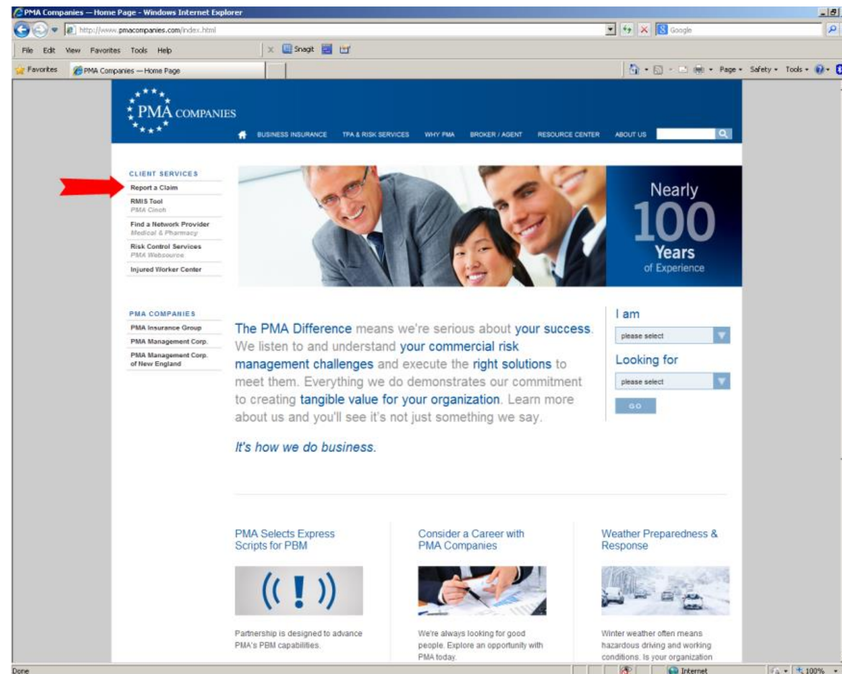
Filing Claims on the Internet

LOGON INSTRUCTIONS

User Name:

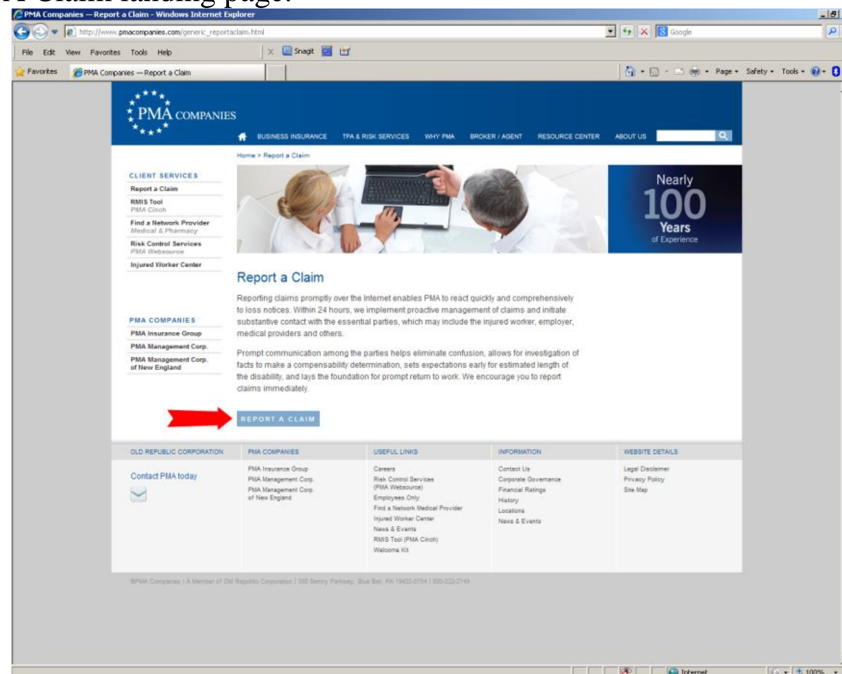
Password: newclaim

Open an Internet browser session. On the URL address line, type **www.pmacompanies.com** You will see PMA's Home Page.



