Drafts that were entered by me

Claim Number	Claimant Name	Client	Date Created	Loss Date
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Claims by Year

Shows claim experience for the last 10 years. Hover over information in the graph for more detail.



Top 10 Claims

Lists the top 10 claims and top 10 open claims based on total incurred. Click on the claim number to view the claim details.

Top 10 Claims						
Claim Number	Name	Client	Loss Date	Incurred	Paid	Reserve
W001976967	Test Claimant	Test Account Name 1	03/21/2017	1,076,390.85	1,076,390.85	0.00
W000448307	Test Claimant	Test Account Name 1	01/27/2012	681,405.39	681,405.39	0.00
W001717358	Test Claimant	Test Account Name 1	06/22/2016	659,290.09	606,164.76	53,125.33
W000806107	Test Claimant	Test Account Name 1	09/21/2012	640,972.70	640,972.70	0.00
L002984026-1	Test Claimant	Test Account Name 1	01/15/2020	455,000.00	42,338.02	412,661.98
W001352899	Test Claimant	Test Account Name 1	01/14/2015	438,247.44	438,247.44	0.00
W003707630	Test Claimant	Test Account Name 1	03/15/2022	437,375.55	319,815.16	117,560.39
W000726485	Test Claimant	Test Account Name 1	03/13/2013	404,724.76	404,724.76	0.00
W003801624	Test Claimant	Test Account Name 1	07/20/2022	392,642.11	303,124.09	89,518.02
W003432459	Test Claimant	Test Account Name 1	06/14/2021	352,298.61	304,082.47	48,216.14

Top 10 Open Claims						
Claim Number	Name	Client	Loss Date	Incurred	Paid	Reserve
W001717358	Test Claimant	Test Account Name 1	06/22/2016	659,290.09	606,164.76	53,125.33
L002984026-1	Test Claimant	Test Account Name 1	01/15/2020	455,000.00	42,338.02	412,661.98
W003707630	Test Claimant	Test Account Name 1	03/15/2022	437,375.55	319,815.16	117,560.39
W003801624	Test Claimant	Test Account Name 1	07/20/2022	392,642.11	303,124.09	89,518.02
W003432459	Test Claimant	Test Account Name 1	06/14/2021	352,298.61	304,082.47	48,216.14
W00344970	Test Claimant	Test Account Name 1	01/06/2021	332,803.27	212,583.66	120,239.61
W001126842	Test Claimant	Test Account Name 1	02/20/2014	304,532.64	244,335.91	60,196.73
W004099248	Test Claimant	Test Account Name 1	08/25/2023	289,852.96	232,755.31	57,097.65
W000845831	Test Claimant	Test Account Name 1	07/08/2013	278,521.74	268,527.02	9,994.72
W000472001	Test Claimant	Test Account Name 1	03/07/2012	266,692.12	89,561.25	177,130.87

Claim Summary

Provides a quick overview of your program. Click on the line of business link to navigate to a list of claims for that line of business.

Line Of Business	Claims	Frequency (%)	Incurred	Severity (%)	Paid	Reserve
Automobile	267	0.0	2,083,334.78	0.0	1,958,769.03	124,565.75
General Liability	1,147	0.0	5,969,212.47	0.0	5,813,075.56	156,136.91
Professional Liability	64	0.0	1,606,889.72	0.0	1,050,032.54	556,857.18
Property	9	0.0	0.00	0.0	0.00	0.00
Workers Compensation	3,414	0.1	31,567,155.62	0.0	29,141,845.52	2,425,310.10
	4,901	0.1	41,226,592.59	0.0	37,963,722.65	3,282,869.94

Filter Options

The filter options appear at the top of the screen. To apply filters to the dashboard, enter the desired parameters and click Apply Options. Click the Refresh Data link to clear the filters.

PMA User Dashboard - Client Level ☆ More ▾

Data is current | [Refresh Data](#)

Filter Options: None Hide Apply Options

Coverage is any value ▾

Loss Date to

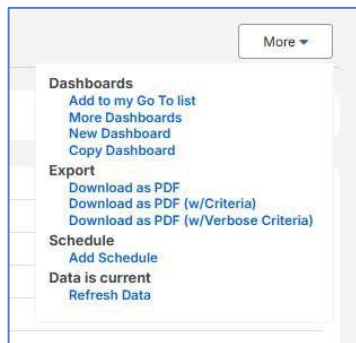
Report Date to

Location is any value ▾

Type Of Claim is any value ▾

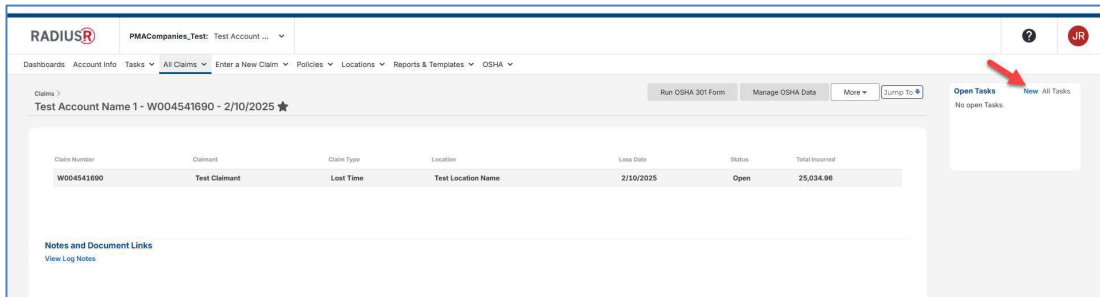
More

Click the More button for additional options including scheduling the dashboard for automated delivery via email. Detailed instructions for creating a schedule are available in the Reports section of this guide.



Tasks

Tasks are follow-up items or diaries that can be created on any claim. To create a task within a claim, click on New in the Open Tasks section in the upper right corner of the claim screen. The owner/backup owner will receive an email reminder on the day the task is due.



The New Task screen will display. Your name will default as the Owner of the task. If you would like, you can change the Owner to another member of your team who has access to the claim. You can also set a Backup Owner in the event you are not available on the date you scheduled the reminder. Please note, you can only set Tasks for a member of your team who has access to the claim. You cannot set a Task for the adjuster. Click Save Changes when you have finished setting the Task. The Task will now appear in the Open Tasks section of the claim and on any Task/Diary list within RadiusR.

New Task

Save Changes Cancel ?

Claim Number	Claimant	Coverage	Type Of Claim	Jurisdiction State	Loss Date	Status	Location	Outstanding - Med/W/Comp	Outstanding - Expense	Outstanding - Int/PS/Coil	Outstanding - Not in Use Adjuster
W004541690	Test Claimant	Workers Compensation	Lost Time	Connecticut	02/10/2025	OPEN	Test Location Name	2,626.22	1,550.00	9,745.70	0.00

Test Account Name 1

Owner: John RadiusR

Backup Owner:

Due Date: 11/05/2025 John RadiusR has 0 other open tasks on this date

Recurring Task?

Complete Date:

Start Date:

End Date:

Category: RTW Status

Priority: Normal

Shared: Private

Subject: Follow Up on RTW

Body: Appointment on 11/5. Was IW released to full duty?

Open Tasks New All Tasks

Follow Up on RTW 11/05/2025 ✓

Personal Notes

You can add documentation for yourself on any claim by entering a Personal Note. This note is only for you and does not become part of the official claim file. Click +New Personal Note. Enter the information for the Personal Note and click Save Changes. The note will now appear in the Personal Notes section of the claim screen.

Personal Notes + New Personal Notes All Personal Notes

Entry Date	Subject	Note Text	Note Type	Priority	Created By

New Personal Notes Save Changes Cancel

Claim Number	Claimant	Coverage	Type Of Claim	Jurisdiction State	Loss Date	Status	Location	Outstanding - Med/BI/Comp	Outstanding - Expense	Outstanding - Ind/PD/Coll	Outstanding - Not In Use	Adjuster
W004610592	Test Claimant	Workers Compensation	Lost Time	Connecticut	06/15/2025	OPEN	Test Location Name	9,717.39	2,177.58	893.97	0.00	

Claim Number	Claimant	Coverage	Location	Loss Date	Status	Total Incurred
W004610592	Test Claimant	Workers Compensation	Test Location Name	6/15/2025	Open	16,943.32

Subject:

Note Text:

Note Type:

Priority:

New Personal Notes Save Changes Cancel

Claim Number	Claimant	Coverage	Type Of Claim	Jurisdiction State	Loss Date	Status	Location	Outstanding - Med/BI/Comp	Outstanding - Expense	Outstanding - Ind/PD/Coll	Outstanding - Not In Use	Adjuster
W004610592	Test Claimant	Workers Compensation	Lost Time	Connecticut	06/15/2025	OPEN	Test Location Name	9,717.39	2,177.58	893.97	0.00	

Claim Number	Claimant	Coverage	Location	Loss Date	Status	Total Incurred
W004610592	Test Claimant	Workers Compensation	Test Location Name	6/15/2025	Open	16,943.32

Subject:

Note Text:

Note Type:

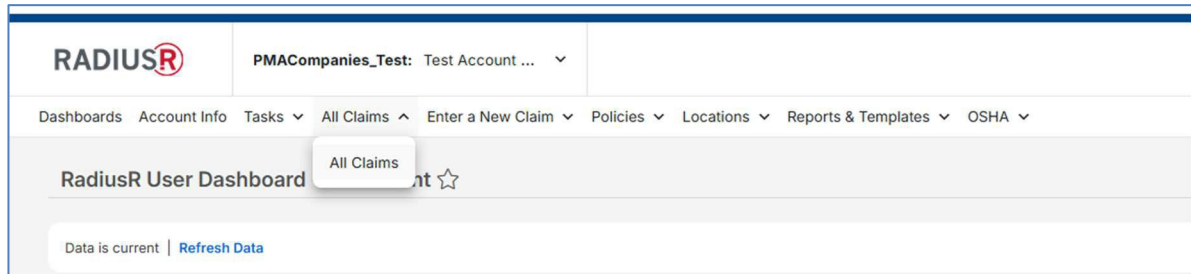
Priority:

Personal Notes + New Personal Notes All Personal Notes

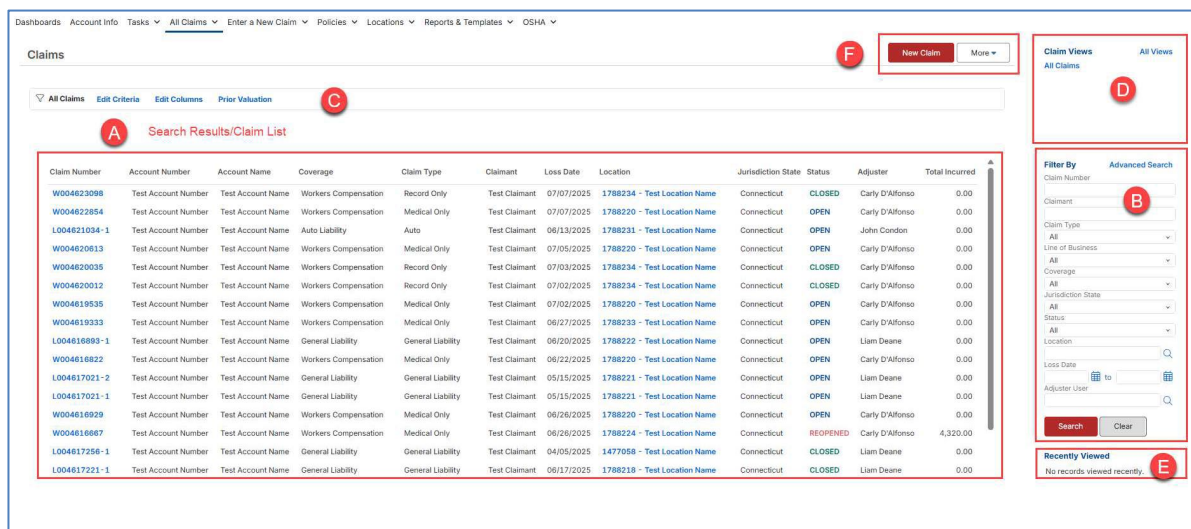
Entry Date	Subject	Note Text	Note Type	Priority	Created By
09/30/2025 8:56 AM	Results of Follow Up Appointment	Injured worker released to full duty. Doctor's note sent to adjuster via email.	Work Status	Normal	John RadiusR

Claim Search

Hover over the **All Claims** menu item and then click **All Claims** to see a list of available claims.



The claim search screen is composed of six sections.



Section A – Claim List

All claims that meet your search criteria will be listed here. To resort the list, click on any column heading to sort in ascending order. Click a second time to sort in descending order. To view the details of any claim, click on the blue claim number. If you click on a blue location, you will see a list of all claims for that location.

Section B – Filter By

To look up a claim by claim number or for a quick one-time claim search, enter your search criteria in the Filter By section and click Search. Your Claim will now display claims meeting your search criteria. Click Advanced Search to apply filters to additional fields.

Section C – List criteria and columns

If you know you will be searching using the same criteria on a regular basis you can create a repeatable Claim View. To do this, click Edit criteria then select the fields desired and apply the filters you would like to use. You can apply more than one filter at a time.

For example, if you want a list of open Lost Time claims that occurred in the current year, you can enter the criteria in the Advanced Search box as detailed below. Once you have entered all the criteria desired, click the Apply Filter button.

Advanced Search

Claim Type is equal to Lost Time

and Loss Date is on or after First day of this year

and Status is equal to Open

Select a field to add to your filter or [add a sub-filter](#).

You will see that your claim list now contains only claims meeting your filter criteria.

Claim Number	Account Number	Account Name	Coverage	Claim Type	Claimant	Loss Date	Location	Jurisdiction State	Status	Adjuster	Total Incurred
W004610592	Test Account Number	Test Account Name	Workers Compensation	Lost Time	Test Claimant	06/15/2025	1788220 - Test Location Name	Connecticut	OPEN	Jose Gaspar	16,943.32
W004590650	Test Account Number	Test Account Name	Workers Compensation	Lost Time	Test Claimant	05/01/2025	1788218 - Test Location Name	Connecticut	OPEN	Jose Gaspar	9,037.50
W004572448	Test Account Number	Test Account Name	Workers Compensation	Lost Time	Test Claimant	04/02/2025	1788221 - Test Location Name	Connecticut	OPEN	Jose Gaspar	7,923.42
W004571872	Test Account Number	Test Account Name	Workers Compensation	Lost Time	Test Claimant	04/01/2025	1788228 - Test Location Name	Connecticut	OPEN	Jose Gaspar	1,650.00
W004566883	Test Account Number	Test Account Name	Workers Compensation	Lost Time	Test Claimant	03/24/2025	1788220 - Test Location Name	Connecticut	OPEN	Jose Gaspar	4,969.81
W004546267	Test Account Number	Test Account Name	Workers Compensation	Lost Time	Test Claimant	01/27/2025	1788221 - Test Location Name	Connecticut	OPEN	Jose Gaspar	6,500.00
W004541690	Test Account Number	Test Account Name	Workers Compensation	Lost Time	Test Claimant	02/10/2025	1788233 - Test Location Name	Connecticut	OPEN	Jose Gaspar	25,034.96
W004509056	Test Account Number	Test Account Name	Workers Compensation	Lost Time	Test Claimant	02/09/2025	1788220 - Test Location Name	Connecticut	OPEN	Jose Gaspar	10,403.84
W004500251	Test Account Number	Test Account Name	Workers Compensation	Lost Time	Test Claimant	01/29/2025	1788220 - Test Location Name	Connecticut	OPEN	Jose Gaspar	30,249.81
W004500260	Test Account Number	Test Account Name	Workers Compensation	Lost Time	Test Claimant	01/29/2025	1788220 - Test Location Name	Connecticut	OPEN	Jose Gaspar	28,545.16
W004491245	Test Account Number	Test Account Name	Workers Compensation	Lost Time	Test Claimant	01/21/2025	1788225 - Test Location Name	Connecticut	OPEN	Jose Gaspar	36,072.83

To save this claim view for future use, click Save. The Save the current view screen will appear. Name your view and click Save View.

You will now see your saved view listed in the Claim Views section.



Section D – Claim Views

To instantly apply filters from a saved view, click the name of the saved Claim View from the list.

Section E – Recently Viewed

This section will display the claims you viewed most recently. Click on any claim in the list to view it again.

Section F – New Claim Button and More Drop-Down List

Click the New Claim button for a shortcut to New Claim Entry. Click the More button for additional options like downloading your claim list to Excel.

Claim View

Workers' Compensation

You will see a banner at the top of the claim screen with the account name, claim number, and loss date. You will also see an open star icon by default next to the loss date. Click the star icon to flag this claim as a favorite. Favorite claims will appear on the Watch List on your dashboard and will be listed in the Favorites view in the Claim Views section of the Claim Search screen.

