WORKERS COMPENSATION INFORMATIONAL CLAIM FORM

Insured Name: ____

Policy Number: ____

Accident Date: ____

Employee Information

(Please list each employee involved)

Full Name: ____

Date of Birth: ____

Description of accident: ______________________________________
(Weather, cause, time, factors, etc.)

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Please note this is an in office form for The Piedmont Group and for file purposes only

Fax or e-mail completed forms to (301) 865-9033 or info@tpgins.net.

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