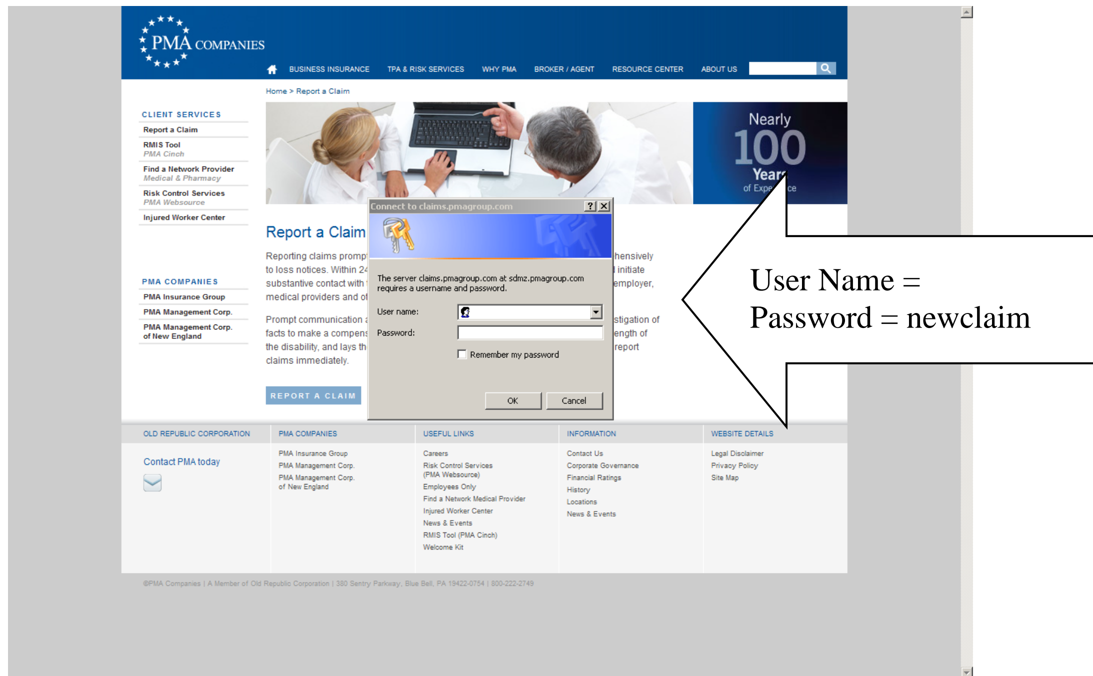
Click “Report a Claim.”

See the Report A Claim landing page.



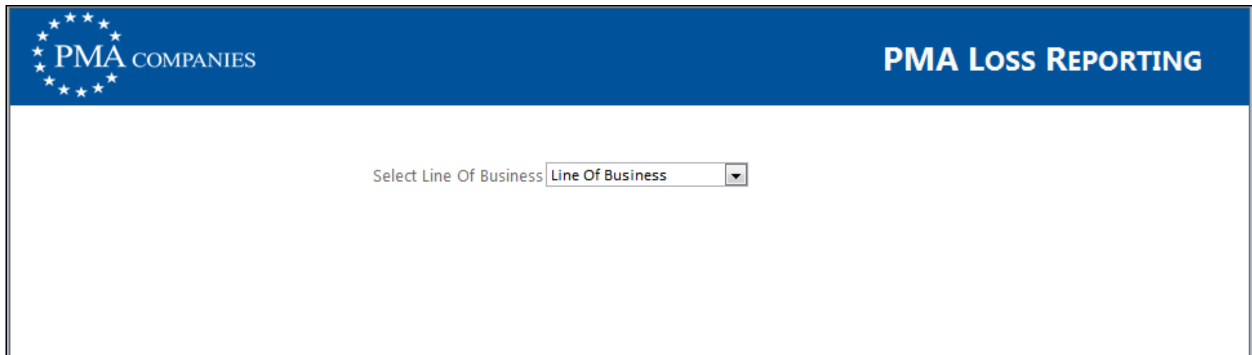
Click REPORT A CLAIM.

You will see a login screen. Type your User Name and your Password in the spaces provided. Click OK.