Navigation: Dashboards Account Info Tasks All Claims Enter a New Claim Policies Locations Reports & Templates OSHA

Claims > Test Account Name 1 - W004541690 - 2/10/2025 ☆

Buttons: Run OSHA 301 Form Manage OSHA Data More Jump To

Claim Number	Claimant	Claim Type	Location	Loss Date	Status	Total Incurred
W004541690	Test Claimant	Lost Time	Test Location Name	2/10/2025	Open	25,034.96

Navigation: Dashboards Account Info Tasks All Claims Enter a New Claim Policies Locations Reports & Templates OSHA

Claim flagged as Favorite

Claims > Test Account Name 1 - W004541690 - 2/10/2025 ☆

Buttons: Run OSHA 301 Form Manage OSHA Data More Jump To

Claim Number	Claimant	Claim Type	Location	Loss Date	Status	Total Incurred
W004541690	Test Claimant	Lost Time	Test Location Name	2/10/2025	Open	25,034.96

Scroll through the screen to view the details of the claim. Click the Jump To button in

Navigation: Dashboards Account Info Tasks All Claims Enter a New Claim Policies Locations Reports & Templates OSHA

Claims > Test Account Name 1 - W004541690 - 2/10/2025 ☆

Buttons: Run OSHA 301 Form Manage OSHA Data More Jump To

Claim Number	Claimant	Claim Type	Location	Loss Date	Status	Total Incurred
W004541690	Test Claimant	Lost Time	Test Location Name	2/10/2025	Open	25,034.96

Notes and Document Links

- View Log Notes
- View EFR Document

Contact Information

Customer Service Center:	(888) 476-2669	Claim Supervisor:	Daniel Butler
Claims Professional:	Jose Gaspar	Claim Supervisor Phone:	203-679-3950
Claims Professional Phone:	203-679-3950	Claims Supervisor Email:	Daniel.Butler@pmagroup.com
Claims Professional Email:	Jose_Gaspar@pmagroup.com		

Dropdown Menu:

- Notes and Document Links
- Contact Information
- Claim Information
- Workers Compensation
- OSHA
- Loss Information
- Event Location Information
- Claim Dates
- Injured Worker Medical Profile
- Injured Worker Information
- Benefit Factors
- PMA Custom Fields
- Claim Body Part
- Litigation Records
- Work Status
- Benefit Status
- Length of Disability
- Weekly Benefit Rate
- Personal Notes
- Current Financials
- Recent Transaction History

Notes and Document Links

Dashboards Account Info Tasks **All Claims** Enter a New Claim Policies Locations Reports & Templates OSHA

Claims > Run OSHA 301 Form Manage OSHA Data More Jump To

Test Account Name 1 - W004541690 - 2/10/2025 ☆

Claim Number	Claimant	Claim Type	Location	Loss Date	Status	Total Incurred
W004541690	Test Claimant	Lost Time	Test Location Name	2/10/2025	Open	25,034.96

Notes and Document Links

[View EFR Document](#)
[View Log Notes](#)

Contact Information

Customer Service Center:	(888) 476-2669	Claim Supervisor:	Daniel Butler
Claims Professional:	Jose Gaspar	Claim Supervisor Phone:	203-679-3851
Claims Professional Phone:	203-679-3950	Claims Supervisor Email:	Daniel.Butler@pmagroup.com
Claims Professional Email:	Jose.Gaspar@pmagroup.com		

Click View EFR Document to display the Employer's First Report of Injury.

Log Notes

The View Log Notes link will provide a list of notes from Adjusters, Supervisors, Nurses, Client Service staff, and others. Log Notes will be listed in descending order by entry date with the most recent note listed first. While the notes are numbered, there may be gaps in the numbering. This is normal. When you click the View Log Notes link, the Log Notes screen will open in a separate tab. If you would like to view a subset of the Log Notes, you can filter by Category, Topic, date range, or any combination of these items. Enter your criteria and click Search to view the Log Notes meeting your criteria. To return to a list of all Log Notes, click Reset and then click Search.

Please close this tab when finished viewing log notes to return to the original claim.

PMA Claim Number: W004610592

Log Notes

Filter By:
 Topic: All
 Category: All
 Earliest Date: mm/dd/yyyy
 Latest Date: mm/dd/yyyy

[Search](#) [Reset](#)

Additional Actions
[Show All Notes](#)
[Open Current Selection in New Window](#)

Note	Topic	Category	Subject	Date Added	Note Text	Created By
33	Action Plan		AP / RTW full duty	07/08/2025	Lorem ipsum dolor sit amet consectetur adipiscing elit. Quisque faucibus ex sapien vitae pellentesque sem placerat. In id cursus mi proleum tellus duis convalis. Tempus leo eu senian sed diam urna tempor. Pulvinar vivamus fringilla lacus nec mius bibendum egetas. laealis massa nisl malesuada lacrisa integer nunc posuere. Ut hendrerit semper vel daps aptent tacis sociosqu. Ad illora torquent per conubia nostra inceptos himenaeos.	Sally Adjuster
32	Loss Management	Work Status & Restrictions	Form 39	07/08/2025	Lorem ipsum dolor sit amet consectetur adipiscing elit. Sit amet consectetur adipiscing elit quisque faucibus ex	Robert Supervisor

Common Abbreviations

A/A	auto accident
ACR	Account Claims Representative
ALOD	actual length of disability
ADA	Americans with Disabilities Act
ADJ	adjuster
A/P	action plan
AWW	average weekly wage
BRC	Benefits Review Conference
CA	Claims Administrator
CCU	Cost Containment Unit
CLMT	claimant
CM	Case Manager
CMU	Commercial Market Underwriting
COC	Corporate Operations Center (Blue Bell / Home Office)
CPC	Corporate Processing Center
C/R, CR	comp rate
CSA	Claims Service Adjuster
CSC	Customer Service Center
CSM	Claims Service Manager
CSR	Customer Service Representation
D/A	Date of Accident
D/H	Date of Hire
DMC	Disability Management Coordinator
DME	durable medical equipment
DR	doctor
EE	employee
EFR	employers first report
ELOD	estimated length of disability
EOB	explanation of benefits
EOR	explanation of review
ER	Employer or Emergency Room
FCE	functional capacity evaluation
FD	full duty
F/F	full / final settlement
FNOI	first notice of injury
FNOL	first notice of loss
F/U	follow up
FX	fracture
HX	history
IDM	Integrated Disability Management
IME	Independent Medical Exam
IV	Insured Vehicle
IW	injured worker
INS, INSD	insured

L/D	light duty
LM	left message
LMTC	left message to call
LTD	long term disability
MMI	maximum medical improvement
MO	medical only
MVA	motor vehicle accident
NICB	National Insurance Crime Bureau
OD	occupational disease
OOW	out of work
OTC	over the counter (medications)
OV	Other Vehicle
PAL	Property/Auto/Liability
P&C	Property & Casualty
PC, Phys caps	physical capabilities form
PMSI	Prescription Medical Services, Inc.
POA	plan of action
PPD	permanent partial disability
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPS	Prescription Processing Services
P/R	police report
PRN	patient return is necessary
PT	perm total
PT	physical therapy
R/C	return the phone call
RMS	Risk Management Services
R/O	rule out
ROM	range of motion
RTW	return to work
RX	prescription
SIU	Special Investigative Unit
SLOD	standard length of disability
SMO	Specialized Medical Only
STD	short term disability
S/W	spoke with
SX	surgery
TPA	third party administrator (self-insured)
TTD	Temporary total disability
TX	treatment
UCR	Usual/customary/reasonable rates
VM	voice mail
VOE	verification of employment
W/P	waiting period
WRI	work related injury

Contact Information

Click on the email address for the Claim Professional or Claim Supervisor to initiate an email in your default email application.

Claim Information/OSHA Outcome

The claim information section contains fields including Claim Status, Jurisdictional Claim Number, Compensability Decision, and Subrogation Status.

Users with access to the optional OSHA Recordkeeping Tool will see the OSHA Most Serious Outcome field. The value in this field is calculated based on information contained in the values in the Date of Death, Lost Days, and Restricted Days fields.

Claim Information	
Workers Compensation	
Claim Number:	W004541690
PMA Claim Number:	W004541690
Injured Worker:	Test Claimant
Injured Worker First Name:	Claimant First Name
Injured Worker Middle Name:	Claimant Middle Name
Injured Worker Last Name:	Claimant Last Name
Claim Segment:	Workers Comp Level 3
Claim Segment Type:	Unknown
Claim Status:	Open
Jurisdictional Claim Number:	1615058
Compensability Decision:	Accepted in full
Subrogation Status:	No Subrogation
Issuing Company:	PMAIC
PMA Policy / Contract Number:	123456789
PMA Policy / Contract Effective Date:	07/01/2024
PMA Policy / Contract Expiration Date:	06/30/2025
OSHA	
Most Serious Outcome:	Other recordable cases The most serious outcome is populated based on the Death date field, number of Lost days and number of Restricted days.

Loss Information

Hover over the eye icon next to the Claim Reporting Location to view a map of the reporting location.

Loss Information

Loss Date:	06/15/2025
Loss Time:	8:58 PM
Date Reported:	06/17/2025
Jurisdiction State:	Connecticut
Claim Reporting Location:	1788220 - Test Location Name
Loss Description:	Test Loss Description
Cause:	Fall, slip, or trip injury, miscella
Nature:	Multiple physical injuries only
Body Part:	Multiple Body Parts - Multiple E

Event Location Information

Event Location:	Loss Location Name
Event Address 1:	Test Street 1
Event City:	Test City
Event State:	Texas
Event Zip Code:	99999

Claim Dates

Date Employer Notified:	06/15/2025
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Test Location Name (1788220)

Address: Test Street 1
Test City, TX 99999
United States of America

Click on the Claim Reporting Location link to view additional information about the reporting location, including a list of recent claims and a summary of claims for the current calendar year. You can also add Personal Notes specific to the location in this section.

Locations > [Test Location Name](#)

Location Dashboard [More](#)

Default Location Hierarchy: [Test Account Territory](#)

Location Details

Location Code:	1788220	Effective Date:	07/05/2011
Description:	Test Location Name	Expiration Date:	
OSHA:	Yes	Location Status:	Active

Location Address

Street:	Test Street 1
City:	Test City
State:	Texas
Zip Code:	99999
County:	NEW HAVEN
Country:	United States of America

Recent Claims (Location)									
Claim Number	Exposure Type Code	Claimant	Coverage	Jurisdiction State	Status	Location	Loss Date	Total Incurred	Claims Professional
W004622854	Medical Details	Test Claimant	Workers Compensation	Connecticut	OPEN	1788220 - Test Location Name	07/07/2025	0.00	
W004620613	Medical Details	Test Claimant	Workers Compensation	Connecticut	OPEN	1788220 - Test Location Name	07/05/2025	0.00	
W004619535	Medical Details	Test Claimant	Workers Compensation	Connecticut	OPEN	1788220 - Test Location Name	07/02/2025	0.00	
W004618822	Medical Details	Test Claimant	Workers Compensation	Connecticut	OPEN	1788220 - Test Location Name	06/22/2025	0.00	
W004618929	Medical Details	Test Claimant	Workers Compensation	Connecticut	OPEN	1788220 - Test Location Name	06/26/2025	0.00	
W004610598	Medical Details	Test Claimant	Workers Compensation	Connecticut	CLOSED	1788220 - Test Location Name	06/15/2025	0.00	
W004610592	Indemnity	Test Claimant	Workers Compensation	Connecticut	OPEN	1788220 - Test Location Name	06/15/2025	16,943.32	
W004609933	Medical Details	Test Claimant	Workers Compensation	Connecticut	CLOSED	1788220 - Test Location Name	06/12/2025	0.00	
W004605085	Medical Details	Test Claimant	Workers Compensation	Connecticut	OPEN	1788220 - Test Location Name	06/04/2025	243.68	
W004605071	Medical Details	Test Claimant	Workers Compensation	Connecticut	CLOSED	1788220 - Test Location Name	05/25/2025	0.00	
L004605209 -1	General	Test Claimant	Law Enforcement Liability	Connecticut	OPEN	1788220 - Test Location Name	04/17/2025	20,000.00	
W004599988	Medical Details	Test Claimant	Workers Compensation	Connecticut	CLOSED	1788220 - Test Location Name	05/26/2025	0.00	
W004597882	Medical Details	Test Claimant	Workers Compensation	Connecticut	CLOSED	1788220 - Test Location Name	05/21/2025	174.54	
L004599127 -1	General	Test Claimant	Law Enforcement Liability	Connecticut	OPEN	1788220 - Test Location Name	05/12/2025	20,000.00	
W004589705	Medical Details	Test Claimant	Workers Compensation	Connecticut	CLOSED	1788220 - Test Location Name	04/25/2025	0.00	
W004587486	Medical Details	Test Claimant	Workers Compensation	Connecticut	CLOSED	1788220 - Test Location Name	04/29/2025	0.00	
W004584856	Medical Details	Test Claimant	Workers Compensation	Connecticut	CLOSED	1788220 - Test Location Name	04/14/2025	0.00	

Personal Notes New Personal Notes All Personal Notes

Entry Date	Subject	Note Text	Note Type	Priority	Created By

Claims Reported After January 1, 2025 at this Location

Name	Claim Count	Paid	Outstanding	Incurred	Average Claim Size
Automobile	9	16,808.41	16,110.50	32,918.91	3,657.66
Professional Liability	3	415.00	59,585.00	60,000.00	20,000.00
Workers Compensation	34	47,344.19	57,518.46	104,862.65	3,084.20
Totals	46	64,567.60	133,213.96	197,781.56	4,299.60

Event Location Information and Important Claim Dates

The Event Location section includes the address where the loss occurred.


Event Location Information			
Event Location:	Loss Location Name	Accident Site Org Name:	Claim Reporting Location Name
Event Address 1:	Test Street 1		
Event City:	Test City		
Event State:	Texas		
Event Zip Code:	99999		

Claim Dates	
Date Employer Notified:	06/15/2025
Date Employer Reported:	06/17/2025
Report Received Date:	06/17/2025
Injured Worker Salary Continuation Stop Date:	06/30/2025

Important dates related to the loss are listed in the Claim Dates section.

Injured Worker Information

Injured Worker Medical Profile			
Age at Time of Loss:	60	Surgery:	No

Injured Worker Information			
Address 1:	*****	Birth Date:	*****
Address 2:	*****	Claimant Age:	60
City:	*****	Hire Date:	*****
State:	*****	Employment Status:	Full-time employee
Zip Code:	*****	Employee ID:	*****
Work Phone:	1234567890	Job Description/Occupation:	Paraprofessional
Mobile Phone:	123456789	Marital Status:	Married
Primary Phone Type:	Home	Gender:	*****
Email:	 test@test.com		

Benefit Factors			
Worker Gross Compensation Rate:	415.960000	Average Weekly Wage Amount:	660.71
Worker Net Compensation Rate:	415.960000	Injured Worker AWW Calculation Method Actual Type:	
		Was Salary Continued:	Yes
		Was Injured Worker Paid in Full:	Yes

PMA Custom Fields	
Additional Cause:	Caught In/Under

Body Part

All accepted and denied body parts will be listed in this section. For additional, details click on the Order link for the body part.

Claim Body Part						
Order	Side Of Body	Area Of Body	Body Part	Decision	Valid From	Valid To
Primary	Right	Upper extremities	Upper Extremities - Shoulder(s)	Accepted	02/10/2025	

Upper Extremities - Shoulder(s) (38) - 0.00%		More ▾
Claim:	Test Claimant (W004541690)	
Body Part:	Upper Extremities - Shoulder(s)	
Order:	Primary	
Side of Body:	Right	
Area of Body:	Upper extremities	
Decision:	Accepted	
Valid From:	02/10/2025	

Litigation

All litigation matters will be listed in this section. Click on the link in the Case Caption for additional details.

