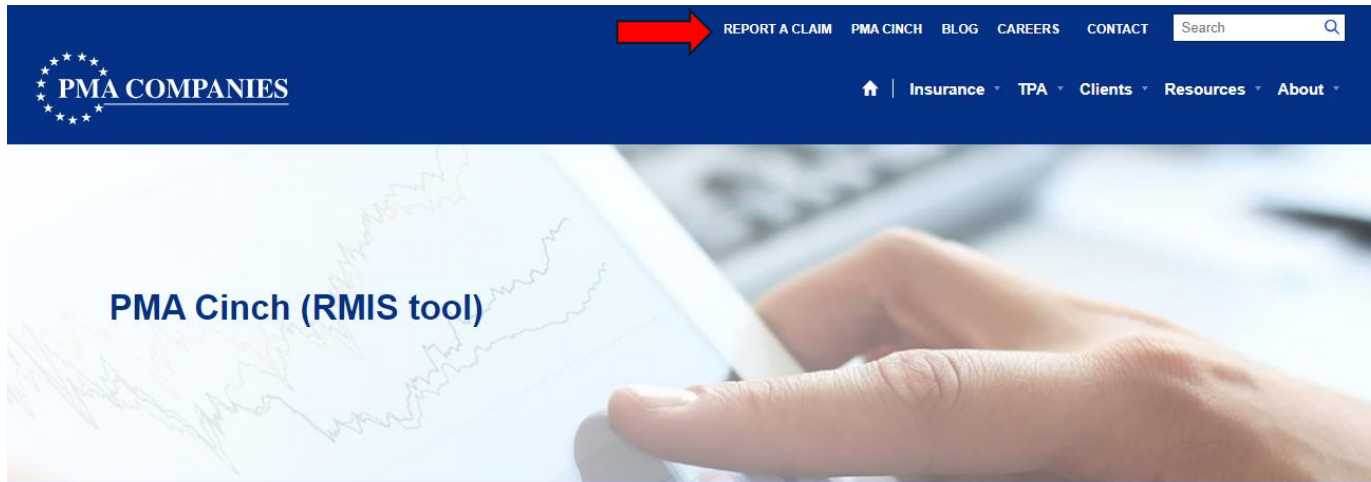


www.pmacompanies.com



PMA Cinch is powerful and easy to use

24/7 access to your claims data

PMA Cinch is a sophisticated Risk Management Information System (RMIS) that is easy and convenient to use. It offers Risk Management executives, CFOs, and other professionals a strategic approach to risk management with comprehensive claims and loss information, as well as data analytics at your fingertips.

The robust capabilities and flexibility of PMA Cinch allow clients to pinpoint the information that can significantly impact their bottom line. By analyzing trends and taking quicker corrective action, organizations can enhance their operating performance, lower costs, and improve their financial results.

Highlights of PMA Cinch

- Enjoy password-protected access to PMA Cinch from any computer with an Internet connection
- Email PMA claims professionals directly from PMA Cinch
- Set up automated email alerts if a significant change occurs to a claim

Clients

[Client Services Overview](#)

[Report a Claim](#)

PMA Cinch (RMIS)

[Find a Network Provider](#)

[Risk Control](#)

[Injured Workers](#)

[Customer Service Center](#)

Choose Report a claim online

REPORT A CLAIM PMA CINCH BROKERS CONTACT Search

Insurance TPA Clients Resources About

Clients » Report a Claim

Report a Claim

Report claims 24/7 online

Timely reporting helps speed claims response

Reporting claims promptly over the Internet enables PMA to react quickly and comprehensively to loss notices. Within 24 hours, we implement proactive management of claims and initiate substantive contact with the essential parties, which may include the injured worker, employer, medical providers and others.

Prompt communication among the parties helps eliminate confusion, allows for investigation of facts to make a compensability determination, sets expectations early for estimated length of the disability, and lays the foundation for prompt return to work. We encourage you to report claims immediately.

This application should only be accessed by authorized individuals.

