Claims Management of Missouri, LLC

# EMPLOYEE INCIDENT
## Supplemental – COVID-19

| NAME | DATE OF INCIDENT | DATE OF REPORT |
|---|---|---|
| ADDRESS | JOB PERFORMED | |
| CITY/STATE/ZIP | EMPLOYER *(IF NOT AN EMPLOYEE)* | |
| PHONE NUMBER | PERSON INJURY REPORTED TO | |
| TIME OF INCIDENT ☐ A.M. ☐ P.M. | SOCIAL SECURITY NUMBER **AND** DATE OF BIRTH | |

| |
|---|
| |
| LIST OF FAMILY MEMBERS AT HOME: |
| SPOUSE EMPLOYMENT: |
| FAMILY MEMBERS EMPLOYMENT: |
| HAVE ANY FAMILY MEMBERS OR CLOSE FRIENDS DISPLAYED SYMPTOMS OR TESTED POSITIVE? |
| EMPLOYEE OR FAMILY MEMBERS TRAVELED ABROAD RECENTLY? IF YES, WHEN / WHERE? |
| EMPLOYEE OR FAMILY MEMBERS ATTENDED ANY EVENTS IN THE PAST 14 DAYS WHERE 10 OR MORE PEOPLE GATHERED? |
| EMPLOYEE OR FAMILY MEMBERS BEEN SHOPPING OR DINING OUT OF THE HOME (GROCERY, WALMART, TARGET, WALGREENS, RESTAURANTS)? |
| ANY FAMILY MEMBERS OR CLOSE FRIENDS EMPLOYED AS FIRST RESPONDERS? |
| ANY FAMILY MEMBERS OR FRIENDS HEALTH CARE WORKERS? |
| CAN A SPECIFIC SOURCE OR EVENT DURING THE PERFORMANCE OF EMPLOYMENT BE IDENTIFIED THAT RESULTED IN EXPOSURE TO COVID-19? |
| CAN A SPECIFIC CO-WORKER(S) BE IDENTIFIED THAT HAS TESTED POSITIVE FOR COVID-19?<br>NAMES: |
| PRINT NAME OF PERSON COMPLETING THIS REPORT |

| SIGNATURE OF PERSON COMPLETING THIS REPORT | CURRENT DATE |
|---|---|
| | |

**Fax or mail or e-mail completed form to:**

**MMMA-Claims Management of Missouri, LLC**
**15450 South Outer 40 Road, Ste. 200**
**Chesterfield, MO 63017-4817**

**Fax: (636) 537-1362**
**E-mail: adjusters@mmm-a.com**