Litigation Records					
Case Caption	Case Number	Case Owner	Primary Case Type	Primary Cause	Venue State
TEST v. TEST		Test Case Owner	General		Connecticut
TEST v. TEST		Test Case Owner	General		Connecticut
TEST v. TEST		Test Case Owner	General		Connecticut

Test Claimant (W004541690): TEST v. TEST General												
Claim Number	Claimant	Coverage	Type Of Claim	Jurisdiction State	Loss Date	Status	Location	Outstanding - Mod/BI/Comp	Outstanding - Expense	Outstanding - Ind/PD/Coif	Outstanding - Not In Use	Adjuster
W004541690	Test Claimant	Workers Compensation	Lost Time	Connecticut	02/10/2025	OPEN	Test Location Name	2,626.22	1,550.00	9,745.70	0.00	

Claim Number	Claimant	Coverage	Location	Loss Date	Status	Total Incurred
W004541690	Test Claimant	Workers Compensation	Test Location Name	2/10/2025	Open	25,034.96

Litigation Matter Details	
Case Owner:	Test Case Owner
Primary Case Type:	General
Plaintiff Name:	Jim Johnson
Plaintiff Law Firm:	Smith & Jones
Defendant Name:	Alfred Flowers

Venue Details	
Venue State:	Connecticut
Venue Type:	Workers' Compensation

Work Status, Benefit Status, Length of Disability and Weekly Benefit Rate

These sections will display if applicable for the claim. Click on the link for any record to see

Work Status	
Start Date	Work Status Type
02/11/2025	Stopped work

Benefit Status	
Date	Benefit Status
02/11/2025	First Date of Disability

Length of Disability							
Expected From Date	Expected To Date	Expected Disability Days	Actual From Date	Actual To Date	Actual Disability Days	Variance	Disability Type
02/11/2025	06/11/2025	121	02/11/2025	06/11/2025	121	0	Temporary Total / Temporary Income

Weekly Benefit Rate		
Weekly Benefit Type Code	Weekly Benefit Gross Compensation Rate	Weekly Benefit Net Compensation Rate
Temporary Total Disability	415.960000	415.960000
Permanent Partial Unschedule	415.960000	415.960000

additional information.

Financials

Current Financials						Prior Valuation Show Graph
Categories	Reserve	Paid	Recovery	Outstanding	Incurred	
+ Medical	4,299.77	1,673.55	0.00	2,626.22	4,299.77	
+ Expense	3,264.87	1,714.87	0.00	1,550.00	3,264.87	
+ Indemnity	17,470.32	7,724.62	0.00	9,745.70	17,470.32	
+ State Fund	0.00	0.00	0.00	0.00	0.00	
Incurring Formula: Net Incurred <input type="checkbox"/> Net of Recovery	25,034.96	11,113.04	0.00	13,921.92	25,034.96	

A financial overview of the claim will appear in the Current Financials Section.

Click the Prior Valuation link to view the financial information as of a prior date. Enter the valuation date desired and click the Refresh button.

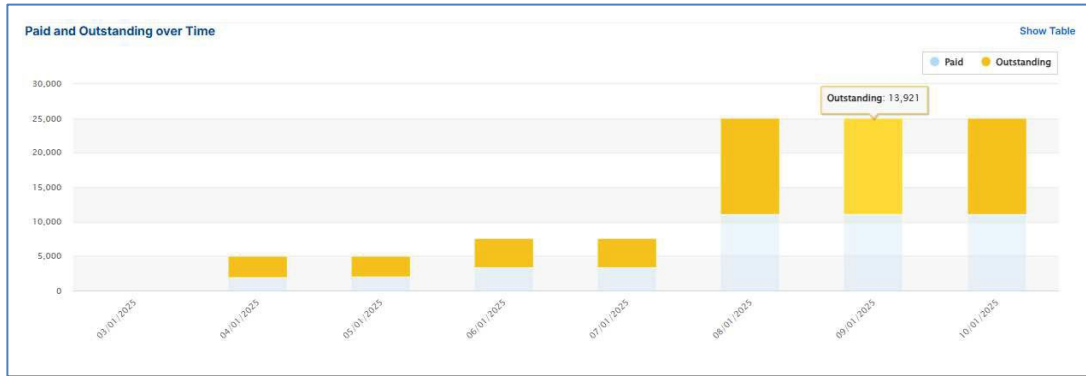
Claim Financials					
Cancel					
Claim Number:	W004541690	Claimant:	Test Claimant		
Status:	OPEN	Report Date:	02/14/2025		
Valuation Date:	<input type="text" value="05/01/2025"/>	Loss Date:	02/10/2025		
	<input type="button" value="Refresh"/>				
Categories	Reserve	Paid	Recovery	Outstanding	Incurred
+ Medical	4,299.77	1,673.55	0.00	2,626.22	4,299.77
+ Expense	3,264.87	1,714.87	0.00	1,550.00	3,264.87
+ Indemnity	17,470.32	7,724.62	0.00	9,745.70	17,470.32
+ State Fund	0.00	0.00	0.00	0.00	0.00
Incurring Formula: Net Incurred <input type="checkbox"/> Net of Recovery	25,034.96	11,113.04	0.00	13,921.92	25,034.96

The grid will now reflect the financials as of the requested valuation date. To return to the original grid, click the Cancel button.

Please note, if the requested Valuation Date is prior to the date Lodestar began handling the claim, the Incurred and Reserve values may be understated.

Claim Financials as of 05/01/2025					
Cancel					
Claim Number:	W004541690	Claimant:	Test Claimant		
Status:	OPEN	Report Date:	02/14/2025		
Valuation Date:	<input type="text" value="05/01/2025"/>	Loss Date:	02/10/2025		
	<input type="button" value="Refresh"/>				
Categories	Reserve	Paid	Recovery	Outstanding	Incurred
+ Medical	4,299.77	1,673.55	0.00	2,626.22	4,299.77
+ Expense	769.75	319.87	0.00	449.88	769.75
+ Indemnity	0.00	0.00	0.00	0.00	0.00
+ State Fund	0.00	0.00	0.00	0.00	0.00
Incurring Formula: Net Incurred <input type="checkbox"/> Net of Recovery	5,069.52	1,993.42	0.00	3,076.10	5,069.52

To view the history of the claim, click on the Show Graph link. Hover over the elements of the graph to view additional detail. Click Show Table to return to the original financial grid.



Recent Transaction History

This section will list all financial transactions – payments, reserves, and recoveries.

Recent Transaction History											All Transactions
Date	Type Of Claim	Transaction Type	Exposure Type	Cost Category	Recovery Category	Check Number	Check Status	Payee Name	Service From	Service To	Amount
07/09/2025		Payment	Indemnity	Temporary Total Disability		B007134264	Issued	Test Payee Name	07/07/2025	07/13/2025	415.96
07/09/2025		Payment	Indemnity	Temporary Total Disability		A100367244	Issued	Test Payee Name	03/06/2025	07/06/2025	7,308.66
07/09/2025		Reserve	Indemnity	Temporary Total Disability				Test Payee Name			4,159.60
07/02/2025		Reserve	Indemnity	Temporary Total Disability				Test Payee Name			7,487.28
07/02/2025		Reserve	Indemnity	Permanent Partial Unschedule				Test Payee Name			5,823.44
05/30/2025		Reserve	Expense	Expense Loss Line				Test Payee Name			2,495.12
05/30/2025		Reserve	Expense	IA/Experts				Test Payee Name			1,395.00
05/30/2025		Reserve	Expense	Expense Loss Line				Test Payee Name			-1,395.00
05/30/2025		Payment	Expense	IA/Experts		B007112035	Cleared	Test Payee Name	05/07/2025	05/07/2025	1,395.00
04/12/2025		Reserve	Expense	Fees				Test Payee Name			8.53
04/12/2025		Reserve	Expense	Expense Loss Line				Test Payee Name			-8.53
04/12/2025		Payment	Expense	Fees		K017917477	Requested	Test Payee Name	04/03/2025	04/03/2025	8.53
04/11/2025		Payment	Medical Details	Doctor		B207979801	Cleared	Test Payee Name	04/03/2025	04/03/2025	135.87
04/11/2025		Reserve	Medical Details	Doctor				Test Payee Name			135.87
04/11/2025		Reserve	Medical Details	Medical Loss Line				Test Payee Name			-135.87
04/01/2025		Reserve	Expense	Fees				Test Payee Name			58.44
04/01/2025		Reserve	Expense	Expense Loss Line				Test Payee Name			-58.44
04/01/2025		Reserve	Expense	Fees				Test Payee Name			5.10
04/01/2025		Reserve	Expense	Expense Loss Line				Test Payee Name			-5.10
04/01/2025		Payment	Expense	Fees		K017862207	Requested	Test Payee Name	03/13/2025	03/13/2025	58.44

Click on the link in the Transaction Type to view additional details about the transaction.

Claims > Test Account Name 1 - W004541690 - 2/10/2025 > Transactions > More ▾

Payment Test Payee Name

Claim Number	Claimant	Coverage	Type Of Claim	Jurisdiction State	Loss Date	Status	Location	Outstanding - Med/BU/Comp	Outstanding - Expense	Outstanding - Ind/PD/Coll	Outstanding - Not In Use Adjuster
W004541690	Test Claimant	Workers Compensation	Lost Time	Connecticut	02/10/2025	OPEN	Test Location Name	2,626.22	1,550.00	9,745.70	0.00

Payment Details

Financial Category: Indemnity/PD/Coll Payment NOC

Transaction Date: 07/09/2025
 Transaction Type: [Payment](#)
 Financial Type: Indemnity
 Financial Category: Temporary Total Disability
 Sub Category: Ongoing Payment
 Check Number: B007134284
 Check Status: Issued

Payee Information

Payee Name: Test Payee Name
 Service From: 07/07/2025
 Service To: 07/13/2025
 Amount: 415.96
 Address: Test Street 1
 City: Test City
 State: Texas
 Zip: 999999

Payment Method Code: Check
 Payment Delivery Method Code: Send

Click the All Transactions link to apply filters to the transaction list or search for a specific transaction.

Claims > Test Account Name 1 - W004541890 - 2/10/2025 > More ▾

Transactions

Claim Number	Claimant	Coverage	Type Of Claim	Jurisdiction State	Loss Date	Status	Location	Outstanding - Med/BU/Comp	Outstanding - Expense	Outstanding - Ind/PO/Col	Outstanding - Not In Use Adjuster
W004541890	Test Claimant	Workers Compensation	Lost Time	Connecticut	02/10/2025	OPEN	Test Location Name	2,626.22	1,550.00	9,745.70	0.00

[All Transactions](#) [Edit Criteria](#) [Edit Columns](#)

Date	Type Of Claim	Transaction Type	Exposure Type	Cost Category	Recovery Category	Check Number	Check Status	Payee Name	Service From	Service To	Amount
07/09/2025		Payment	Indemnity	Temporary Total Disability		8007134264	Issued	Test Payee Name	07/07/2025	07/13/2025	415.96
07/09/2025		Payment	Indemnity	Temporary Total Disability		A100367244	Issued	Test Payee Name	03/09/2025	07/06/2025	7,308.66
07/09/2025		Reserve	Indemnity	Temporary Total Disability				Test Payee Name			-4,159.60
07/02/2025		Reserve	Indemnity	Temporary Total Disability				Test Payee Name			7,487.28
07/02/2025		Reserve	Indemnity	Permanent Partial Unschedule				Test Payee Name			5,823.44
05/30/2025		Reserve	Expense	Expense Loss Line				Test Payee Name			2,495.12
05/30/2025		Reserve	Expense	IA/Experts				Test Payee Name			1,395.00
05/30/2025		Reserve	Expense	Expense Loss Line				Test Payee Name			-1,395.00
05/30/2025		Payment	Expense	IA/Experts		8007112035	Cleared	Test Payee Name	05/07/2025	05/07/2025	1,395.00
04/12/2025		Reserve	Expense	Fees				Test Payee Name			8.53
04/12/2025		Reserve	Expense	Expense Loss Line				Test Payee Name			-8.53

Transaction Views All Transactions All Views

Filter By Advanced Search

Type:

Financial Type:

Payee Name:

Transaction Date:

Service From: to

Service To: to

Recovery Category:

Search Clear

Use the options under the More button to export a list of all transactions or your filtered list of transactions.

Claims > Test Account Name 1 - W004541890 - 2/10/2025 > More ▾

Transactions

Claim Number	Claimant	Coverage	Type Of Claim	Jurisdiction State	Loss Date	Status	Location	Outstanding - Med/BU/Comp	Outstanding - Expense	Outstanding - Ind/PO/Col	Outstanding - Not In Use Adjuster
W004541890	Test Claimant	Workers Compensation	Lost Time	Connecticut	02/10/2025	OPEN	Test Location Name	2,626.22	1,550.00	9,745.70	0.00

[All Transactions](#) [Edit Criteria](#) [Edit Columns](#)

Export

[Export to Excel](#)

[Export to CSV](#)

[Export to PDF](#)

Claim View

Auto

Claim vs Occurrence

Individual loss lines for a casualty loss are set up as claims and roll up to an occurrence. The occurrence is represented by a 10-digit number. The claim number for each loss line (claim) will begin with the 10-digit occurrence number followed by a dash and then the exposure number.

Claim

Claims >
Test Account Name 1 - L004415726-1 - 7/21/2024 ☆

Claim Number	Claimant	Claim Type	Location	Loss Date	Status	Total Incurred
L004415726-1	Test Claimant	Auto	Test Location Name	7/21/2024	Closed	6,638.05


Notes and Document Links
[View Log Notes](#)

Contact Information

Customer Service Center:	(888) 476-2669	Claim Supervisor:	Brittany Faulk
Claims Professional:	Kristin Mayes	Claim Supervisor Phone:	888-476-2669
Claims Professional Phone:	484-530-4957	Claims Supervisor Email:	Brittany_Faulk@pmagroup.com
Claims Professional Email:	Kristin_Mayes@pmagroup.com		

Click the link in the Lodestar Claim Number to view the Occurrence information.

Claim Information

Claim Number:	L004415726-1	PMA Policy / Contract Number:	123456789
PMA Claim Number:	L004415726 	PMA Policy / Contract Effective Date:	07/01/2024
Exposure Type Code:	Vehicle	PMA Policy / Contract Expiration Date:	06/30/2025
Claimant:	Test Claimant		
Claimant Last Name:	Claimant Last Name		
Claimant First Name:	Claimant First Name		
Claimant Middle Name:	Claimant Middle Name		
Loss Date:	07/21/2024		
Loss Time:	1:27 AM		
Report Date:	09/10/2024		
Claim Reporting Location:	1788220 - Test Location Name		
Claim Status:	Open		
Claim Entered Date:	09/11/2024		
Last Close Date:	01/23/2025		

Loss Information

Loss Description ⓘ	Test Loss Description	Loss Location Name:	Loss Location Name
Loss Cause:	Collision with motor vehicle	Loss Street 1:	Test Street 1
Additional Loss Cause Type 1:	Inattention	Loss City:	Test City
Additional Loss Cause Type 2:	No additional loss cause	Loss State:	Texas
Loss Type Description:	Auto	Loss Zip:	99999

Claimant Information

Claimant Address 1:	•••••	Claimant Date of Birth:	•••••
Claimant Address 2:	•••••	Claimant Age at Accident:	44
Claimant City:	•••••	Claimant Gender:	•••••
Claimant State:	•••••	Claimant Business Phone:	1234567890
Claimant Zip ^① :	•••••	Claimant Email Address:	test@test.com

Claimant Vehicle/Vehicle Driver Information

Claimant Vehicle Make:	Mercedes-Benz	Claimant Vehicle Owner Last Name:	Robinson
Claimant Vehicle Model:	C300 4 Matic	Claimant Vehicle Owner First Name:	Erica
Claimant VIN:	99999999	Claimant Vehicle Driver Last Name:	Robinson
Claimant Vehicle Year:	2014	Claimant Vehicle Driver First Name:	Erica
Claimant Vehicle License Plate:	TESTLIC		
Claimant Vehicle State Registered:	Connecticut		
Claimant Vehicle Jurisdiction State:	Connecticut		
Is Claimant Vehicle Parked?:	No		

Additional Detail

Subrogation Status: No Subrogation

PMA Custom Fields

Additional Cause: MVA Pursuit Suspect

Recent Transaction History

[All Transactions](#)

Date	Type Of Claim	Transaction Type	Exposure Type	Cost Category	Recovery Category	Check Number	Check Status	Payee Name	Service From	Service To	Amount
01/23/2025								Test Payee Name			
01/22/2025		Reserve	Vehicle	Unspecified Cost Category				Test Payee Name			138.05
01/22/2025		Payment	Vehicle	Unspecified Cost Category		8007031386	Cleared	Test Payee Name			6,638.05
11/20/2024		Reserve	Vehicle	Unspecified Cost Category				Test Payee Name			6,500.00
09/30/2024	Auto							Test Payee Name			
09/10/2024	Pending Claim Type							Test Payee Name			
09/10/2024								Test Payee Name			

Personal Notes

[New Personal Notes](#) [All Personal Notes](#)

Entry Date	Subject	Note Text	Note Type	Priority	Created By
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Current Financials

[Prior Valuation](#) [Show Graph](#)

Categories	Paid	Recovery	Outstanding	Incurred
+ Bodily Injury	0.00	0.00	0.00	0.00
+ Expense	0.00	0.00	0.00	0.00
+ Property Damage	6,638.05	0.00	0.00	6,638.05
Incurred Formula: <input type="text" value="Net Incurred"/> <input type="checkbox"/> Net of Recovery	6,638.05	0.00	0.00	6,638.05

Occurrence

When you view information at the occurrence level all claims, financials, and payments will be listed. To view the individual information related to the claim, click on the claim number.

