

# FIRST NOTICE OF LOSS

Insured / Employer: \_\_\_\_\_ Your File No.: \_\_\_\_\_  
(If insured / employer is the member of an association, provide full name of association.)

Reason for Report:  Catastrophic (Call 1-877-975-2667)  52 Weeks Disability  50% of SIR  Other (multiple employees), etc. \_\_\_\_\_

Employer Address: \_\_\_\_\_

MECC Policy Number: \_\_\_\_\_ Jurisdiction of claim: \_\_\_\_\_

Claimant Name: \_\_\_\_\_ SSN: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Spouse D.O.B. : \_\_\_\_\_

Date of Injury: \_\_\_\_\_ A.W.W.: \_\_\_\_\_ Job Title: \_\_\_\_\_

Accident Description: \_\_\_\_\_  
\_\_\_\_\_

Nature / Extent of Injury: \_\_\_\_\_  
\_\_\_\_\_

Current Claim Status: \_\_\_\_\_

Claimant applied for Social Security Disability? Y or N (circle one) Accepted? Y or N (circle one)

SIR: \_\_\_\_\_ T.T.D. Rate: \_\_\_\_\_ P.P.D. Rate: \_\_\_\_\_

	Paid to Date	+	Outstanding Reserves	=	Incurred
Indemnity	_____		_____		_____
Medical	_____		_____		_____
Misc. (Burial, Rehab)	_____		_____		_____
Allocated (Atty. Fees)	_____		_____		_____
Total	_____		_____		_____

On what are reserves based? \_\_\_\_\_

Claim Handler: \_\_\_\_\_ Date: \_\_\_\_\_

Email Address: \_\_\_\_\_

Service Company: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Please attach copies of the most recent narrative medical report, nurse case manager report and any legal summary reports. Unless specifically requested, it is not necessary to forward a complete copy of your file. Washington Fraud Warning: "It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."



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