



PMA's Enhanced Online Report a Claim Solution

Claim Reporting Guide

October 2025
Version 1.03



OLD REPUBLIC INSURANCE GROUP

Welcome to RADIUS^R

PMA's Enhanced Online Report a Claim Solution featuring

- New look and feel to PMA's online claim reporting functionality
- User self-registration
- Multi-factor authentication for greater client data security
- Ability to save draft claims to complete during a later session

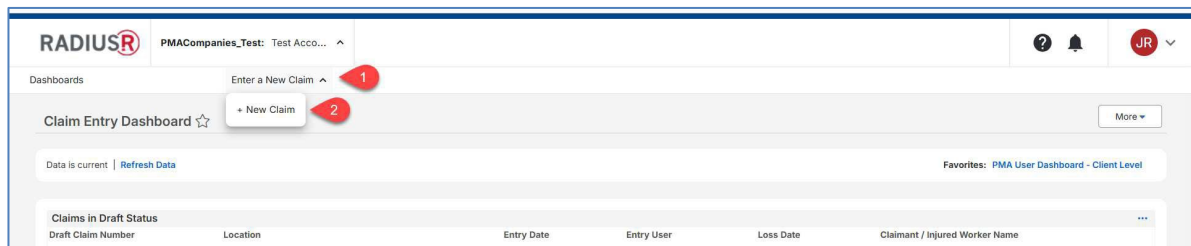
Claim Reporting Guide

Go to <https://www.pmacompanies.com/support/report-a-claim> and click on the gold **"Report a claim online"** button at the bottom of the page.

Report a claim online

Please review the Self Registration and Multi-factor Authentication Guide for log in assistance.

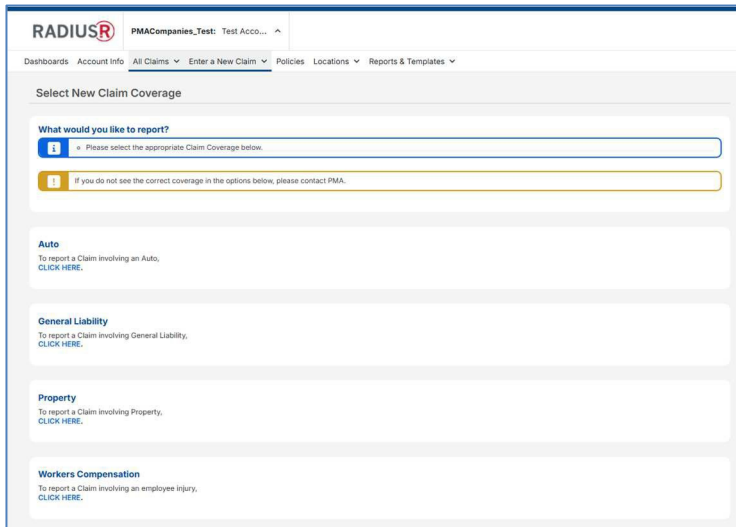
You know you have logged in successfully, when you see the Radius^R Claim Reporting Dashboard. Please note, if you have access to file claims for more than one account, you will be asked to select an account before the Radius^R Claim Reporting Dashboard is displayed.



Click **Enter New Claim** in the upper right corner 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.

Claims in Draft Status						...
Draft Claim Number	Location	Entry Date	Entry User	Loss Date	Claimant / Injured Worker Name	
733	1788222 - Test Location Name	10/08/2025	John RadiusR	10/06/2025	Undefined	

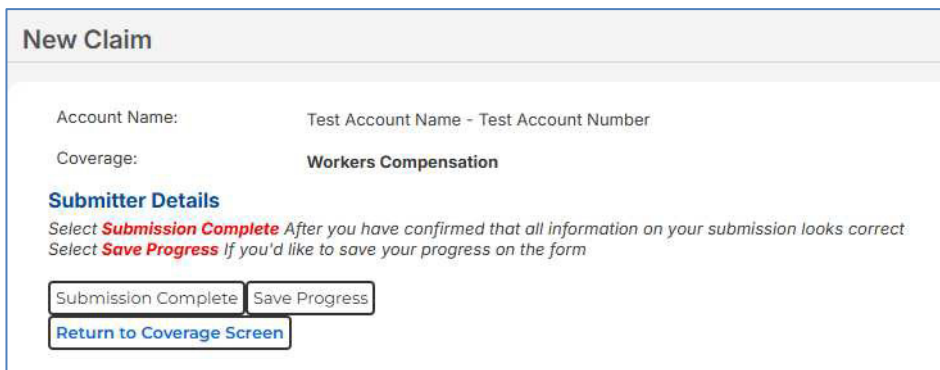
You will see the New Claim Coverage screen. Select the coverage desired. Please note, your coverage selections will be limited to the coverage available for the selected account number.