Occurrence - L004415726
Printable Abstract

Lead Claim Details

Occurrence Number: L004415726
 Claimant: Test Claimant
 Location: 1788220 - Test Location Name
 Accident State: Texas
 Report Date: 09/10/2024
 Loss Date: 07/21/2024

Description of Event

Loss Description: Test Loss Description
 Policy: 1275874 - Test Policy Description

Current Financials

Categories	Paid	Recovery	Outstanding	Incurred
+ Bodily Injury	0.00	0.00	5,000.00	5,000.00
+ Expense	369.75	0.00	1,030.25	1,400.00
+ Property Damage	6,638.05	0.00	0.00	6,638.05
Incurred Formula: Net Incurred <input type="checkbox"/> Net of Recovery	7,007.80	0.00	6,030.25	13,038.05

Claims in Occurrence (2)

All Claims

Claim Number	Account Number	Account Name	Coverage	Claim Type	Claimant	Loss Date	Location	Jurisdiction State	Status	Adjuster	Total Incurred
L004415726-1	Test Account Number	Test Account Name	Auto Liability	Auto	Test Claimant	07/21/2024	1788220 - Test Location Name	Connecticut	CLOSED	Kristin Mayes	6,638.05
L004415726-2	Test Account Number	Test Account Name	Auto Liability	Auto	Test Claimant	07/21/2024	1788220 - Test Location Name	Connecticut	OPEN	Kristin Mayes	6,400.00

Recent Transactions

All Transactions

Date	Type Of Claim	Transaction Type	Exposure Type	Cost Category	Recovery Category	Check Number	Check Status	Payee Name	Service From	Service To	Amount
05/23/2025		Payment	Bodily Injury	Fees			Requested	Test Payee Name			0.00
05/13/2025		Reserve	Bodily Injury	IA/Experts				Test Payee Name			350.00
05/13/2025		Payment	Bodily Injury	IA/Experts		B208031024	Cleared	Test Payee Name	04/29/2025	04/29/2025	350.00
05/02/2025		Reserve	Bodily Injury	Fees				Test Payee Name			1,000.00
01/23/2025								Test Payee Name			
01/23/2025		Reserve	Bodily Injury	Fees				Test Payee Name			25.00
01/22/2025		Reserve	Vehicle	Unspecified Cost Category				Test Payee Name			138.05
01/22/2025		Payment	Vehicle	Unspecified Cost Category		B007031386	Cleared	Test Payee Name			6,638.05
12/13/2024		Payment	Bodily Injury	Fees			Requested	Test Payee Name			0.00
11/20/2024		Reserve	Vehicle	Unspecified Cost Category				Test Payee Name			6,500.00
10 RECORDS											15,001.10

Claim View

General Liability

Claims >
Test Account Name 1 - L003768213-1 - 5/5/2022 ☆

Claim Number	Claimant	Claim Type	Location	Loss Date	Status	Total Incurred
L003768213-1	Test Claimant	General Liability	Test Location Name	5/5/2022	Closed	25,358.44

Notes and Document Links
[View Log Notes](#)

Contact Information

Customer Service Center:	(888) 476-2669	Claim Supervisor:	Brittany Faulk
Claims Professional:	Sarah Roberto	Claim Supervisor Phone:	888-476-2669
Claims Professional Phone:	203-679-3874	Claims Supervisor Email:	Brittany_Faulk@pmagroup.com
Claims Professional Email:	Sarah_Roberto@pmagroup.com		

General Liability

Claim Number:	L003768213-1	PMA Policy / Contract Number:	123456789
PMA Claim Number:	L003768213	PMA Policy / Contract Effective Date:	07/01/2021
Exposure Type Code:	Property	PMA Policy / Contract Expiration Date:	06/30/2022
Claimant:	Test Claimant		
Claimant Last Name:	Claimant Last Name		
Claimant First Name:	Claimant First Name		
Claimant Middle Name:	Claimant Middle Name		
Loss Date:	05/05/2022		
Loss Time:	12:01 AM		
Report Date:	05/09/2022		
Claim Reporting Location:	1477058 - Test Location Name		
Claim Status:	Closed		
Claim Entered Date:	05/10/2022		
Last Close Date:	08/18/2022		

Loss Information

Loss Description ⓘ	Test Loss Description	Loss Location Name:	Loss Location Name
Loss Cause:	Leak/Spill of Pollutant	Loss Street 1:	Test Street 1
Additional Loss Cause Type 1:	Accidental Discharge	Loss City:	Test City
Additional Loss Cause Type 2:	No additional loss cause	Loss State:	Texas
Loss Type Description:	General Liability	Loss Zip:	99999

Claimant Information

Claimant Address 1:	•••••	Claimant Date of Birth:	•••••
Claimant Address 2:	•••••	Claimant Business Phone:	1234567890
Claimant City:	•••••	Claimant Primary Phone Type:	Work
Claimant State:	•••••	Claimant Email Address:	test@test.com
Claimant Zip ⓘ	•••••		

Claimant Vehicle/Driver Information

Claimant VIN:	99999999
Claimant Vehicle License Plate:	TESTLIC

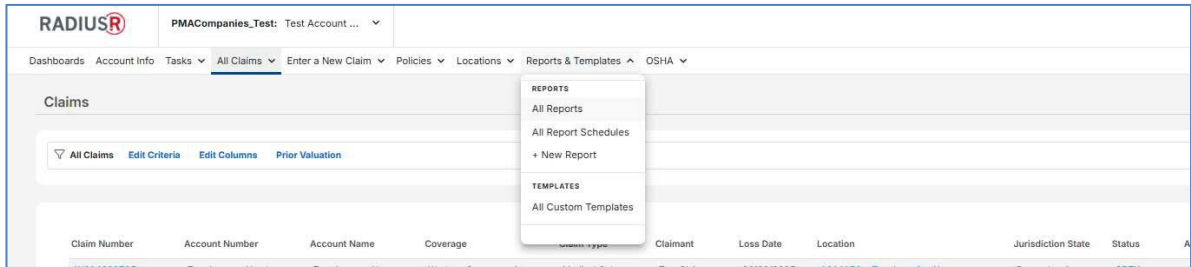
Additional Detail	
Subrogation Status:	No Subrogation
PMA Custom Fields	
Additional Cause:	Not Otherwise Clsfd

Personal Notes						New Personal Notes All Personal Notes
Entry Date	Subject	Note Text	Note Type	Priority	Created By	

Current Financials					Prior Valuation Show Graph
Categories	Paid	Recovery	Outstanding	Incurred	
+ Bodily Injury	0.00	0.00	0.00	0.00	
+ Expense	1,583.58	0.00	0.00	1,583.58	
+ Property Damage	23,774.86	0.00	0.00	23,774.86	
Incurred Formula: Net Incurred	25,358.44	0.00	0.00	25,358.44	<input type="checkbox"/> Net of Recovery

Recent Transaction History											All Transactions
Date	Type Of Claim	Transaction Type	Exposure Type	Cost Category	Recovery Category	Check Number	Check Status	Payee Name	Service From	Service To	Amount
08/18/2022								Test Payee Name			
08/18/2022		Reserve	Property	IA/Experts				Test Payee Name			-16.42
08/18/2022		Reserve	Property	Unspecified Cost Category				Test Payee Name			-2,225.14
07/29/2022		Payment	Property	Unspecified Cost Category		B006475570	Cleared	Test Payee Name			14,513.47
07/06/2022		Payment	Property	IA/Experts		B206453616	Cleared	Test Payee Name	05/06/2022	05/26/2022	45.00
06/08/2022		Reserve	Property	IA/Experts				Test Payee Name			1,600.00
06/08/2022		Payment	Property	IA/Experts		B206410053	Cleared	Test Payee Name	05/06/2022	05/26/2022	1,538.58
06/08/2022		Reserve	Property	Unspecified Cost Category				Test Payee Name			21,000.00
06/08/2022		Payment	Property	Unspecified Cost Category		B206410052	Cleared	Test Payee Name			9,261.39
05/31/2022	General Liability							Test Payee Name			
05/10/2022		Reserve	Property	Unspecified Cost Category				Test Payee Name			5,000.00
05/09/2022	Pending Claim Type							Test Payee Name			
05/09/2022								Test Payee Name			

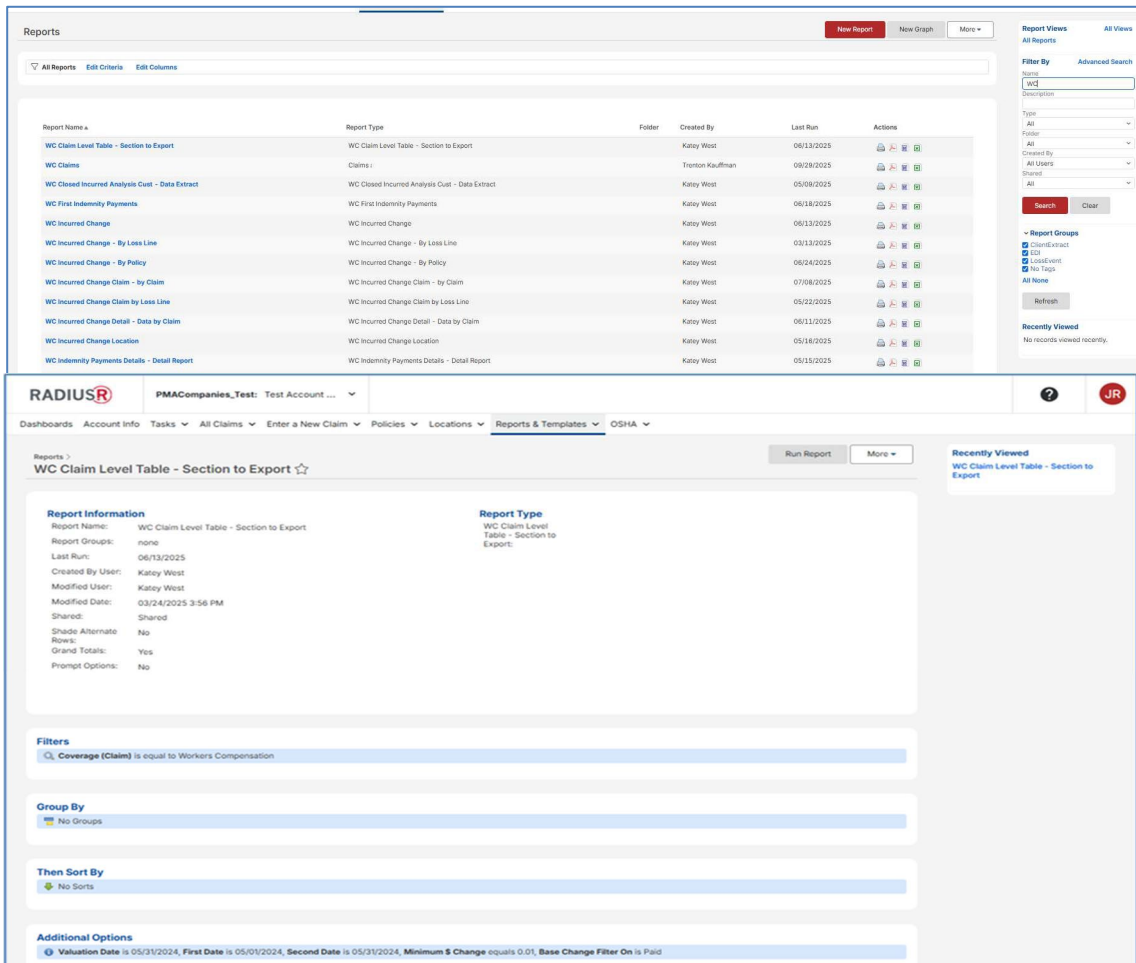
Reports



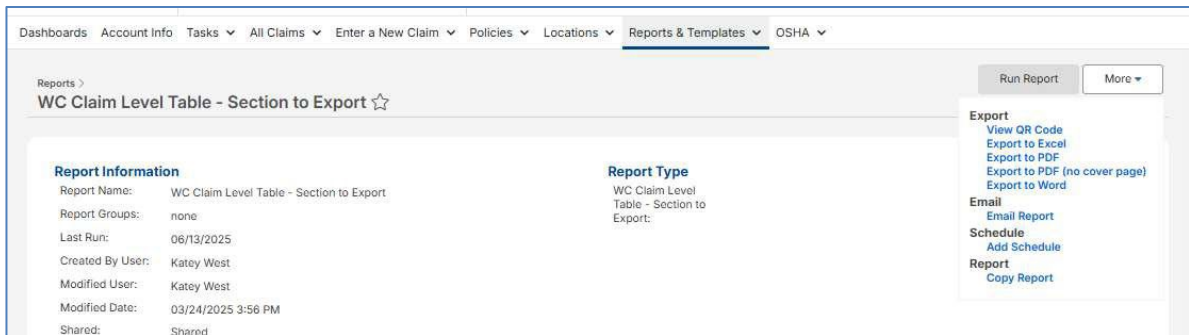
Hover over the Reports & Templates menu item and click All Reports.

Narrow the list of reports using the Filter By search feature. For example, enter WC in the name field to see a list of Workers' Compensation reports or enter Payment for a list of payment reports. Click Search. Click on the report you would like to generate.

Although you can click the Run Report button to generate the report, this may take some time to process. We recommend using one of the alternative methods listed below.



Click the More button for additional options.



Export

Export the report to a desired format.

Email Report

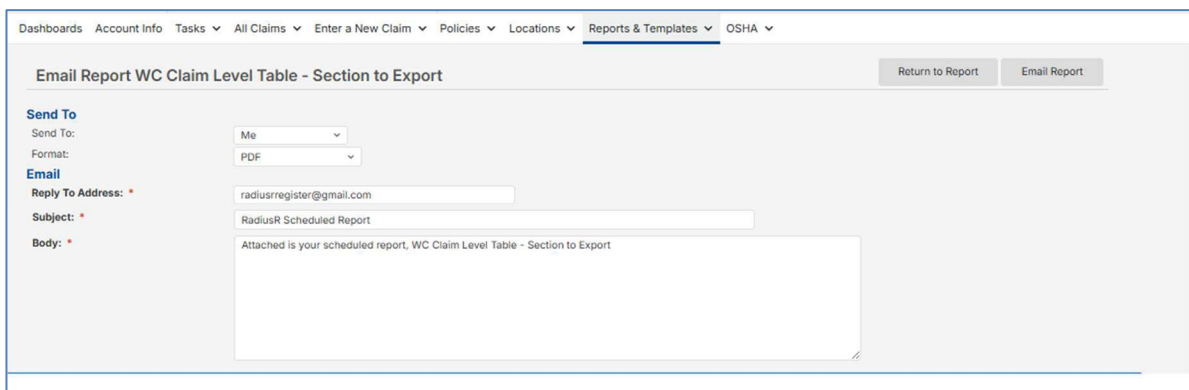
Generate the report in the background while you work on other items. The report will be emailed to you when ready. This feature should be used to send reports that are needed once. If you want to email the report on a regular basis, use the Add Schedule feature.

Send To – Select “Me” to send the report to yourself or select Email List to create and enter a list of email recipients.

Format – Determine if you would like a PDF, Excel, or Word version of the report. Please note that some reports lend themselves to certain formats. For example, the WC Loss Run Data Summary should be generated as Excel where a report with limited information may work best as a PDF.

Email – Your email will appear in the Reply To Address. Edit the subject and body of the email if desired.

When you are ready to generate the report, click Email Report.



Add Schedule

You can schedule reports for regular delivery to yourself and/or other individuals.

Dashboards Account Info Tasks All Claims Enter a New Claim Policies Locations Reports & Templates OSHA

Schedule Report WC Claim Level Table - Section to Export Return to Report Save Schedule

Create new schedule

Schedule

Frequency: *

Run on the selected month(s) each year:

January February March April May June July August September October November December

All None

Run on this date each month:

or

Run on the: First of each month

Skip on Business-Closed Holidays

Schedule Starts: * Time:

Schedule Ends:

Description:

Send To

Send To:

Format:

Send download link instead of actual file (link expires 7 days after email is sent)

If No Data:

Email

Reply To Address: * Request Read Receipt

Subject: *

Body: *

Additional Reports to Include

Report Name	Format

[Add Report](#)

Frequency

Most common selections would be Daily, Weekly, or Monthly. There is also an option for One Time and Every Other Week.

Run On

Review the Run On options. For example, if you would like to schedule the report to run on a quarterly basis, select January, April, July, and October. Select when you would like the report to run. You can select a date like the 1st of the month, or you can select a day of the week like the 1st Monday of the month.

Schedule Start/End

Add a start and end date for the schedule for this report. You may also enter a brief description here.

Send To

Select “Me” to send the report to yourself or select Email List to create and enter a list of email recipients.

Format

Determine if you would like a PDF, Excel, or Word version of the report. Please note that some reports lend themselves to certain formats. For example, the WC Loss Run Data Summary should be generated as Excel where a report with limited information may work best as a PDF. There are also options for Excel and CSV data extract formats.