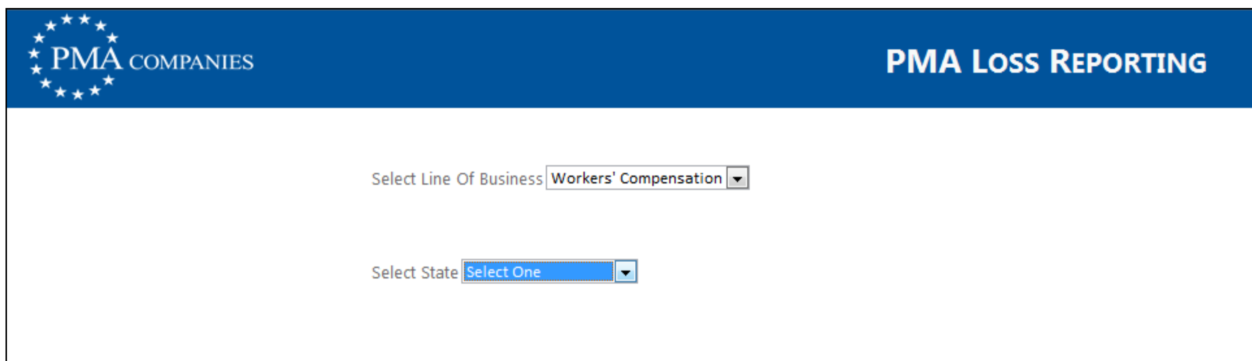


After a few seconds, you will see the New Claim Entry main screen.

From the drop-down, choose the type of claim you want to report (Workers' Compensation, Automobile, Liability, Property). If you only have one type with PMA, you will not see this screen.



For Worker's Compensation only, choose your accident state and click **Go**.



Complete each of the screens. Click the blue headings to move between the various screens. Note required fields are blue. For all dates, use the format mm/dd/yyyy, like 06/20/2013 for June 20, 2013. For telephone numbers and social security number, do not type the dashes.

PMA COMPANIES

PMA LOSS REPORTING

WORKERS' COMPENSATION

Employee Information

* Fields in Blue are required

Location [Select One]

Employee First Name

Employee Last Name

Address

City

State [Select One]

Zip

Telephone

SSN

Sex [Select One]

Dates must be in mm/dd/yyyy format

Birth Date [mm/dd/yyyy]

Hire Date [mm/dd/yyyy]

Marital Status [Select One]

Number of Dependants [Select One]

Employment Status [Select One]

Occupation/Job Title

Occurrence Information

Contact Information

Customer Special Coding

Claim Submission

If you missed entering any required fields, you will see a screen reminding you (in red) about missing information. Open each red section, complete the missing information, and return to the Claim Submission section.

PMA COMPANIES

PMA LOSS REPORTING

WORKERS' COMPENSATION

Employee Information

* Fields in Blue are required

Location [Select One] Location of Loss is required

Employee First Name — Employee First Name is required

Employee Last Name — Employee Last Name is required

Address — Employee Address is required

City — Employee City is required

State [Select One] Employee State is required

Zip — Employee Zip is required

Telephone

SSN — SSN is required

Sex [Select One]

Dates must be in mm/dd/yyyy format

Birth Date [mm/dd/yyyy] Birth Date in (mm/dd/yyyy) is required

Hire Date [mm/dd/yyyy]

Marital Status [Select One]

Number of Dependants [Select One]

Employment Status [Select One]

Occupation/Job Title — Employee Occupation is required

Occurrence Information

Contact Information

Customer Special Coding

Claim Submission

Sample Workers' Compensation screens continue below.