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 (*).



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 of time, 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: - None Selected - 


Address: *
Address 2:
City: *
State: * 
ZIP: *
Birth Date: * 
SSN: *
Occupation/Job Title: *
Location of Loss: * 

Sex: - None Selected - 
Home Phone:
Work Phone:
Mobile Phone:
Hire Date: 
Claimant Email:
Marital Status: - None Selected - 
Injured Worker Employment Status Code: - None Selected - 
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 on at the end of this guide.


Marital Status: - None Selected - 

Injured Worker Employment Status Code: - None Selected - 


Number Of Dependents:

Employee Number:

Common law spouse
Divorced
Married
Separated
Single
Spouse deceased
Unknown

State: * con 

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"/>
Date Employer Notified: *	<input type="text"/> 
Date Expected Return to Work:	<input type="text"/> 
Full Pay for Date of Injury:	- None Selected - ▼
Work Week Type: *	Standard ▼
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 - ▼
Time of Occurrence:	<input type="text"/>
Last Date Worked:	<input type="text"/> 
Date Returned to Work:	<input type="text"/> 
Payment Frequency:	- None Selected - ▼
Hours Worked per Day:	- 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?	<div></div> <div>Maximum 255 Characters.</div>
Make Loss Location same as Claim Reporting Location:	<input type="checkbox"/>
Claim Reporting Location Name:	<div></div>
Address: *	<div></div>
City: *	<div></div>
ZIP: *	<div></div>

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

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.

Witness Contact Information			
First Name:	<input type="text"/>	Telephone:	<input type="text"/>
Middle Name:	<input type="text"/>	Occupation:	<input type="text"/>
Last Name:	<input type="text"/>		
Additional Witness Contact Information			
First Name:	<input type="text"/>	Telephone:	<input type="text"/>
Middle Name:	<input type="text"/>	Occupation:	<input type="text"/>
Last Name:	<input type="text"/>		

Claim Submission

Claim Submission
Comments (Intake)

Maximum 900 Characters.

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:

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 PMA claim number, click the **Click Here to obtain the PMA 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 PMA Claim Number will be assigned and will be included in the email notification.

Claims >
Test Account Name 1 - 730 - 7/28/2025 ☆

☒ Save Successful.

[Click Here to obtain the PMA Claim Number](#)

Please attach files and other documents in the files gridpanel below.

Uploading Documents

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

Claims >
Test Account Name 1 - L005002583 - 7/28/2025 ☆

Please attach files and other documents in the files gridpanel below.

File Upload

File Name	Date

Upload File

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

Upload New File

File: * [Choose File] No file chosen

Attached To: Default (L005002583)

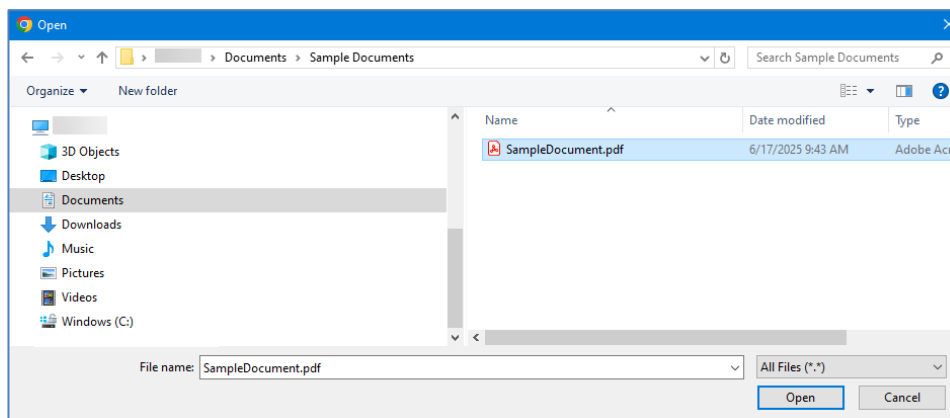
Allowed file extensions: .bmp, .gif, .jpg, .tif, .tiff, .html, .txt, .xml, .rtf, .doc, .docx, .pdf, .xls, .xlsx, .ppt, .mpg, .aiff, .wav, .mov, .mpeg, .asf, .avi

Maximum file size allowed: 100 MB

Upload Multiple Files Save Cancel

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 PMA at claimsmail@pmagroup.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.