If No Data

Determine what you would like the system to do if your report does not contain any data.

- Send Report – Sends a blank report
- Do Nothing – Does not generate an email (not recommended)
- Send Email Indicating No Data – Sends an email to the recipient letting them know there was no data meeting the criteria for the report. We recommend selecting this option.

Email

Your email will appear in the Reply To Address. Edit the subject and body of the email to make it more meaningful to you and the recipient.

Additional Reports to Include

You can include additional reports in this email schedule. Click Add Report and select the report(s) you would like to include. The report will be listed in the Additional reports section. Click the format drop down to modify the format of the report.

Report Name	Format
WC First Indemnity Payments	PDF

When finished, click Save Schedule.

Reports >
WC Claim Level Table - Section to Export ☆

Run Report More ▾

Report has been scheduled.

Editing Report Criteria

Please note, you cannot make changes to the default reports, but you can create a copy for yourself and modify the copy.

Select the standard report you would like to change. From the More menu, select Copy Report.

Enter a name for the new report in the Report Name field.

The screenshot shows the 'New Report' form in the RADIUSR application. The form is titled 'New Report' and contains several sections:

- Report Information:** Fields for Report Name (filled with 'Copy of WC Claim Level Table - Section to Export'), Description, Title, Subtitle, and Comments.
- Report Groups:** A dropdown menu.
- Report Folder:** A dropdown menu with '- None Selected -' selected.
- Report Type:** A dropdown menu with 'WC Claim Level Table - Section to Export' selected.
- Shade Alternate Rows:** A checkbox that is unchecked.
- Grand Totals:** A checkbox that is checked.
- Prompt Options:** A checkbox that is unchecked.

Below the form is a 'Filters' section with the following content:

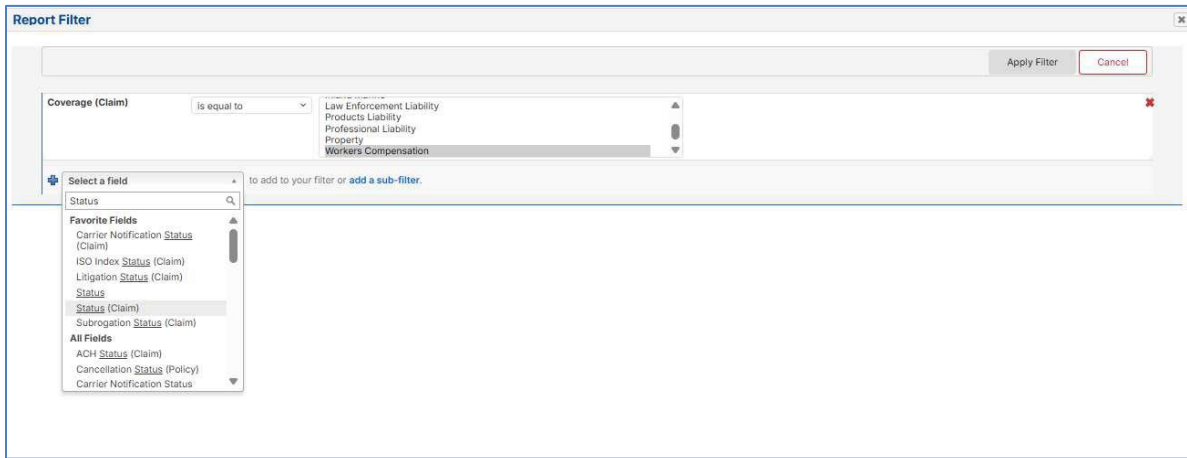
Filters
Coverage (Claim) is equal to Workers Compensation [Edit Filters](#)
or
Use saved view: <Use Regular Filter>

Filters

Applying filters limits the information included in the report. For example, you can select claims for specific locations, claim types, claim status(es), or a combination of these. To modify the filters, click Edit Filter.

Click Select A Field and search for the field you would like to use as a filter. Click your selection.

Add your criteria to the filter and click the Apply Filter button.



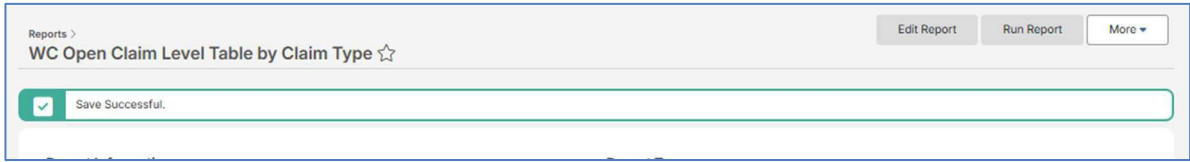
You will see your selection has been added to the filter criteria.

If you have created a Claim View that you would also like to use for reports, you can apply it as a filter. Simply select the view from the Use Saved View drop-down.

Other Report Options

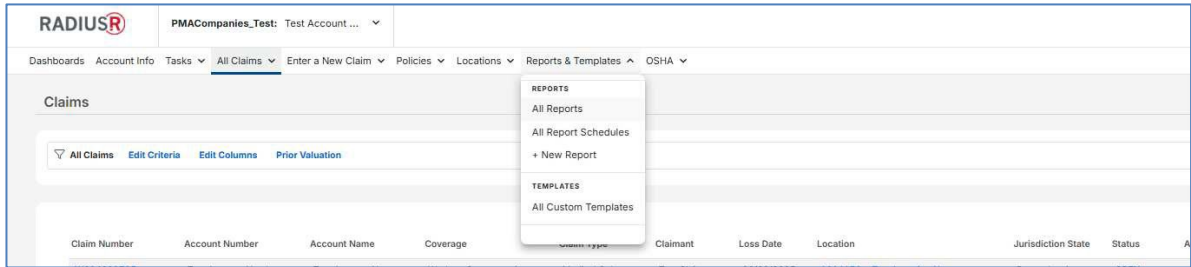
You can determine how you would like information to be grouped and sorted within the report. You can also determine date ranges if applicable. You can enter the actual date or set the report to use a monthly or weekly date range.

When you have finished modifying your report, click Save Changes. Your report will now be available in the report list. You can run it as needed or schedule it for delivery.



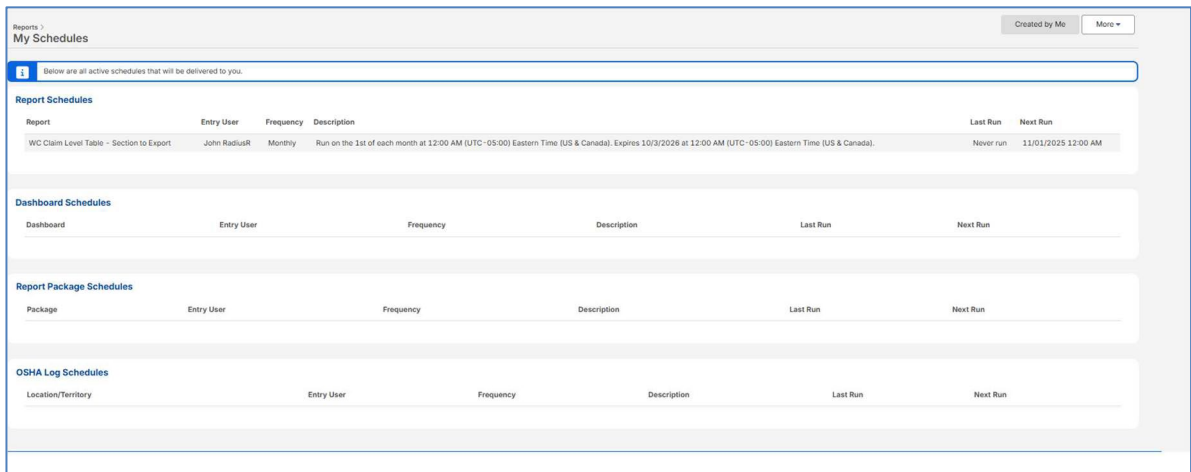
Viewing Report Schedules

To view your scheduled reports, click All Report Schedules under the Reports &



Templates menu item.

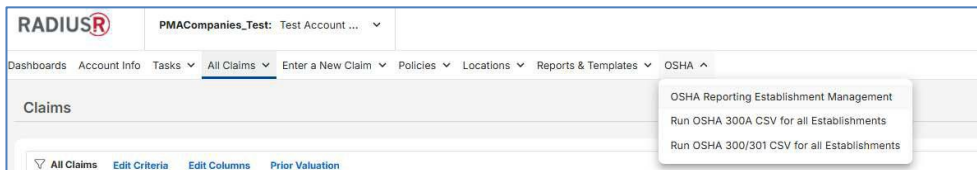
You will see a list of all active report schedules, including the last and next run dates.



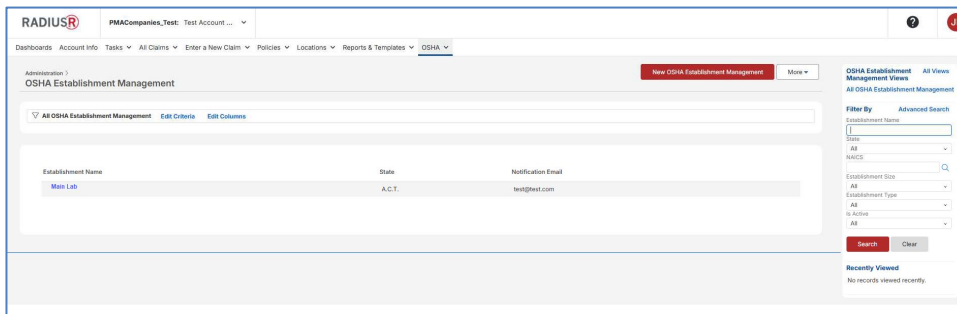
OSHA Recordkeeping

OSHA Reporting Establishment Management

Each unique entry will generate a new OSHA log and summary when you create the OSHA 300 and OSHA 300 A reports. To create or manage establishment information, click the OSHA menu item and select OSHA Reporting Establishment Management.



Adding a New Establishment



Click the New OSHA Establishment Management button.

Enter information about the OSHA Establishment and click Save Changes.

🏠 New OSHA Establishment Management
Save Changes

Establishment Name:

EIN:

Company Name:

Street Address:

City:

State:

Postal Code:

NAICS:

SIC:

Industry Description:

Establishment Size:

Establishment Type:

OSHA Signature Title:

OSHA Signature Phone:

Notification Email:

Is Active:

OSHA Establishment Management > 10/3/2025 ☆ Edit OSHA Establishment Management More ▾

Save Successful.

Establishment Name: Corporate Headquarters
 EIN: 999999999
 Company Name ⓘ Test Account 1

Street Address: 123 Main St
 City: Any City
 State: Pennsylvania
 Postal Code: 99999

NAICS: Research and Development in Biotechnology
 SIC: COMMERCIAL PHYSICAL AND BIOLOGICAL RESEARCH
 Industry Description: Biotech Research

Establishment Size: 100-249 Employees
 Establishment Type: Non Government

OSHA Signature Title: VP of HR
 OSHA Signature Phone: 999-999-9999

Notification Email: radiusregister@gmail.com
 Is Active: Yes

You will see an indicator that your changes were successful.

Additional sections will now be available for the new establishment.

Reports – Provides links to generate the OSHA logs or ITA csv files for uploading to the OSHA website.

Headcount and Working Hours – Enter the current year and then complete the annual average number of employees in the Headcount field and the total hours worked by all employees in the Hours Worked field. Click the Plus icon. Please note, you will need to enter a new record for Headcount and Hours Worked for each

Reports

OSHA 300A CSV: OSHA 300A
 OSHA 300/301 CSV: OSHA 300/301 CSV
 OSHA Logs (300/300A): OSHA Logs

Headcount and Working Hours New OSHA Establishment Value

Year	Headcount	Hours Worked
<input type="text"/>	<input type="text"/>	<input type="text"/>

Reports

OSHA 300A CSV: OSHA 300A
 OSHA 300/301 CSV: OSHA 300/301 CSV
 OSHA Logs (300/300A): OSHA Logs

Headcount and Working Hours New OSHA Establishment Value

Year	Headcount	Hours Worked
01/01/2024	152	542,125

establishment every year

Headcount and Working Hours New OSHA Establishment Value

Year	Headcount	Hours Worked
<input type="text"/>	<input type="text"/>	<input type="text"/>
2025	163	652,651
2024	152	542,125

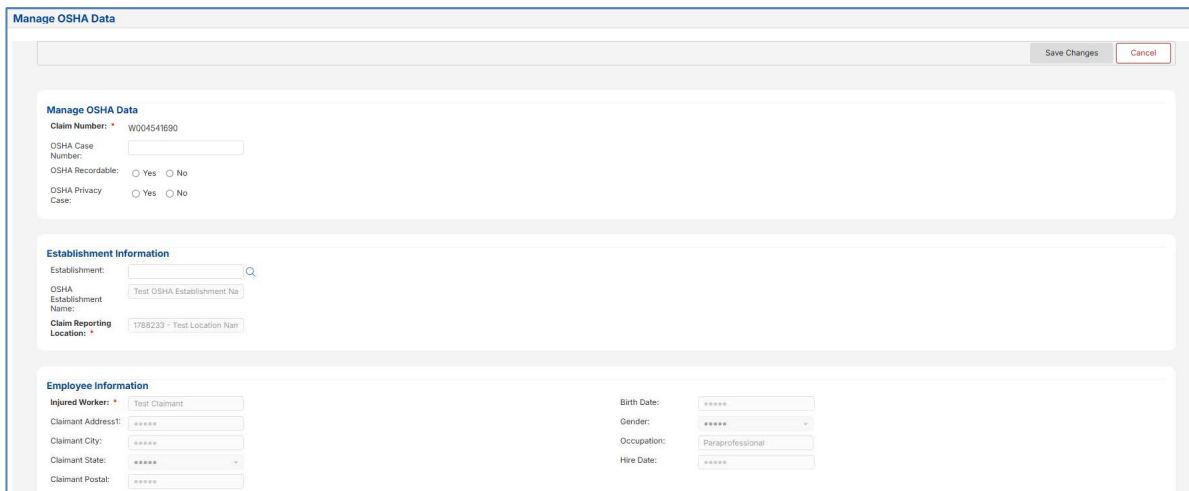
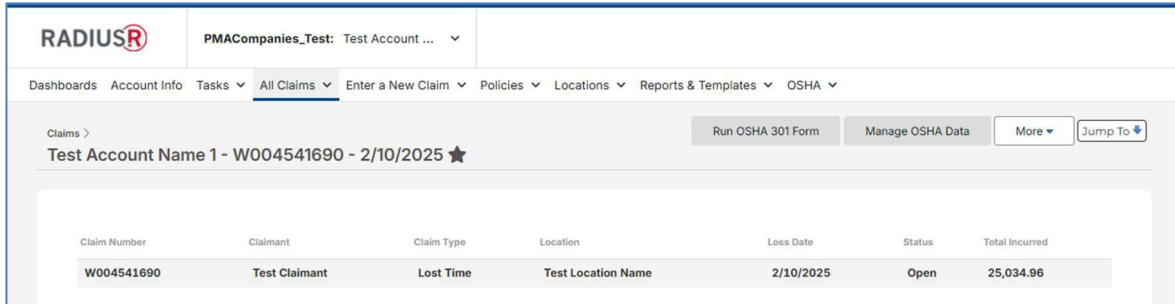
Headcount and Working Hours New OSHA Establishment Value

Year	Headcount	Hours Worked
<input type="text"/>	<input type="text"/>	<input type="text"/>
2024	152	542,125

Managing OSHA Data

If you are using RadiusR to maintain your OSHA log(s), you can update information for specific incidents directly from the claim screen.

Search for the claim desired in the Claim Search screen. Select the Claim Number to view the claim screen, then click the Manage OSHA Data button.



Review the OSHA details of the claim and update as needed. Please note, some critical claim fields like loss date and injured worker name cannot be edited in the Manage OSHA Data screen. If a change should be made to one of these fields, please contact your adjuster and ask them to update the claim. Once the change is made and visible in the claim screen in RadiusR, it will be reflected in the OSHA record as well.

Excluding Non-Recordables and Updating Privacy

Following the OSHA recordkeeping guidelines, determine if the claim is recordable. Select No in the OSHA Recordable field to exclude a non-recordable case from the log.

