1111 W. San Marnan Drive
P.O. BOX 1328
WATERLOO, IA 50704
PHONE: 844-898-2321
FAX: 855-313-6925

WORKERS' COMPENSATION LOSS FORM

Please complete this form when reporting a claim or a possible claim. We will contact you for additional details. Claims can also be filed electronically using the "Report a Claim" feature on our website **vgminsurance.com.**

Insured Name__________________________ Policy Number __________________________

Date of Accident__________________________ Time __________________________

Contact Name __________________________

Contact Email__________________________ Phone__________________________

Insured's Physical Address __________________________

Insured's City __________________________ State ______________ ZIP______________

Description of the accident (what was the employee doing at the time of injury, and what type of injury was sustained?)

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Injured Employee Information

Name__________________________

Address __________________________

Phone Number __________________________

Email Address __________________________

Where did the employee receive treatment (name of facility)? __________________________

Address __________________________

Phone__________________________

Has the employee returned to work? ❒ Yes ❒ No

Reported by:__________________________ Date: ______________

Upon receipt, VGM Insurance Services will contact the appropriate carrier with these details and provide you with a claim number and adjuster information. Do not hesitate to contact us with questions.

IMPORTANT NOTE

Please do not divulge any of this information to any party except VGM Insurance. Direct any inquiries from claimant, lawyers, manufacturers, etc. to our office.

Submit to: VGM Insurance Claims

Fax: 855-313-6925 or

Email: claims@vgminsurance.com

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