Upload New File

Upload Multiple Files Save Cancel

File: Choose File SampleDocument.pdf

*Click or drop file above to add.

Attached To: Default (L005002583)

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

Maximum file size allowed: 100 MB

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.

Upload Multiple Files

Start Upload Cancel

File Upload Destination: Default (L005002583)

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

Click or Drag & Drop Files

Files to Upload

File: Folder

Upload Multiple Files

Start Upload Cancel

File Upload Destination: Default (L005002583)

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

Click or Drag & Drop Files

Files to Upload

File: Document2.pdf (1 KB) Remove File

File: SampleDocument.pdf (1 KB) Remove File

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

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


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

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"/> 
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:	<div><input type="text"/> Maximum 300 Characters.</div>	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"/>
Model:	<input type="text"/>
Year:	<input type="text"/> <input type="button" value="Q"/>
VIN:	<input type="text"/>
Body Type:	<input type="text" value="- None Selected -"/>
Plate No.	<input type="text"/>
Vehicle No.	<input type="text"/>
State:	<input type="text" value="- None Selected -"/>
Other Driver Information	
Check if Driver is Owner:	<input type="checkbox"/>
First Name:	<input type="text"/>
Last Name:	<input type="text"/>
Residence Phone:	<input type="text"/>
Business Phone:	<input type="text"/>
Check if Driver is Injured:	<input type="checkbox"/>
Description of Injury:	<div><div></div><div>Maximum 300 Characters.</div></div>
Address:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/> <input type="button" value="Q"/>
Zip:	<input type="text"/>
Check if Fatal:	<input type="checkbox"/>


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:	<div><div></div><div>Maximum 300 Characters.</div></div>
Estimate Amount:	<input type="text"/>
Where can damage be seen:	<input type="text"/>
When can damage be seen:	<input type="text"/>


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"/> 
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"/> 
		ZIP:	<input type="text"/>
> Witness 2			

Reporting Party Information

Complete reporting party information, if available.

Reporting Party Information	
Reported by First Name:	<input type="text"/>
Reported by Last Name:	<input type="text"/>
Remarks:	<input type="text"/>
	Maximum 500 Characters.
Reported To:	<input type="text"/>

Claim Submission

Claim Submission	
Comments (Intake)	<div>Enter miscellaneous claim details in the comments box</div> <div>Maximum 900 Characters.</div>
Record Only:	<input type="checkbox"/>

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:	<div>Multiple addresses can be entered separated by a comma</div>
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 PMA claim number and have the opportunity to 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			
<input type="button" value="Submission Complete"/> <input type="button" value="Save Progress"/> <input type="button" value="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"/>		Maximum 500 Characters.
Contact Business Phone: *	<input type="text"/>		
Location of Loss: *	<input type="text"/>	Description of Damage:	<input type="text"/>
Address:	<input type="text"/>		Maximum 500 Characters.
City:	<input type="text"/>		
State of Loss: *	<input type="text"/>		
Zip:	<input type="text"/>		

Claim Submission

Claim Submission	
Comments (Intake)	<input type="text"/>
	Enter miscellaneous claim details in the comments box
	Maximum 900 Characters.
Record Only:	<input type="checkbox"/>

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:	<div>Multiple addresses can be entered separated by a comma</div>
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 PMA claim number and have the opportunity to 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: *	<input type="text"/>	Contact Business Phone: *	<input type="text"/>
Time of Occurrence:	<input type="text"/>	Authority Contacted:	<input type="text"/>
Contact First Name: *	<input type="text"/>	Describe Loss: *	<div></div> <div>Maximum 500 Characters.</div>
Contact Last Name: *	<input type="text"/>		
Location of Loss: *	<input type="text"/>		
Address:	<input type="text"/>		
City:	<input type="text"/>		
Zip:	<input type="text"/>		
State of Loss: *	<input type="text"/>		

Claimant Information

Claimant Information

First Name:	<input type="text"/>	Address:	<input type="text"/>
Last Name:	<input type="text"/>	City:	<input type="text"/>
Organization:	<input type="text"/>	State:	<input type="text"/>
Birth Date:	<input type="text"/>	Zip:	<input type="text"/>
Social Security:	<input type="text"/>		
Phone:	<input type="text"/>		

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)	<input checked="" type="radio"/> Property Damage	<input type="radio"/> Vehicle Damage
Describe Property		
Describe Property:	<input type="text"/>	

Vehicle Damage Information

To report property damage, select Property Damage

Indicate Damage to Vehicle or Property (SELECT ONE)	<input type="radio"/> Property Damage	<input checked="" type="radio"/> Vehicle Damage
Describe Vehicle		
Make:	<input type="text"/>	
Model:	<input type="text"/>	
Year:	<input type="text" value="- None Selected -"/>	
VIN:	<input type="text"/>	