[Report a claim online](#)

[Call our Customer Service Center @ 1-888-476-2669](#)

Clients

- Client Services Overview
- Report a Claim**
- PMA Cinch (RMS)
- Find a Network Provider
- Risk Control
- Injured Workers
- Customer Service Center

Sign in to access this site

Authorization required by <https://ilr.pmagroup.com>

Username

Password

Sign in

Cancel

**CONTACT THE INSURANCE COVERAGE OFFICE
FOR THIS INFORMATION**



PMA Loss Reporting


Select Line of Business:

Workers' Compensation

State:

- Select One
- Arkansas
 - California
 - Colorado
 - Connecticut
 - Delaware
 - District of Columbia
 - Florida

Screens in Accordion Format – Click Heading to Expand



PMA Loss Reporting

Workers' Compensation Submit Cancel

* Fields in Blue are required

Employee Information

* Location:

* First Name:

Middle Name:

* Last Name:

Suffix:

* Address:

Address2:

* City:

* State:

* Zip:

* Birth Date:

* SSN:

* Occupation/Job Title:

Other Information

Sex:

Home Phone:

Work Phone:

Mobile Phone:

Hire Date:

Email:

Marital Status:

Employment Status:

Number of Dependents:

Employee ID:


Occurrence Information

Contact Information

Customer Special Coding

Claim Submission

Workers' Compensation – Enter Injured Worker Data



PMA Loss Reporting

Workers' Compensation Submit Cancel

* Fields in Blue are required

Employee Information

* Location:	<input type="text"/>
* First Name:	<input type="text"/>
Middle Name:	<input type="text"/>
* Last Name:	<input type="text"/>
Suffix:	Select One <input type="text"/>
* Address:	<input type="text"/>
Address2:	<input type="text"/>
* City:	<input type="text"/>
* State:	Select One <input type="text"/>
* Zip:	<input type="text"/>
* Birth Date:	<input type="text"/>
* SSN:	<input type="text"/>
* Occupation/Job Title:	<input type="text"/>

Other Information

Sex:	**Select One** <input type="text"/>
Home Phone:	<input type="text"/>
Work Phone:	<input type="text"/>
Mobile Phone:	<input type="text"/>
Hire Date:	<input type="text"/>
Email:	<input type="text"/>
Marital Status:	Select One <input type="text"/>
Employment Status:	Select One <input type="text"/>
Number of Dependents:	Select One <input type="text"/>
Employee ID:	<input type="text"/>

Occurrence Information

Contact Information

Customer Special Coding

Claim Submission

Workers' Compensation – Enter Occurrence Information



PMA COMPANIES

PMA Loss Reporting

* Fields in Blue are required

Workers' Compensation

Submit Cancel

Employee Information

Occurrence Information

* Date of Injury/Illness: * State: Delaware

* Accident Cause:

* Injury Type:

* Body Part:

* Side Of Body:

* Accident Description:

Maximum 500 Characters. Characters remaining: 500

Injury Information

Time Employee 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 to Return to Work:	<input type="text"/>	Date Returned to Work:	<input type="text"/>
Full Pay For Date of Injury:	<input type="text"/>	Payment Frequency:	<input type="text"/>
Work Week Type	Standard <input type="text"/>	Hours Worked Per Day:	<input type="text"/>
Work Days Scheduled:	<input checked="" type="checkbox"/> Mon <input checked="" type="checkbox"/> Tues <input checked="" type="checkbox"/> Wed <input checked="" type="checkbox"/> Thurs <input checked="" type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun	Days Worked per Week:	<input type="text"/>
If Fatal, Date of Death:	<input type="text"/>	Date Disability Began:	<input type="text"/>
* Is the Injured Worker Losing Time?	<input type="text"/>	Date Modified Duty Began:	<input type="text"/>
* Is the Injured Worker On Modified Duty?	<input type="text"/>		

Workers' Compensation – Enter Occurrence Information

Loss Location Address

Where did Injury/Illness occur?

Make Loss Location as

* Address

* City:

* State: * Zip:

Primary Physical Work Location

Make Primary Physical Work Location the same as Loss Location

* Address

* City

* State Zip:

Physical Work Location Unknown

Was Employee Injured During Employment?

Did Injury or Illness Occur on Employer's Premises?

Were Safeguards or Safety Equipment Provided?

Does Employer Question the Claim?

Reason Employer Questions Claim:

Were Drugs or Alcohol Involved?

Were They Used?

Is Employee Represented By Attorney?

Workers' Compensation – Provider and Contact Names



PMA Loss Reporting

* Fields in Blue are required

Workers' Compensation

Submit Cancel

Employee Information [v]

Occurrence Information [v]

Contact Information [^]

Physician/Health Care Provider Name and Address

Name: Telephone: () -

Address:

City: State: Zip:

Hospital/Provider Information

Name: Telephone: () -

Address:

City: State: Zip:

Other Information

Date Prepared:

Preparer's Information

* First Name: * Last Name:

* Telephone:

Employer Contact Information (if different than preparer)

First Name: Last Name: Telephone: () -

Witness Contact Information

First Name: Middle Name: Last Name:

Telephone: () - Occupation:

Additional Witness Contact Information

First Name: Middle Name: Last Name:

Telephone: () - Occupation:

Customer Special Coding [v]

Claim Submission [v]



* Fields in Blue are required

Workers' Compensation

Submit

Cancel

Employee Information



Occurrence Information



Contact Information



Customer Special Coding




Next Office Visit

Date of next scheduled office visit with treating provider

Claim Submission



Enter Additional Comments



PMA Loss Reporting

* Fields in Blue are required

Workers' Compensation

- Employee Information
- Occurrence Information
- Contact Information
- Customer Special Coding
- Claim Submission

Comments (Enter miscellaneous claim details in the comments box below)

Your comments here.