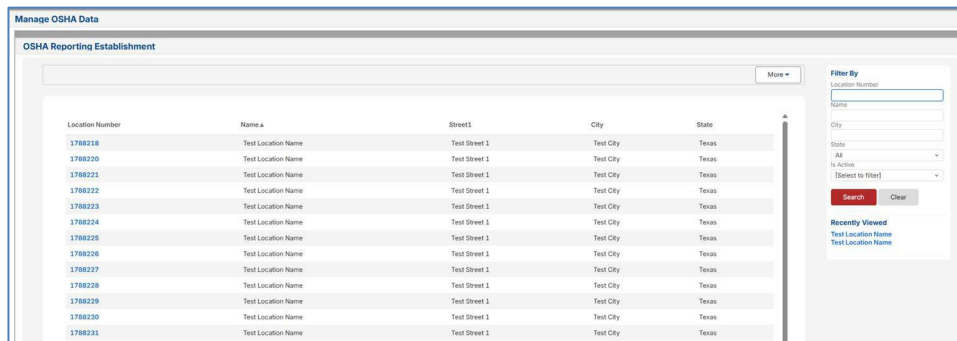
To mark a case as a Privacy case, select Yes in the OSHA Privacy Case field. Selecting Yes will display “Privacy Case”, rather than the employee’s name when you print the log.

Updating Cases

Confirm the Employee Information, Physician Information, and Descriptions are all correct.

Establishment Information

Review the OSHA Establishment name for the claim. To move this claim to a different establishment, click the magnifying glass to view a list of establishments. Click the Location Number link to select the desired establishment. If you do not see the Establishment needed, return to the OSHA Reporting Establishment Management section to create a new Establishment.



The screenshot displays the 'Manage OSHA Data' interface. The main section is titled 'OSHA Reporting Establishment' and contains a table with the following columns: Location Number, Name, Street1, City, and State. The table lists 13 test entries, each with a unique location number and the same test data. To the right of the table is a search filter panel with the following fields: 'Filter By' (set to 'Location Number'), 'Name' (text input), 'City' (text input), 'State' (dropdown menu set to 'All'), and 'In Active' (dropdown menu set to 'Select to Filter'). Below these fields are 'Search' and 'Clear' buttons. At the bottom of the filter panel, there is a 'Recently Viewed' section listing 'Test Location Name' twice.

Location Number	Name	Street1	City	State
1788218	Test Location Name	Test Street 1	Test City	Texas
1788220	Test Location Name	Test Street 1	Test City	Texas
1788221	Test Location Name	Test Street 1	Test City	Texas
1788222	Test Location Name	Test Street 1	Test City	Texas
1788223	Test Location Name	Test Street 1	Test City	Texas
1788224	Test Location Name	Test Street 1	Test City	Texas
1788225	Test Location Name	Test Street 1	Test City	Texas
1788226	Test Location Name	Test Street 1	Test City	Texas
1788227	Test Location Name	Test Street 1	Test City	Texas
1788228	Test Location Name	Test Street 1	Test City	Texas
1788229	Test Location Name	Test Street 1	Test City	Texas
1788230	Test Location Name	Test Street 1	Test City	Texas
1788231	Test Location Name	Test Street 1	Test City	Texas

Classify the Case

Select the appropriate OSHA code.

Classify the Case
 OSHA Code: Injury Skin Disorder Respiratory Condition Poisoning Hearing Loss All Other Illnesses

Treatment
 Physician Name:
 Hospital Name:
 Hospital Street:
 Hospital City:
 Hospital State:
 Hospital Postal:

Emergency Room Indicator: Yes No
 Hospitalization Indicator: Yes No

Incident Details
 Loss Date: *
 Loss Time:
 Time of Injury Cannot be Determined: Yes No
 Shift Start Time:
 Death Date:
 OSHA Event Location:

Activity During Accident:
 Activity Result Description:
 Injury or Illness Description:
 Object Causing Injury:

The best way to track Lost Days and Restricted Days is to add information to the Lost Time Detail section. This will allow you to keep detailed records of the days the employee was out of work or on restriction. It will also ensure accurate totals, particularly if the employee is on intermittent leave. To add information to this section, click +Add Lost Time Detail.

Lost/Restricted Days
 Lost Days: Restricted Days:

OSHA eTools: [Click Here](#)

Questions on OSHA? [Click here](#)

Lost Time Detail + Add Lost Time Detail

Start Date	End Date	Lost Time Type	Accommodated	Transitional	Disability Type	Calendar Days	Work Days	Comments

The New Lost Time Detail screen will appear. Enter the first day the employee was out of work in the Start Date. Enter the last day the employee was out of work as the End Date. In the Lost Time Type, select Lost Days or Restricted Days. If you would like to add a note for your records, complete the Comments field. Click Save Changes.

New Lost Time Detail

Save Changes Cancel

Claim Number	Claimant	Coverage	Type Of Claim	Jurisdiction State	Loss Date	Status	Location	Outstanding - Miss/BU/Comp	Outstanding - Expense	Outstanding - Ind/PD/Cost	Outstanding - Not in Use	Adjuster
W004610592	Test Claimant	Workers Compensation	Lost Time	Connecticut	06/15/2025	OPEN	Test Location Name	9,717.38	2,177.58	893.97	0.00	

Start Date: * 07/01/2025

End Date 07/10/2025

Lost Time Type: * Lost Days

Transitional Duty: - None Selected -

Disability Type: - None Selected -

Comments: Add my comments here

Work Days: * 8

Calendar Days: * 10

Note: Lost days calculation does not include date of loss (06/15/2025).

Employee Work Schedule

The entries below are used to calculate lost work days. Changes to the employee work schedule will update the claim record.

Work Week: Sun Mon Tue Wed Thu Fri Sat

Holidays

Confirmation that your changes were saved will appear at the top of the screen.

RADIUS PMACompanies_Test: Test Account ...

Dashboards Account Info Tasks All Claims Enter a New Claim Policies Locations Reports & Templates OSHA

Claims > Test Account Name 1 - W004541690 - 2/10/2025 ★

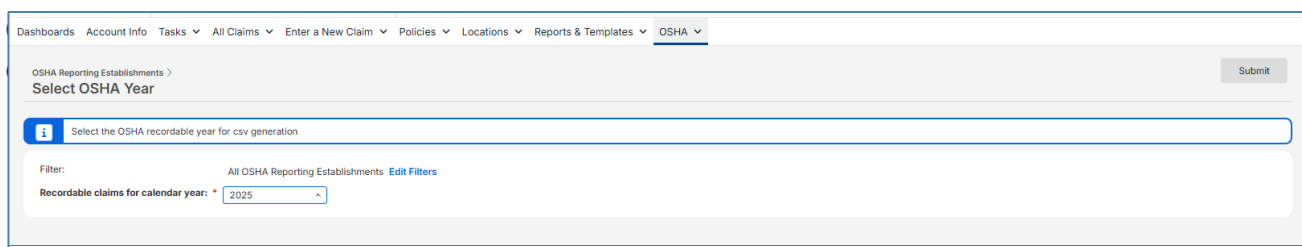
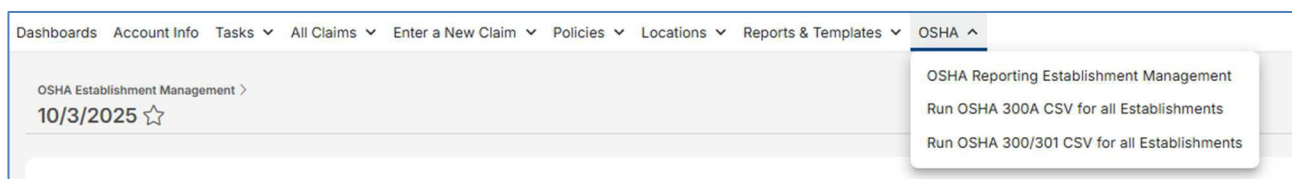
Run OSHA 301 Form Manage OSHA Data More Jump To

OSHA Data Save Successful.

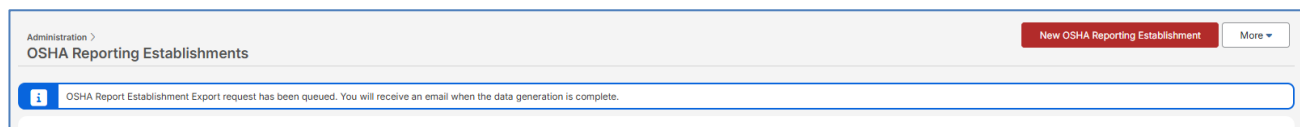
Claim Number	Claimant	Claim Type	Location	Loss Date	Status	Total Incurred
W004541690	Test Claimant	Lost Time	Test Location Name	2/10/2025	Open	25,034.96

OSHA Reports

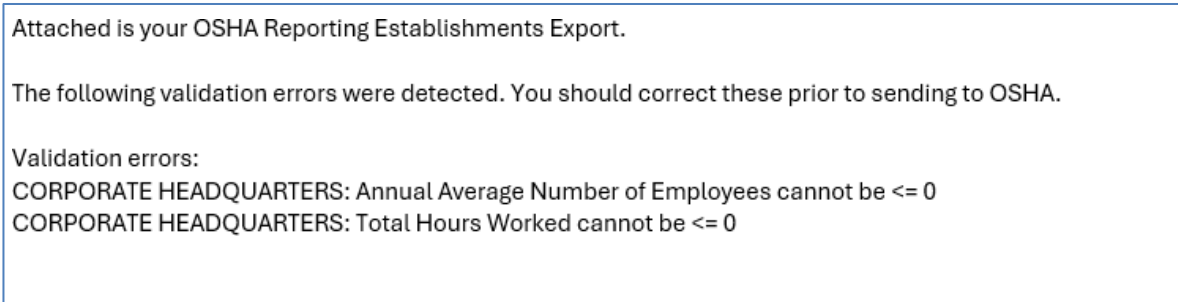
OSHA 300A CSV and OSHA 300/301 CSV for all Establishments



You will see a notification that the report has been requested and will receive an email with the csv file.



The email may list potential validation errors that should be reviewed prior to submitting the CSV to OSHA. If your report contains validation errors, please review and correct the items noted.



OSHA 300 and OSHA 300A

Select any establishment. Under the Reports section, click the OSHA Logs link.

Generate OSHA Log

Territories:

Locations:

OSHA Reporting Establishments:

Claim Filter: **OSHA Recordable** is true [Edit Filters](#)

Incident Filter: **OSHA Recordable** is true [Edit Filters](#)

Number of Records per Page:

Report Year From:

Report Year To:

Date Run on Report:

Select Log(s): OSHA 300A OSHA 300

Select Export Format(s): Excel PDF

Save in Zip:

Select Private Column(s):

Use Counter for Column A:

Signature:

Signature Title:

Signature Phone:

Orientation of Report:

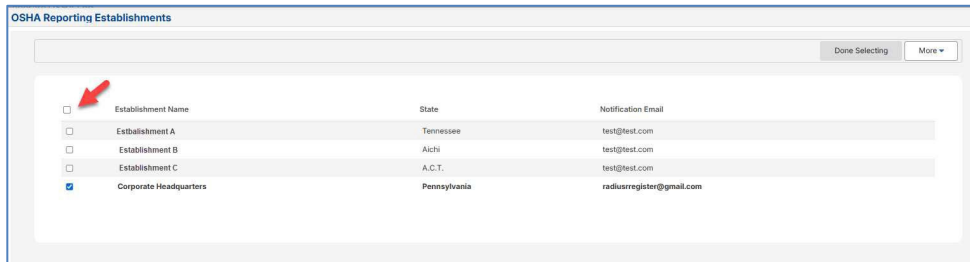
Column F Override (Claims):

Column F Override (Incidents):

Use California Template:

1. Select Establishments – Click the magnifying glass to open the OSHA Reporting Establishments selection window.

Check the box next to Establishment Name to Select all establishments. Click Done Selecting.



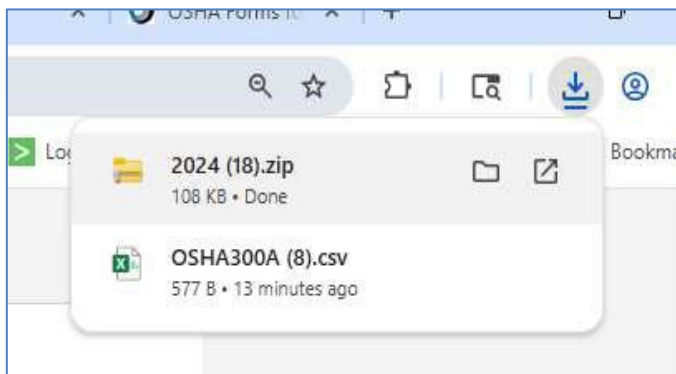
2. Report Year From/Report Year To – Enter the year for the report.

3. Select the report(s) and format(s) desired.

4. Click Generate Log(s).

The OSHA Logs will appear in a zip file in your downloaded item in your browser.

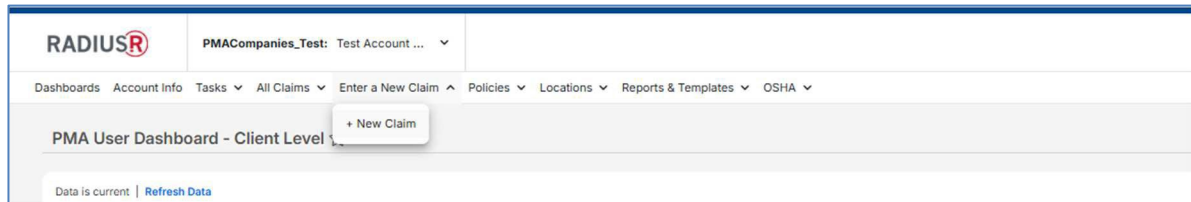
Be sure to save the files with your other OSHA information on your local or network drive.



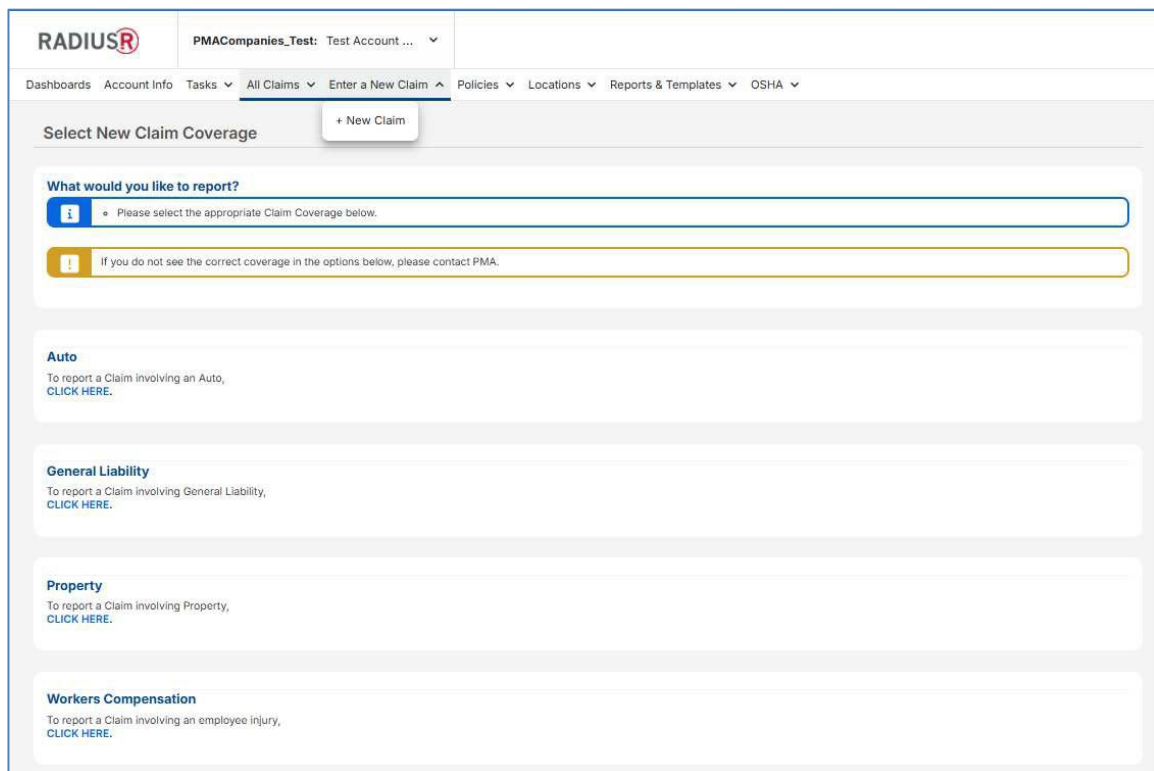
Name	Type	Compressed size	Password ...	Size	Ratio
2024CorporateHeadquarters.xlsx	Microsoft Excel Worksheet	28 KB	No	47 KB	43%
2024 TEST.xlsx	Microsoft Excel Worksheet	27 KB	No	47 KB	43%
2024 TEST4.xlsx	Microsoft Excel Worksheet	27 KB	No	47 KB	43%
2024 TEST6.xlsx	Microsoft Excel Worksheet	27 KB	No	47 KB	43%

Claim Reporting

Hover over the **Enter New Claim** menu item and then click **+ New Claim** to file a new claim. To continue working on a claim draft from a prior session, click the temporary Claim Number listed in the Claims in Draft Status list.