Property/Vehicle Damage Information

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

Property/Vehicle Damage Information	
Estimate Amount:	<input type="text"/>
Where can property be seen:	<input type="text"/>
When can property be seen:	<input type="text"/>

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:	<input type="text"/>
Reported by Last Name:	<input type="text"/>
Remarks:	<div><div></div><div>Maximum 500 Characters.</div></div>
Reported To:	<input type="text"/>

Claim Submission

Claim Submission	
Comments (Intake)	<div><div>Enter miscellaneous claim details in the comments box</div><div>Maximum 900 Characters.</div></div>
Record Only:	<input type="checkbox"/>

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:	<div>Multiple addresses can be entered separated by a comma</div>
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.

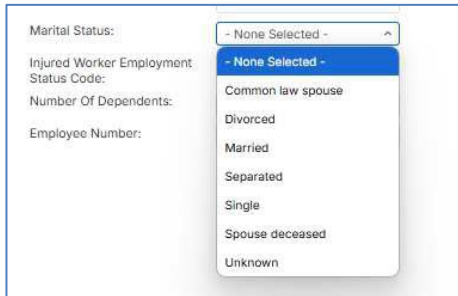
When you are finished, click **Submission Complete** at the top or bottom of the page. You will then receive the PMA claim number and have the opportunity to upload documents.

Helpful Hints

Claim Reporting

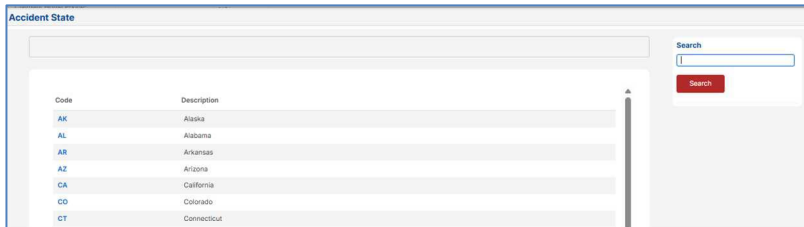
Fields with an arrow or a magnifying glass icon contain a list of predefined values.

For fields with an arrow, click the arrow to display a list of options.



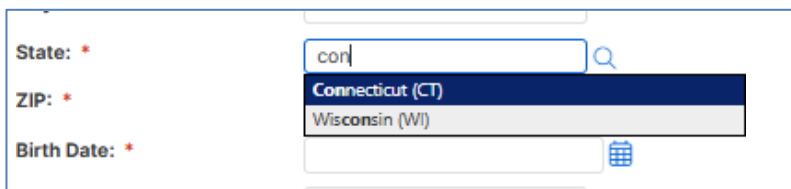
A screenshot of a web form with several fields: 'Marital Status:', 'Injured Worker Employment Status Code:', 'Number Of Dependents:', and 'Employee Number:'. The 'Marital Status:' field has a dropdown arrow icon. The dropdown menu is open, showing a list of options: '- None Selected -', 'Common law spouse', 'Divorced', 'Married', 'Separated', 'Single', 'Spouse deceased', and 'Unknown'. The first option is highlighted in blue.

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.



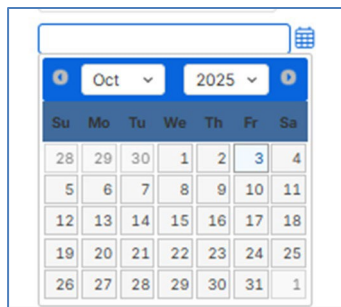
A screenshot of a web form titled 'Accident State'. It features a search bar with a magnifying glass icon and a 'Search' button. Below the search bar is a table with two columns: 'Code' and 'Description'. The table lists states: AL (Alabama), AR (Arkansas), AZ (Arizona), CA (California), CO (Colorado), and CT (Connecticut). The 'CT' row is highlighted in blue.

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



A screenshot of a web form with fields for 'State: *', 'ZIP: *', and 'Birth Date: *'. The 'State: *' field has a magnifying glass icon. A dropdown menu is open, showing a list of states: 'Connecticut (CT)' and 'Wisconsin (WI)'. The 'Connecticut (CT)' option is highlighted in blue.

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.



A screenshot of a date picker calendar. It shows a grid of days for the month of October 2025. The days are arranged in a 5x7 grid. The date '3' is highlighted in blue. The calendar is titled 'Oct' and '2025'.

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 you can click Go to Account Level to see a list of options.