Maximum 900 Characters. Characters remaining: 900

Record Only - no medical treatment and no lost time

Claim Information Email
Click on the check-box below to receive an email copy of the claim information just entered.


Send Email Copy
Email Address(es) - Multiple addresses can be entered separated by a comma.

Click the envelope icon to review and validate email addresses.

Your email address(es) here.

Maximum 800 Characters. Characters remaining: 800

Click "Submit"



PMA Loss Reporting

Workers' Compensation

* Fields in Blue are required

- Employee Information
- Occurrence Information
- Contact Information
- Customer Special Coding
- Claim Submission

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Send Email Copy

Email Address(es) - Multiple addresses can be entered separated by a comma.

Click the envelope icon to review and validate email addresses.

Maximum 800 Characters. Characters remaining: 800



Click the **Record Only** box only when the claim is for reporting purposes. This means an injured worker who will **not** be seeking medical treatment.

Type any additional information about the claim into the Comments box.

Click the **Send Email Copy** and **type** your email address to receive a copy of the completed form after you submit the claim. Add additional recipients to the list by typing a comma and then adding the next email address.

Click **Submit** when you are finished. You will receive a claim number immediately. Record this claim number for your records.

Errors and Missing Fields in Red



PMA Loss Reporting

* Fields in Blue are required

Workers' Compensation

Submit Cancel

Employee Information

* Location:	<input type="text"/>	Required Field
* First Name:	<input type="text"/>	Required Field
Middle Name:	<input type="text"/>	
* Last Name:	<input type="text"/>	Required Field
Suffix:	Select One	
* Address:	<input type="text"/>	Required Field
* City:	<input type="text"/>	Required Field
* State:	Select One	Required Field
* Zip:	<input type="text"/>	Invalid Format
* Birth Date:	<input type="text"/>	Required Field
* SSN:	<input type="text"/>	Invalid Format
* Occupation/Job Title:	<input type="text"/>	Required Field

Other Information


Sex:	**Select One**
Telephone:	() - -
Hire Date:	
Marital Status:	Select One
Employment Status:	Select One
Number of Dependents:	Select One

Occurrence Information

Contact Information

Claim Submission

Receive A Claim Number



PMA Loss Reporting

Workers' Compensation Submit Cancel

* Fields in Blue are required
The claim information you entered has been recorded and saved.

- Employee Information
- Occurrence Information
- Contact Information
- Claim Submission
- Claim Number

Claim Number : **W002033877**

Add Attachments

Allowed file extensions: .bmp,.gif,.jpg,.tif,.tiff,.html,.txt,.doc,.xml,.rtf,.docx,.pdf,.xls,.xlsx,.ppt,.mpg,.alff,.wav,.mov,.asf,.avi

Select multiple files... Browse...

Attached Files

File Name

Attach File(s) New Claim

Attach Files – Browse Folders and Files

Claim Number

Claim Number : **W002033877**

Add Attachments

Allowed file extensions: .bmp,.gif,.jpg,.tif,.tiff,.html,.txt,.doc,.xml,.rtf,.docx,.pdf,.xls,.xlsx,.ppt,.mpg,.aiff,.wav,.mov,.asf,.avi

