



State of Vermont

Filing Workers' Compensation Claims Online

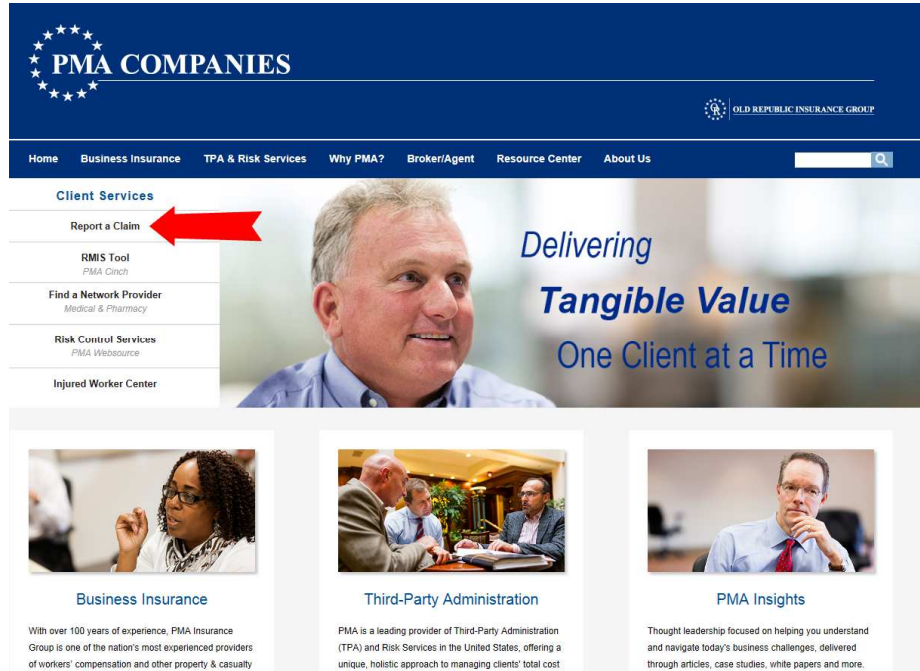
v 2016.03

LOGON INSTRUCTIONS

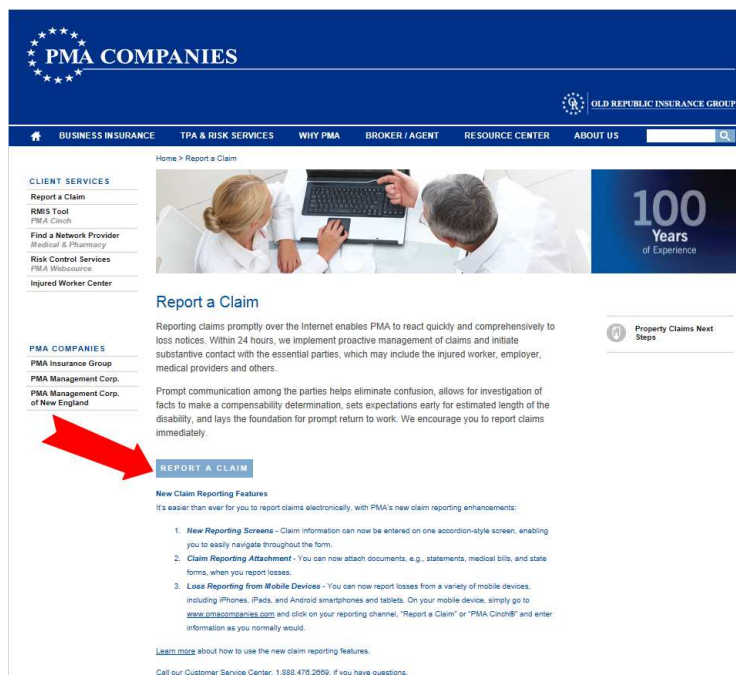
User Name: 0786749

Password: newclaim

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

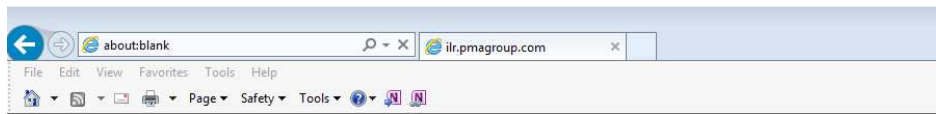


Click “Report a Claim.”
See the Report A Claim landing page.



Click REPORT A CLAIM.

