risico claims management

Employee ID No.:

COVID-19 REPORTING FORM

Pursuant to Labor Code § 3212.88(i), (k)(2)

REPORTING DEADLINES

Test Dates Between 07/06/20 to 09/16/20	If an employee has tested positive for COVID-19, or there is a reasonable indication of a positive test, you are required to report the following information in writing to the Claims Administrator *within 30* days after 09/17/20.
Test Dates Between 09/17/20 and After	If an employee has tested positive for COVID-19, or there is a reasonable indication of a positive test, you are required to report the following information in writing to the Claims Administrator *within 3* business days.

ADDITIONAL CONSIDERATIONS

This form must be completed regardless of the illness' work-relatedness or the employee filing a workers' compensation claim. If multiple employees have tested positive for COVID-19, a separate form must be completed for each employee. If the employee contends that the illness is work-related you must report a workers' compensation claim using Form 5020 and DWC1 *in addition* to completing this form.

Please email the completed form to covidreporting@risico.com, or fax (559) 277-4961.

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1. Insured Name:

   Insured Address:

   Policy Number:

2. Employee ID Number:
   This is your internal Employee ID Number. **Do not provide the employee's personal identification information such as name or SSN, which is protected by HIPPA.**

3. Employee's Positive COVID-19 Test Date (MM/DD/YYYY):
   The test date is the date the specimen was collected.

4. Provide the information respective to each place of employment where the employee worked during the 14-day period prior to the date of the employee's positive test in the location fields on the next page. Information includes actual address of the building, facility, plant, ranch, agricultural field, etc. where the employee worked under the employer's direction. This may be a different location than the insured's address in question #1.
   If space for additional locations is needed, copy page 4 as needed and complete.

BE SURE TO COMPLETE PAGE 5, AFTER THE LOCATION FIELDS.

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Employee ID No.:

Location No. 1

Location Name:

Location Address:

City/State/Zip:

Last Day Worked at Location (MM/DD/YYYY):

Location Total Employee Count:

Has this location been ordered to close due to risk of COVID-19 infection? No

If yes, please explain:

Answer only if test date is 07/06/20 to 09/16/20:

What is the highest number of employees reporting to work at this location during 07/06/20 through 09/17/20?

Answer only if test date is 09/17/20 after:

What is the highest number of employees reporting to work during the 45 days prior to the employee's last day worked at this location?

Location No. 2

Location Name:

Location Address:

City/State/Zip:

Last Day Worked at Location (MM/DD/YYYY):

Location Total Employee Count:

Has this location been ordered to close due to risk of COVID-19 infection? No

If yes, please explain:

Answer only if test date is 07/06/20 to 09/16/20:

What is the highest number of employees reporting to work at this location during 07/06/20 through 09/17/20?

Answer only if test date is 09/17/20 after:

What is the highest number of employees reporting to work during the 45 days prior to the employee's last day worked at this location?

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Employee ID No.:

Location No. 3

Location Name:

Location Address:

City/State/Zip:

Last Day Worked at Location (MM/DD/YYYY):

Location Total Employee Count:

Has this location been ordered to close due to risk of COVID-19 infection? No

If yes, please explain:

Answer only if test date is 07/06/20 to 09/16/20:

What is the highest number of employees reporting to work at this location during 07/06/20 through 09/17/20?

Answer only if test date is 09/17/20 after:

What is the highest number of employees reporting to work during the 45 days prior to the employee's last day worked at this location?

Location No. 4

Location Name:

Location Address:

City/State/Zip:

Last Day Worked at Location (MM/DD/YYYY):

Location Total Employee Count:

Has this location been ordered to close due to risk of COVID-19 infection? No

If yes, please explain:

Answer only if test date is 07/06/20 to 09/16/20:

What is the highest number of employees reporting to work at this location during 07/06/20 through 09/17/20?

Answer only if test date is 09/17/20 after:

What is the highest number of employees reporting to work during the 45 days prior to the employee's last day worked at this location?

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Employee ID No.:

Location No.

Location Name:

Location Address:

City/State/Zip:

Last Day Worked at Location (MM/DD/YYYY):

Location Total Employee Count:

Has this location been ordered to close due to risk of COVID-19 infection? No

If yes, please explain:

Answer only if test date is 07/06/20 to 09/16/20:

What is the highest number of employees reporting to work at this location during 07/06/20 through 09/17/20?

Answer only if test date is 09/17/20 after:

What is the highest number of employees reporting to work during the 45 days prior to the employee's last day worked at this location?

Location No.

Location Name:

Location Address:

City/State/Zip:

Last Day Worked at Location (MM/DD/YYYY):

Location Total Employee Count:

Has this location been ordered to close due to risk of COVID-19 infection? No

If yes, please explain:

Answer only if test date is 07/06/20 to 09/16/20:

What is the highest number of employees reporting to work at this location during 07/06/20 through 09/17/20?

Answer only if test date is 09/17/20 after:

What is the highest number of employees reporting to work during the 45 days prior to the employee's last day worked at this location?

Employee ID No.:

5. Has the employee filed a workers' compensation claim for COVID-19?
   ☐ Yes ☐ No

   If yes, please indicate:

   Employee Name:

   Claim Number:

INSURED REPRESENTATIVE

I hereby certify that I am an authorized representative of the insured name above and the information provided is accurate and complete to the best of my knowledge.

Print Full Name:

Date (MM/DD/YYYY):

Contact Email:

Direct Phone Number:

Signature: _____