You will see the New Claim Coverage screen. Select the coverage desired. Please note, your coverage selections will be limited to the coverage available for the selected account number.



Select the coverage desired.

After selecting the coverage needed, you will see the entry screen for that coverage.

Required Fields are listed in **bold font** and contain an asterisk (*).

New Claim

Account Name: Test Account Name - Test Account Number

Coverage: **Workers Compensation**

Submitter Details

Select **Submission Complete** After you have confirmed that all information on your submission looks correct
Select **Save Progress** If you'd like to save your progress on the form

Please note the buttons under the **Submitter Details**.

- Click **Submission Complete** to submit your claim.
- Click **Save Progress** to save a draft of the claim. Your entry will be assigned a temporary claim number will it remains in draft status. You will be able to come back to complete the claim later. Drafts will be automatically deleted after 30 days. If your claim remains in draft status for an extended period, you will receive email reminders at 7 and 28 days.
- **Return to Coverage Screen** will bring you back to the coverage selection screen.

Workers' Compensation Claims

Employee Information

Employee Information

Claimant Home Phone: ext
Enter digits for "US" or type + for international numbers.

Accident State: *

First Name: *

Middle Name:

Last Name: *

Claimant Suffix:

Address: *

Address 2:

City: *

State: *

ZIP: *

Birth Date: *

SSN: *

Occupation/Job Title: *

Location of Loss: *

Sex:

Home Phone:

Work Phone:

Mobile Phone:

Hire Date:

Claimant Email:

Marital Status:

Injured Worker Employment Status Code:

Number Of Dependents:

Employee Number:

Complete as much information about the injured worker as possible. Adding contact information like home phone, mobile phone, and email address, when available, will allow multiple options for communication between the adjuster and the injured worker.

Fields with an arrow or a magnifying glass icon contain a list of predefined values. Click the arrow or magnifying glass to see a list of available options for that field. Fields with a magnifying glass, like **Location of Loss**, allow you to type a portion of the name or code to narrow the list of options. For more details, refer to the **Helpful Hints** section at the end of this guide.

Marital Status:

Injured Worker Employment Status Code:

Number Of Dependents:

Employee Number:

- None Selected -
- Common law spouse
- Divorced
- Married
- Separated
- Single
- Spouse deceased
- Unknown

State: *


ZIP: *


Birth Date: *


- Connecticut (CT)
- Wisconsin (WI)


Occurrence Information

Occurrence Information

Date of Injury/Illness: * 

Accident Cause: * 

Injury Type: * 

Body Part: * 

Accident Description: *

Maximum 500 Characters.

Body Part (Fingers or Toes)

For claims with a Body Part of Fingers or Toes, an additional drop-down will appear. Select the affected finger or toe from the list. If unknown, select one and then provide Comments on the Claim Submission page to indicate the actual toe or finger is currently unknown.

Injury Information

Injury Information			
Time Began Work:	<input type="text"/>	Time of Occurrence:	<input type="text"/>
Date Employer Notified: *	<input type="text"/>	Last Date Worked:	<input type="text"/>
Date Expected Return to Work:	<input type="text"/>	Date Returned to Work:	<input type="text"/>
Full Pay for Date of Injury:	- None Selected -	Payment Frequency:	- None Selected -
Work Week Type: *	Standard	Hours Worked per Day:	- None Selected -
If fatal, date of death:	<input type="text"/>		
Is the injured worker losing time? *	- None Selected -		
Is the injured worker on modified duty? *	- None Selected -		

Work Week Type

Standard

The default for **Work Week Type** is Standard. Standard applies when the employee works five days per week and the work days are Monday – Friday.

Fixed

Fixed indicates that the employee works a fixed schedule, but the days worked are not Monday – Friday. When selected, **Work Days Scheduled** becomes required. The default for **Work Days Scheduled** is blank and you will need to indicate the days the employee works (for example, an employee may only work Monday, Wednesday, and Friday or they may work a five-day week, but the days worked are Wednesday – Sunday).

Varied

When selected, the **Days Worked Per Week** field, rather than the **Work Days Scheduled** field, becomes required. Since the work days vary there is no need to complete **Work Days Scheduled**. You should indicate the number of days the employee works each week in the **Days Worked Per Week field**. If the days worked per week is not consistent, indicate the average number of days per week.

Loss Location/Primary Physical Work Location

Loss Location Address	
Where did injury/illness occur?	<input type="text"/>
	Maximum 255 Characters.
Make Loss Location same as Claim Reporting Location:	<input type="checkbox"/>
Claim Reporting Location Name:	<input type="text"/>
Address: *	<input type="text"/>
City: *	<input type="text"/>
ZIP: *	<input type="text"/>

Primary Physical Work Location	
Make Primary Physical Work Location the same as Loss Location:	<input type="checkbox"/>
Address: *	<input type="text"/>
City: *	<input type="text"/>
State: *	<input type="text"/> <input type="button" value="Q"/>
ZIP: *	<input type="text"/>
Physical Work Location Unknown:	<input type="checkbox"/>
Medical Attention Required: *	- None Selected - <input type="button" value="v"/>
Were Safeguards/Safety Equipment Used?	- None Selected - <input type="button" value="v"/>
Was Employee injured during employment?	- None Selected - <input type="button" value="v"/>
Is Employee Represented by Attorney?	- None Selected - <input type="button" value="v"/>
Did Injury or Illness Occur on Employer's Premises?	- None Selected - <input type="button" value="v"/>
Were Safeguards or Safety Equipment Provided?	- None Selected - <input type="button" value="v"/>
Does Employer Question the Claim?	- None Selected - <input type="button" value="v"/>
Were Drugs or Alcohol Involved:	- None Selected - <input type="button" value="v"/>

Where did injury/illness occur? is a freeform field. Use this field to indicate the specific location of the injury such as “Rear stairwell” or “Patient Room 27A”.

Check the **Make Loss Location same as Claim Reporting Location** box if the injury occurred at the same physical address as the loss location. If not, complete the address.

If the injured worker’s primary physical work location is the same as the loss location address, check the box. If not, complete the address. If the primary physical work location is unknown, check the **Primary Work Location Unknown** box.


Complete the **Medical Attention Required** field. If you are unsure, select Unknown.

Physician/Health Care Provider and Hospital/Provider Information

If you know the injured work was treated at an occupation health center, clinic, or hospital, expand the appropriate section and complete the provider information. Any information you can provide will be helpful.

▼ Physician / Health Care Provider Name and Address			
Name:	<input type="text"/>	Address:	<input type="text"/>
Telephone:	<input type="text"/>	City:	<input type="text"/>
		State:	<input type="text"/> Q
		ZIP:	<input type="text"/>
▼ Hospital / Provider Information			
Name:	<input type="text"/>	Address:	<input type="text"/>
Telephone:	<input type="text"/>	City:	<input type="text"/>
		State:	<input type="text"/> Q
		ZIP:	<input type="text"/>

Preparer and Contact Information

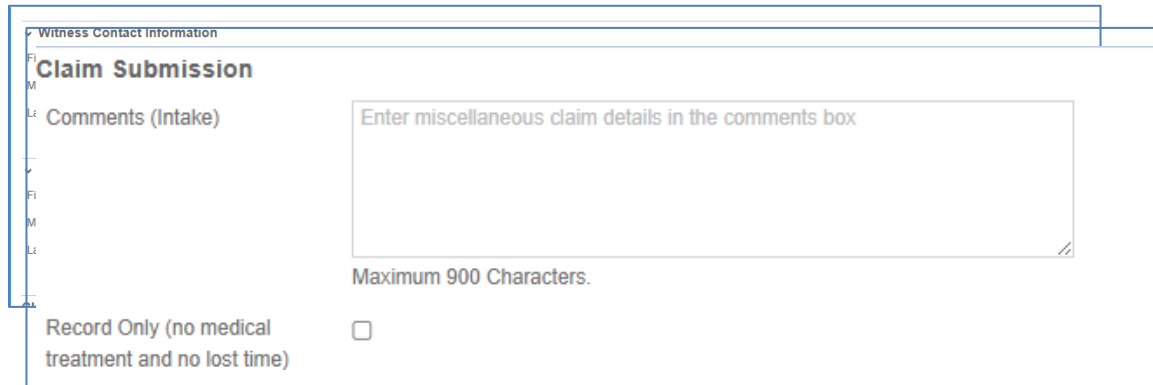
Other Information	
Date Prepared:	<input type="text" value="06/10/2025"/> 
Preparer's Information	
First Name: *	<input type="text" value="John"/>
Last Name: *	<input type="text" value="Smith"/>
Telephone: *	<input type="text" value="(999) 555-1212"/>
Employer Contact Information (If different than Preparer)	
First Name:	<input type="text"/>
Last Name:	<input type="text"/>
Telephone:	<input type="text"/>

Your name and phone number will prefill in the Preparer section. Please complete the **Employer Contact Information** if we should reach out to someone other than you to discuss the claim.

Witness Information

Please expand and complete the witness information section if there were witnesses to the injury.

Claim Submission



The screenshot shows a web form titled "Claim Submission" within a "Witness Contact Information" section. The form includes a "Comments (Intake)" field with a placeholder text "Enter miscellaneous claim details in the comments box" and a character limit of "Maximum 900 Characters." Below the comments field is a checkbox labeled "Record Only (no medical treatment and no lost time)".

Type any additional information about the claim in the **Comments** box. Your comments will become the first Log Note in the file. Treat this information as legally discoverable.

Check the **Record Only** box when the claim is for informational purposes only. Record Only claims will not be assigned to an adjuster.

For Workers' Compensation, this means an injured worker will not be seeking medical treatment and will not be losing any time from work. If you submit a Record Only claim, and the situation changes, please contact us at 888-476-2669 to have the claim assigned to an adjuster.

Claim Information Email

Claim Information Email	
Additional Emails to copy on Notification:	Multiple addresses can be entered separated by a comma
Distribution list - Account Level:	
Location Distribution List:	

You will automatically receive an email copy of the claim information provided. This email will include our claim number. If you would like to send a copy of the claim information to someone else, enter the email address in the **Additional Emails to copy on Notification** field. Your employer may have a standard distribution list for these new claim emails. If so, you will see email address(es) in the Account Level or Location Distribution List.

Claim Submission and Uploading Documents

Claim Submission

When you are finished, click **Submission Complete** at the top or bottom of the page.

Files and other documents can be attached on the next page at the top of the page.

Submitter Details

Select **Submission Complete** After you have confirmed that all information on your submission looks correct
Select **Save Progress** If you'd like to save your progress on the form

Submission Complete Save Progress
Return to Coverage Screen

After clicking **Submission Complete**, you may see a notification indicating missing required fields. If so, complete the missing information and click Submission Complete to file the claim.

New Claim

Please correct the following errors.

- **Address:** A value is required.
- **City:** A value is required.
- **ZIP:** A value is required.
- **Date of Injury/Illness:** A value is required.
- **Date Employer Notified:** A value is required.
- **Location of Loss:** A value is required.
- **Accident State:** A value is required.

Employee Information

Claimant Home Phone: ext
Enter digits for 'US' or type + for international numbers.

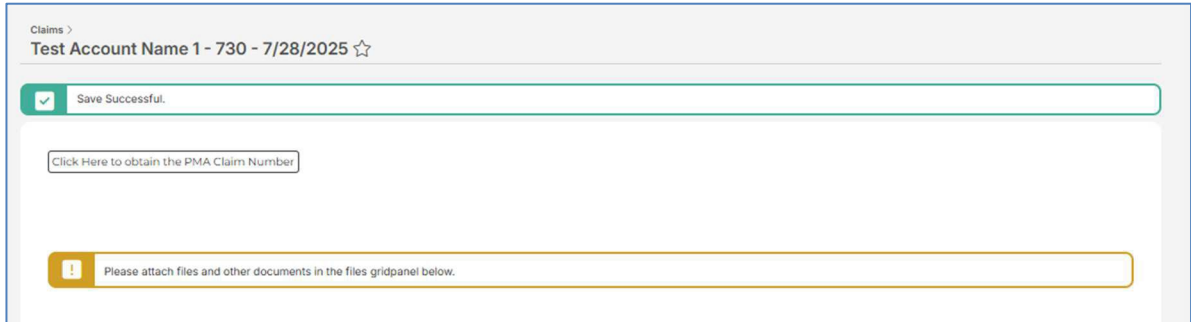
Accident State: * A value is required.

First Name: * A value is required.

Middle Name:

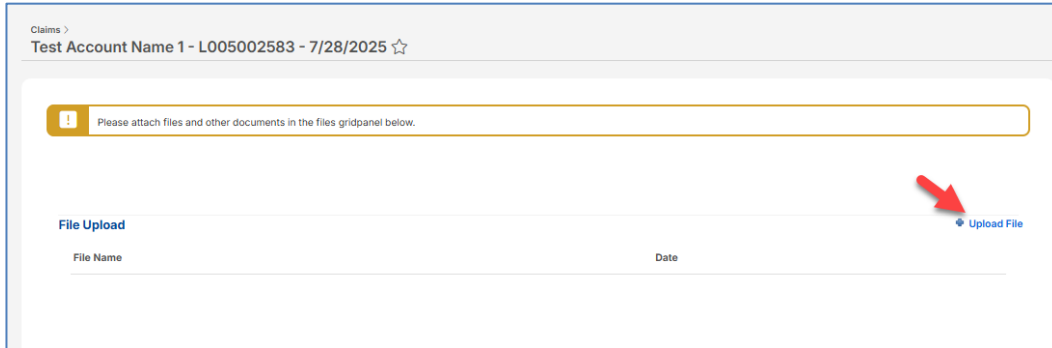
Last Name: * A value is required.

You will see a notification that your claim was saved successfully. To view the Lodestar claim number, click the **Click Here to obtain the Lodestar Claim Number** button. The claim number will appear in the blue banner next to the account name and number. Please note, even if you do not click that button, the Lodestar Claim Number will be assigned and will be included in the email notification.



Uploading Documents

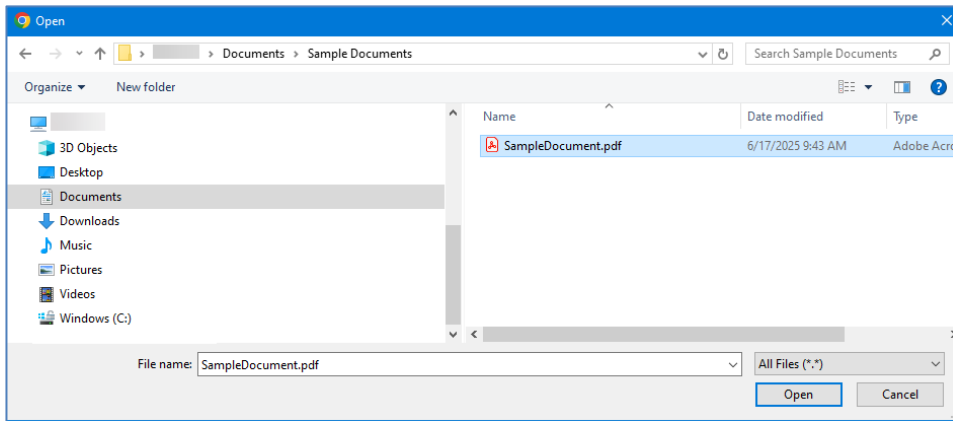
To submit additional documentation, such as internal investigation reports, surveillance footage, medical reports, or photographs, click the **Upload File** link.



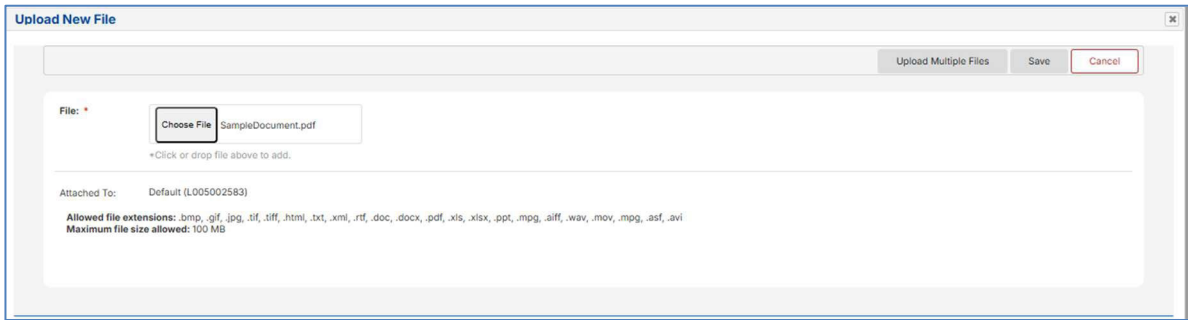
Click the **Choose File** button to upload a single document or the **Upload Multiple Files** button to attach multiple documents.