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



User Name = 0786749
Password = newclaim

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

A screenshot of a web application interface. At the top is a dark blue header bar with the "PMA COMPANIES" logo on the left and "PMA Loss Reporting" on the right. Below the header is a white area. In the center of this area is a label "Select State" followed by a dropdown menu that currently shows "Select One".

For Worker's Compensation only, choose your accident state.

A screenshot of the same web application interface as before. In addition to the "Select State" dropdown, there is now a "Select Line Of Business" dropdown menu above it, which is set to "Workers' Compensation". The "PMA COMPANIES" logo and "PMA Loss Reporting" text remain in the header.

Enter the last name or the employee ID of the injured worker.



The image shows a web interface for PMA COMPANIES. The header is dark blue with the PMA COMPANIES logo on the left and 'PMA Loss Reporting' on the right. Below the header, there is a white area with a search form. The form includes a prompt: 'Enter search criteria and click the Search button to generate a list of employees.' Below this prompt are two input fields: 'Employee Last Name Search' and 'Employee ID Search'. To the right of these fields is a 'Search' button. Further right is a button labeled 'Employee Not On List'.


Enter search criteria and click the Search button to generate a list of employees.

Employee Last Name Search Employee ID Search Search Employee Not On List

Enter the last name, and employee ID dash employee record ex, 12345-0. Employee with that ID will be listed. Select the appropriate employee from the list or choose Employee Not On List.

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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 <input style="width: 100%;" type="text"/>	Employee Last Name <input style="width: 100%;" type="text"/>
Address <input style="width: 100%;" type="text"/>	
City <input style="width: 100%;" type="text"/>	
State Select One ▼	Zip <input style="width: 100%;" type="text"/>
Telephone <input style="width: 100%;" type="text"/>	SSN <input style="width: 100%;" type="text"/>
Sex Select One ▼	
Birth Date <input style="width: 100%;" type="text" value="mm/dd/yyyy"/>	Hire Date <input style="width: 100%;" type="text" value="mm/dd/yyyy"/>
Marital Status Select One ▼	Number of Dependents Select One ▼
Employment Status Select One ▼	
Occupation/Job Title <input style="width: 100%;" type="text"/>	

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 ▼ Required Field	
Employee First Name <input style="width: 100%;" type="text"/> Required Field	Employee Last Name <input style="width: 100%;" type="text"/> Required Field
Address <input style="width: 100%;" type="text"/> Required Field	
City <input style="width: 100%;" type="text"/> Required Field	
State Select One ▼ Required Field	Zip <input style="width: 100%;" type="text"/> Required Field
Telephone <input style="width: 100%;" type="text"/>	SSN <input style="width: 100%;" type="text"/> Required Field
Sex Select One ▼	
Birth Date <input style="width: 100%;" type="text" value="mm/dd/yyyy"/> Birth Date in (mm/dd/yyyy) is required	Hire Date <input style="width: 100%;" type="text" value="mm/dd/yyyy"/>
Marital Status Select One ▼	Number of Dependents Select One ▼
Employment Status Select One ▼	
Occupation/Job Title <input style="width: 100%;" type="text"/> Required Field	

Occurrence Information

Contact Information

Claim Submission

Sample Workers' Compensation screens continue below.

Occurrence Information

* Fields in Blue are required

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

Contact Information

* Fields in Blue are required

Physician/Health Care Provider Name and Address:

Name	<input type="text"/>	Telephone	<input type="text"/>
Address	<input type="text"/>		
City	<input type="text"/>	State	<input type="text" value="Select One"/>
		Zip	<input type="text"/>

Hospital/Provider Information

Name	<input type="text"/>	Telephone	<input type="text"/>
Address	<input type="text"/>		
City	<input type="text"/>	State	<input type="text" value="Select One"/>
		Zip	<input type="text"/>

Other Information

Date Prepared:	<input type="text" value="03/15/2016"/>		
Preparer's First Name	<input type="text"/>	Last Name	<input type="text"/>
Telephone	<input type="text"/>		
Employer Contact First Name	<input type="text"/>	Last Name	<input type="text"/>
Telephone	<input type="text"/>		
Witness First Name	<input type="text"/>	Last Name	<input type="text"/>
Telephone	<input type="text"/>		

Any custom fields will be displayed in the Customer Special Coding section. Any items specific to the employee, may be included in the employee demographic feed and will be pre-filled when the employee is selected.

Any custom fields specific to the incident, will need to be completed at the time of claim entry.

Customer Special Coding	
* Fields in Blue are required	
Question	AGENCY
Answer	AOA - Administration
Question	REPT_ENTITY
Answer	OS - Taxes

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.

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

Claim Number

Claim Number : **W001171292**

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