Select multiple files... **Browse...**

Attached Files

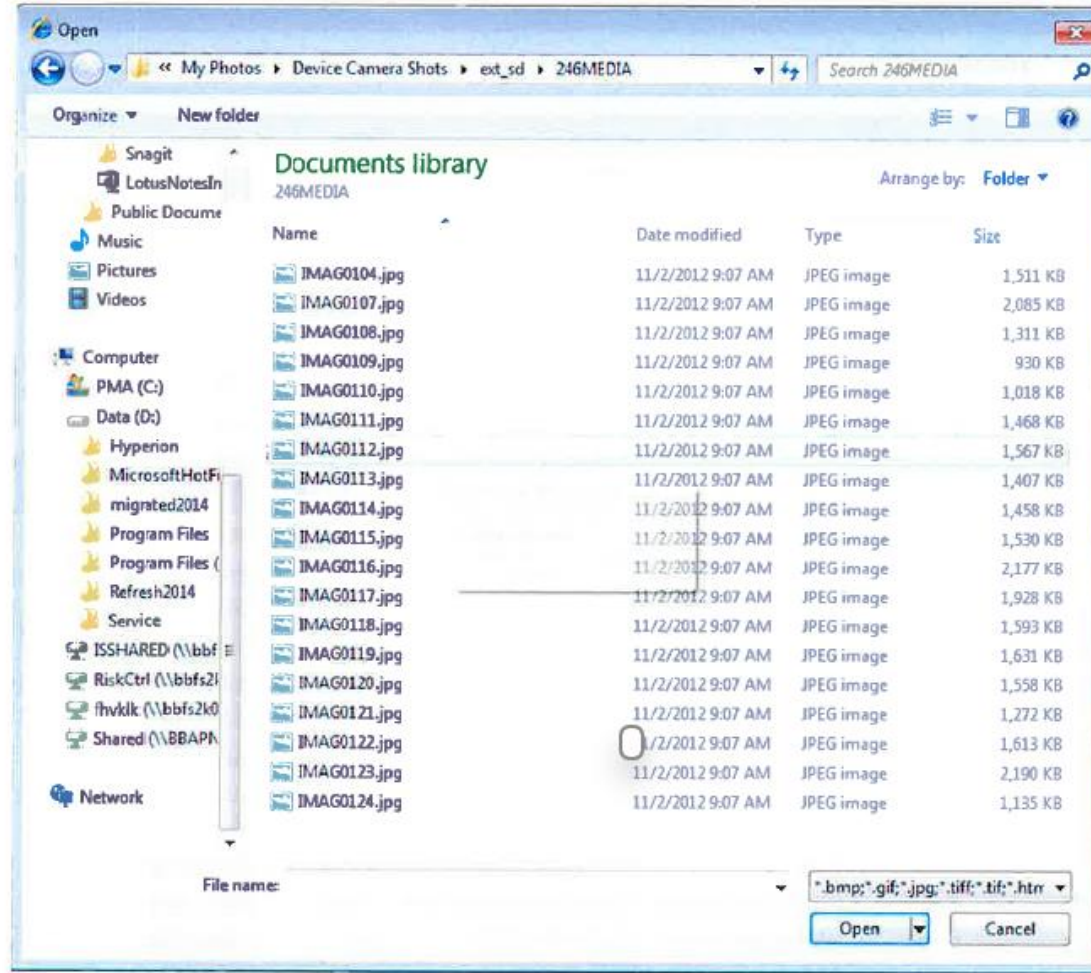
Attach File(s) **New Claim**

Supported Types of Attachments, in file sizes up to 50 megabytes each:

Document Type	Extension	File Type	Document Type	Extension	File Type
BITMAP	.bmp	Image	RTF	.rtf	Text
GIF	.gif	Image	MSEXCEL	.xls	Excel Document
JPEG	.jpg	Image	MSEXCEL	.xlsx	Excel Document
TIF	.tif	Image	POWERPOINT	.ppt	Powerpoint Document
TIFF	.tiff	Image	MPEGAUDIO	.mpg	Audio File
HTML	.html	Browser File	AIFFAUDIO	.aiff	Audio File
TEXT	.txt	Text	WAVAUDIO	.wav	Audio File
XML	.xml	Browser File	MPEGVIDEO	.mpg	Video File
DCARFT	.rtf	Text	QUICKTIME	.mov	Video File
MSWORD	.doc	Word Document	VIDEOCHARGER	.mpg	Video File
MSWORD	.docx	Word Document	ASFVIDEO	.asf	Video File
PDF	.pdf	PDF	AVIVIDEO	.avi	Video File



Select Files from Your Folders



Attach Files

Claim Number

Claim Number : **W002033877**

Add Attachments

Allowed file extensions: .bmp,.gif,.jpg,.tiff,.tif,.html,.txt,.doc,.xml,.rtf,.docx,.pdf,.xls,.xlsx,.ppt,.mpg,.aiff,.wav,.mov,.asf,.avi

Select multiple files... [Browse...](#)

D5CN4067.JPG [Remove](#)

Emergency Response Plan.pdf [Remove](#)

[Attach File\(s\)](#) [New Claim](#)

Attached Files

Confirm File Attachments

Add Attachments

Files have been uploaded **successfully**.

Allowed file extensions: .bmp,.gif,.jpg,.tiff,.tif,.html,.txt,.doc,.xml,.rtf,.docx,.pdf,.xls,.xlsx,.ppt,.mpg,.aiff,.wav,.mov,.asf,.avi

Select multiple files...

Browse...

Attached Files

DSCN4067.JPG	4722 KB
Emergency Response Plan.pdf	446 KB

Attach File(s)

New Claim