Occurrence Information

* Fields in Blue are required

Date of Injury/Illness mm/dd/yyyy
Accident State Alabama
Accident Cause Select One
Injury Nature Select One
Body Part Select One
Side of Body Select One
Accident Description
Maximum 500 Characters.
Time Employee Began Work Hour Minute AM PM
Time of Occurrence Hour Minute AM PM
Date Employer Notified mm/dd/yyyy
Last Date Worked mm/dd/yyyy
Date Expected to Return to Work: mm/dd/yyyy
Date Returned to Work: mm/dd/yyyy
Full Pay For Date of Injury?
Hours Worked Per Day Select One
Days Worked Per Week Select One
Payment Frequency Select One
If Fatal, Date of Death: mm/dd/yyyy
Is the Injured Worker Losing Time?
Date Disability Began: mm/dd/yyyy
Is the Injured Worker On Modified Duty?
Date Modified Duty Began: mm/dd/yyyy
Where did Injury/Illness occur?
Injury/Illness Occurrence Address
City
State Select One
Zip
Did Injury or Illness occur on Employer's Premises? Yes No
Were Safeguards or Safety Equipment Provided? Yes No
Were They Used? Yes No
Does Employer Question the Claim?
Was Employee Injured During Employment?
Were Drugs or Alcohol Involved?
Is Employee Represented By Attorney?

Contact Information

* Fields in Blue are required

Physician/Health Care Provider Name and Address:

Name
Telephone
Address
City
State Select One
Zip

Hospital/Provider Information

Name
Telephone
Address
City
State Select One
Zip

Other Information

Date Prepared: 3/20/2014
Preparer's First Name
Last Name
Telephone
Employer Contact First Name
Last Name
Telephone
Witness First Name
Last Name
Telephone

Claim Submission

* Fields in Blue are required

The Claim Entry Wizard has been completed. You may add additional comments below and click the Submit button to send the data to PMA.

Comments

Enter miscellaneous claim details in the comments box below.

Comments:

Maximum 900 Characters.

☐ Record Only

Claim Information Email

Click on the checkbox below to receive an email copy of the claim information just entered.

☐ Send Email Copy

Email Address(es) - Multiple addresses can be entered separated by a comma.

Submit

Cancel

Check the **Record Only** box when the claim is for informational purposes only. For Workers' Compensation, this means an injured worker who will **not** be seeking medical treatment.

Type any additional information about the claim into the Comments box.

Click the **Send Email Copy** and **type** your email address in order to receive a copy of these screens after you submit the claim. Add additional recipients to the list by typing a comma and then adding the next address.

Click **Submit Claim** when you are finished. You will receive a claim number immediately. Record this claim number for your records.

Claim Number

Claim Number : **W001171292**

Attach File(s)

New Claim

To submit additional documentation, such as internal investigation reports, surveillance footage, medical reports, or photographs, click the Attached File(s) button. You will see the folders on your computer. Select the folders you would like to include with the claim and then click Upload File(s). When the upload is complete, you can attach more files, exit or start entering a new claim.

Claim Number

Claim Number : **W001171292**

Attach File(s)

IMAG0104.jpg
IMAG0107.jpg
common abbreviations.doc
Cell Phone List.xls

Cancel all Uploads

Attachments will not be uploaded unless Upload File(s) button is clicked.

Upload File(s)

New Claim

Claim Number

Claim Number : **W001171292**

Attach File(s)

Files
IMAG0104.jpg (1.0MB)
IMAG0107.jpg (2.0MB)

Total attachments submitted for this claim : 2

New Claim

To enter another claim, choose New Claim from bottom of the screen. When you are finished entering claims, choose Exit from the menu. Click **Yes** to close PMA New Claim Entry.

Supported Types of Attachments, in file sizes up to 50 megabytes each:

Document Type	Extension	File Type	Document Type	Extension	File Type
BITMAP	.bmp	Image	RTF	.rtf	Text
GIF	.gif	Image	MSEXCEL	.xls	Excel Document
JPEG	.jpg	Image	MSEXCEL	.xlsx	Excel Document
TIF	.tif	Image	POWERPOINT	.ppt	Powerpoint Document
TIFF	.tiff	Image	MPEGAUDIO	.mpg	Audio File
HTML	.html	Browser File	AIFFAUDIO	.aiff	Audio File
TEXT	.txt	Text	WAVAUDIO	.wav	Audio File
XML	.xml	Browser File	MPEGVIDEO	.mpg	Video File
DCARFT	.rtf	Text	QUICKTIME	.mov	Video File
MSWORD	.doc	Word Document	VIDEOCHARGER	.mpg	Video File
MSWORD	.docx	Word Document	ASFVIDEO	.asf	Video File
PDF	.pdf	PDF	AVIVIDEO	.avi	Video File