# Large Loss Detail

## Loss #1

**Employee First Name**:________________________________ **Employee Last Name**:________________________________

**Claim Status**: Open ☐ Closed ☐ Carrier:________________________________________________________________

**Policy Start Date**:____________________________________ **Policy End Date**: ____________________________________

**Claim Number**:______________________________________ **Date of Injury**: _____________________________________

**Description of Accident**:________________________________________________________________________________

____________________________________________________________________________________________________

**Description of Injury**:___________________________________________________________________________________

____________________________________________________________________________________________________

**Litigation**: Yes☐ No ☐ **Medical Paid $**: _________________________ **Medical Reserved $**: ________________________

**Release Status**: Light Duty☐ Full Duty☐ Vocational Rehabilitation☐ **Indemnity Paid $**:___________________________

**Indemnity Reserved $**:____________________________ **Continuing Treatment**: Yes ☐ No☐

**Type of Treatment**:______________________________________________________________________________________

**Disability**: Totally Temporarily disabled☐ Permanent Disability☐ Permanent Partial Disability ☐

Qualified Injured Worker ☐ Permanent and Stationary ☐

**Is claimant back to work for employer?** Yes ☐ No☐ **Why or why not**:___________________________

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## Loss #2

**Employee First Name**:________________________________ **Employee Last Name**:________________________________

**Claim Status**: Open ☐ Closed ☐ Carrier:________________________________________________________________

**Policy Start Date**:____________________________________ **Policy End Date**: ____________________________________

**Claim Number**:______________________________________ **Date of Injury**: _____________________________________

**Description of Accident**:________________________________________________________________________________

____________________________________________________________________________________________________

**Description of Injury**:___________________________________________________________________________________

____________________________________________________________________________________________________

**Litigation**: Yes☐ No ☐ **Medical Paid $**: _________________________ **Medical Reserved $**: ________________________

**Release Status**: Light Duty☐ Full Duty☐ Vocational Rehabilitation☐ **Indemnity Paid $**:___________________________

**Indemnity Reserved $**:____________________________ **Continuing Treatment**: Yes ☐ No☐

**Type of Treatment**:______________________________________________________________________________________

**Disability**: Totally Temporarily disabled☐ Permanent Disability☐ Permanent Partial Disability ☐

Qualified Injured Worker ☐ Permanent and Stationary ☐

**Is claimant back to work for employer?** Yes ☐ No☐ **Why or why not**:___________________________