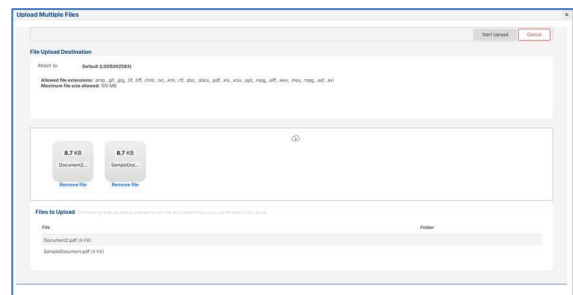
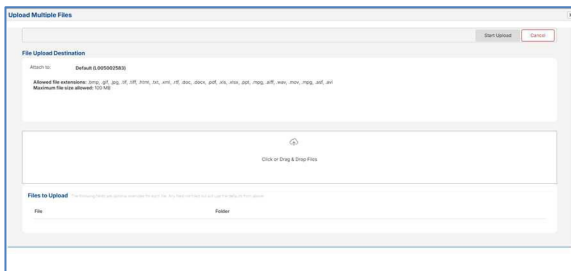
The File Explorer window will open. Navigate to the folder where you have stored the document(s) you want to upload. Select the file(s) you would like to submit and click **Open**. Please note, your corporate IT policy may prohibit this step. In that case, you can email your document(s) to Lodestar at claimsmail@lodestar.com. Be sure to include the claim number in the subject line.



When uploading a single document, the name of the selected document will appear next to the **Choose File** button. Click **Save** to upload the document.



When uploading multiple documents, the name of the documents will appear in the list under the **Click or Drag & Drop Files** box. Click **Start Upload** to upload the documents.



When the upload is complete, you can attach more files, close the application, or enter a new claim.

Any documents uploaded will be scanned for viruses. You will see the status of the virus scan in parentheses after the file name.

File Upload		Upload File
File Name	Date	
Document2pdf (Queued for scanning)	10/03/2025 12:20 PM	✖
SampleDocumentpdf (Queued for scanning)	10/03/2025 12:20 PM	✖

Auto Claims

Loss Information

Account Name:	Test Account Name - Test Account Number
Coverage:	AUTO

Submitter Details
Select **Submission Complete** After you have confirmed that all information on your submission looks correct
Select **Save Progress** If you'd like to save your progress on the form

Loss Information

Date of Occurrence: *	<input type="text"/>	Contact Business Phone: *	<input type="text"/>
Time of Occurrence:	<input type="text"/>	Violations/Citations:	- None Selected -
Contact First Name: *	<input type="text"/>	Authority Contacted:	<input type="text"/>
Contact Last Name: *	<input type="text"/>	Report Number:	<input type="text"/>
Location of Loss: *	<input type="text"/>	Describe Loss: *	<input type="text"/>
Address:	<input type="text"/>		Maximum 500 Characters.
City:	<input type="text"/>		
State of Loss: *	<input type="text"/>		
ZIP:	<input type="text"/>		

Insured Vehicle/Insured Driver Information

Insured Vehicle Information			
Make:	<input type="text"/>	Body Type:	<input type="text"/>
Model:	<input type="text"/>	Plate No.:	<input type="text"/>
Year:	- None Selected -	Vehicle No.:	<input type="text"/>
VIN:	<input type="text"/>	State:	<input type="text"/>

Insured Vehicle Driver Information			
First Name:	<input type="text"/>	Relation to Insured:	- None Selected -
Last Name:	<input type="text"/>	Date of Birth:	<input type="text"/>
Address:	<input type="text"/>	Driver's License #:	<input type="text"/>
City:	<input type="text"/>	License State:	<input type="text"/>
State:	<input type="text"/>	Purpose of Use:	- None Selected -
Zip:	<input type="text"/>	Used with Permission?:	- None Selected -
Residence Phone:	<input type="text"/>	Check if Fatal:	<input type="checkbox"/>
Business Phone:	<input type="text"/>		
Check if Driver is Injured:	<input type="checkbox"/>		
Description of Injury:	<input type="text"/>		
	Maximum 300 Characters.		
Check if Driver is Owner:	<input type="checkbox"/>		

Insured Vehicle Owner/Insured Vehicle Damage Information

Insured Vehicle Owner Information			
First Name:	<input type="text"/>	Address:	<input type="text"/>
Last Name:	<input type="text"/>	City:	<input type="text"/>
Organization Name:	<input type="text"/>	State:	<input type="text"/> Q
Residence Phone:	<input type="text"/>	Zip:	<input type="text"/>
Business Phone:	<input type="text"/>		

Insured Vehicle Damage Information			
Describe Damage:	<input type="text"/> Maximum 300 Characters.	When can vehicle be seen?	<input type="text"/>
Estimate Amount:	<input type="text"/>	Other Vehicle / Property Insurance?	- None Selected - v
Where can vehicle be seen?	<input type="text"/>	Other Insurance on Insured Vehicle Information:	<input type="text"/>

Property Damage Information

To report property damage, select Property Damage.

Damage Information (Select One)	
Indicate vehicle or property damage:	<input checked="" type="radio"/> Property Damage <input type="radio"/> Vehicle Damage

Describe Property	
Describe Property:	<input type="text"/> Maximum 300 Characters.

Property Owner Information			
Owner First Name:	<input type="text"/>	Address:	<input type="text"/>
Last Name:	<input type="text"/>	City:	<input type="text"/>
Organization Name:	<input type="text"/>	State:	<input type="text"/> Q
Residence Phone:	<input type="text"/>	Zip:	<input type="text"/>
Check if Property Owner is Injured:	<input type="checkbox"/>	Business Phone:	<input type="text"/>
Description of Injury:	<input type="text"/> Maximum 300 Characters.	Check if Injury is Fatal:	<input type="checkbox"/>

Property Damage Information

To report other vehicle damage, select Vehicle Damage.

Damage Information (Select One)			
Indicate vehicle or property damage:		<input type="radio"/> Property Damage	<input checked="" type="radio"/> Vehicle Damage
Describe Vehicle			
Make:	<input type="text"/>	Body Type:	<input type="text" value="- None Selected -"/>
Model:	<input type="text"/>	Plate No.:	<input type="text"/>
Year:	<input type="text"/>	Vehicle No.:	<input type="text"/>
VIN:	<input type="text"/>	State:	<input type="text" value="- None Selected -"/>
Other Driver Information			
Check if Driver is Owner:	<input type="checkbox"/>	Address:	<input type="text"/>
First Name:	<input type="text"/>	City:	<input type="text"/>
Last Name:	<input type="text"/>	State:	<input type="text"/>
Residence Phone:	<input type="text"/>	Zip:	<input type="text"/>
Business Phone:	<input type="text"/>	Check if Fatal:	<input type="checkbox"/>
Check if Driver is Injured:	<input type="checkbox"/>	Description of Injury:	
Description of Injury:		<input type="text"/>	
Maximum 300 Characters.			

Property/Other Vehicle Damage Information

Describe damage to the property or other vehicle and include estimate information if available.

Property / Other Vehicle Damage Information	
Describe Damage:	<input type="text"/>
Estimate Amount:	<input type="text"/>
Where can damage be seen:	<input type="text"/>
When can damage be seen:	<input type="text"/>
Maximum 300 Characters.	

Party Information

Expand and complete information for Party 1 and Party 2, if details are available.

▼ Party 1			
First Name:	<input type="text"/>	Address:	<input type="text"/>
Last Name:	<input type="text"/>	City:	<input type="text"/>
Phone:	<input type="text"/>	State:	<input type="text"/> <input type="button" value="Q"/>
Description of Injury:	<input type="text"/>		
	Maximum 300 Characters.		
Injury is Fatal:	<input type="checkbox"/>		
Passenger in which Vehicle?	<input type="radio"/> Passenger in Insured Vehicle <input type="radio"/> Passenger in Other Vehicle		
Passenger in Vehicle Information:	<input type="checkbox"/> Injured in the accident		
	<input type="checkbox"/> Witness to the accident		
> Party 2			

Witness Information

Expand and complete information for Witness 1 and Witness 2, if details are available.

▼ Witness 1			
First Name:	<input type="text"/>	Address:	<input type="text"/>
Last Name:	<input type="text"/>	City:	<input type="text"/>
Phone:	<input type="text"/>	State:	<input type="text"/> <input type="button" value="Q"/>
		ZIP:	<input type="text"/>
> Witness 2			

Reporting Party Information

Complete reporting party information, if available.

Reporting Party Information

Reported by First Name:

Reported by Last Name:

Remarks:

Maximum 500 Characters.

Reported To:

Claim Submission

Claim Submission

Comments (Intake)

Maximum 900 Characters.

Record Only:

Type any additional information about the claim in the **Comments** box. Your comments will become the first Log Note in the file. Treat this information as legally discoverable.

Check the **Record Only** box when the claim is for informational purposes only. Record Only claims will not be assigned to an adjuster.

Claim Information Email

Claim Information Email

Additional Emails to copy on Notification:

Distribution list - Account Level:

Location Distribution List:

You will automatically receive an email copy of the claim information provided. This email will include our claim number. If you would like to send a copy of the claim information to someone else, enter the email address in the **Additional Emails to copy on Notification** field. Your employer may have a standard distribution list for these new claim emails. If so, you will see email address(es) in the Account Level or Location Distribution List.

When you are finished, click **Submission Complete** at the top or bottom of the page. You will then receive the Lodestar claim number and can upload documents.

Property Claims

Loss Information

Account Name: Test Account Name - Test Account Number
Coverage: **Property**

Submitter Details
Select **Submission Complete** After you have confirmed that all information on your submission looks correct
Select **Save Progress** If you'd like to save your progress on the form

Submission Complete Save Progress
Return to Coverage Screen

Loss Information

Date of Occurrence: *	<input type="text"/>	Estimated Loss Amount:	<input type="text"/>
Time of Occurrence:	<input type="text"/>	Kind of Loss:	<input type="text"/>
Contact First Name: *	<input type="text"/>	Describe Loss: *	<input type="text"/>
Contact Last Name: *	<input type="text"/>		
Contact Business Phone: *	<input type="text"/>		Maximum 500 Characters.
Location of Loss: *	<input type="text"/>	Description of Damage:	<input type="text"/>
Address:	<input type="text"/>		
City:	<input type="text"/>		
State of Loss: *	<input type="text"/>		
Zip:	<input type="text"/>		Maximum 500 Characters.

Claim Submission

Claim Submission

Comments (Intake)

Maximum 900 Characters.

Record Only:

Type any additional information about the claim in the **Comments** box. Your comments will become the first Log Note in the file. Treat this information as legally discoverable.

Check the **Record Only** box when the claim is for informational purposes only. Record Only claims will not be assigned to an adjuster.

Claim Information Email

Claim Information Email

Additional Emails to copy on Notification:

Distribution list - Account Level:

Location Distribution List:

You will automatically receive an email copy of the claim information provided. This email will include our claim number. If you would like to send a copy of the claim information to someone else, enter the email address in the **Additional Emails to copy on Notification** field. Your employer may have a standard distribution list for these new claim emails. If so, you will see email address(es) in the Account Level or Location Distribution List.

When you are finished, click **Submission Complete** at the top or bottom of the page. You will then receive the Lodestar claim number and can upload documents.


General Liability Claims

Loss Information

Account Name: Test Account Name - Test Account Number
Coverage: **General Liability**

Submitter Details
Select **Submission Complete** After you have confirmed that all information on your submission looks correct
Select **Save Progress** if you'd like to save your progress on the form


Loss Information

Date of Occurrence: * 

Time of Occurrence:

Contact First Name: *


Contact Last Name: *

Location of Loss: * 

Address:

City:

Zip:

State of Loss: * 

Contact Business Phone: *

Authority Contacted:

Describe Loss: *
Maximum 500 Characters.


Claimant Information

Claimant Information

First Name:

Last Name:

Organization:


Birth Date: 

Social Security:

Phone:

Address:

City:

State: 

Zip:

Check if Injury is Fatal:

Description of Injury:
Maximum 1000 Characters.

Where was Injured Person Taken:
Maximum 500 Characters.

What was Injured Person Doing Prior to Injury:
Maximum 500 Characters.

Property Damage Information

To report property damage, select Property Damage.

Indicate Damage to Vehicle or Property (SELECT ONE) Property Damage Vehicle Damage

Describe Property

Describe Property:

Vehicle Damage Information

To report vehicle damage, select Vehicle Damage.

Indicate Damage to Vehicle or Property (SELECT ONE) Property Damage Vehicle Damage

Describe Vehicle

Make:

Model:

Year:

VIN:

Property/Vehicle Damage Information

Describe damage to the property or other vehicle and include estimate information, if available.

Property/Vehicle Damage Information

Estimate Amount:

Where can property be seen:

When can property be seen:

Witness Information

Expand and complete information for Witness 1 and Witness 2, if details are available.

▼ Witness Information 1			
First Name:	<input type="text"/>	Address:	<input type="text"/>
Last Name:	<input type="text"/>	City:	<input type="text"/>
Residence Phone:	<input type="text"/>	State:	<input type="text"/> Q
Business Phone:	<input type="text"/>	Zip:	<input type="text"/>
▶ Witness Information 2			

Reporting Party Information

Reporting Party Information

Reported by First Name:

Reported by Last Name:

Remarks:

Maximum 500 Characters.

Reported To:

Claim Submission

Claim Submission

Comments (Intake)

Enter miscellaneous claim details in the comments box

Maximum 900 Characters.

Record Only:

Type any additional information about the claim in the **Comments** box. Your comments will become the first Log Note in the file. Treat this information as legally discoverable.

Check the **Record Only** box when the claim is for informational purposes only. Record Only claims will not be assigned to an adjuster.

Claim Information Email

Claim Information Email

Additional Emails to copy on Notification:

Distribution list - Account Level:

Location Distribution List:

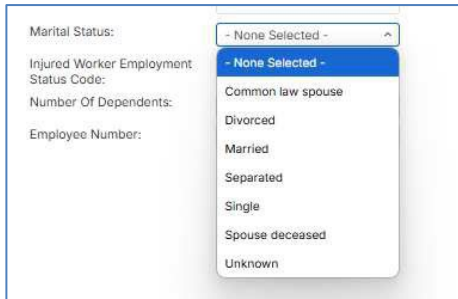
You will automatically receive an email copy of the claim information provided. This email will include our claim number. If you would like to send a copy of the claim information to someone else, enter the email address in the **Additional Emails to copy on Notification** field. Your employer may have a standard distribution list for these new claim emails. If so, you will see email address(es) in the Account Level or Location Distribution List.

When you are finished, click **Submission Complete** at the top or bottom of the page. You will then receive the Lodestar claim number and can upload documents.

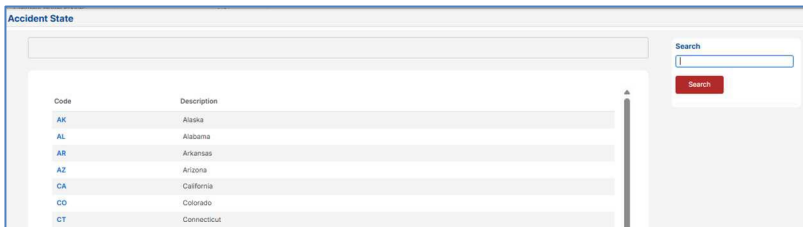
Helpful Hints

Claim Reporting

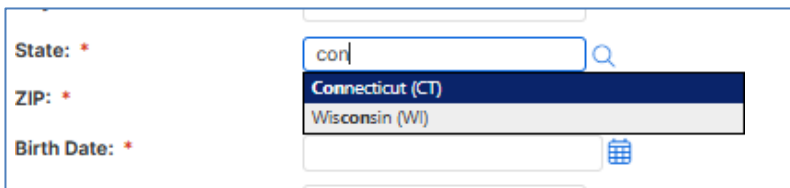
Fields with an arrow or a magnifying glass icon contain a list of predefined values. For fields with an arrow, click the arrow to display a list of options.



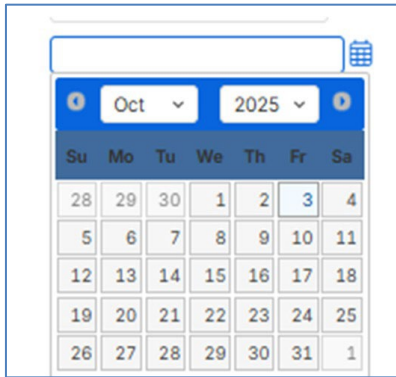
To search for a value in a field with the magnifying glass, click the magnifying glass to view the full list of options and click the blue item desired.



For a smaller list of options, type a portion of the name or code and select the value desired.



Date fields are indicated by a calendar icon. You can click on the calendar icon to select a date or, if you prefer, you can enter the date manually using the 4-digit year.



Multiple Accounts

If you have access to multiple accounts and would like to switch to a different account, click the drop-down at the top of the screen. You can search or select from anything listed in the drop-down or click Go to Account Level to see a list of options.

