The Beacon
Mutual Insurance Co.

Online Claim Reporting

September 14, 2016

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Overview

Beacon Mutual's new Online Claim Reporting software will supply our policyholders with a streamlined entry process. The Claim "Wizard" will guide you go through the entry process with ease. Once the claim is submitted, the user will receive an online claim summary, which includes claim number, claim representative name, phone number and email address. In addition, an email confirmation will be sent to the policyholder email address entered during this process.

Note: If a claim is submitted from 8:30 PM to midnight, Monday thru Friday in the online system, the email confirmation with the claim information will not be sent until the next business day.

There are two scenarios where the claim cannot be entered online.

1. There is no coverage for the policyholder available.

2. The claimant's last name, Security Number, and Date of Birth do not match.

In both cases, a message will display instructing you to call Beacon Mutual during normal business hours.

BEACONNECT

Policyholders must be a registered BEACONNECT user to be able to enter a claim online. BEACONNECT access also gives our policyholders claim, policy and loss information.

Required Information

The following information is required to enter a claim:

- Address where the injury occurred
- Has the employee been, or does the employee plan to be, treated for this injury?
- Has the employee been taken out of work for more than 3 full days (not including injury date)?
- Employee Injury information
  - Body Part/Location
  - Nature of Injury
  - Action that caused injury
  - What was the employee working on or with when the injury occurred?
  - Description of how the injury occurred.
- Employee Information
  - Social Security Number
  - Date of Birth
  - Name
  - Gender
  - Marital Status
  - Address
  - Phone
- Dates Needed:
  - Date of Injury
  - Date of Death (if a fatality)
  - Last Date Worked
  - Date Employee Started Work
  - Date you were notified
  - Date of Hire

Getting Started

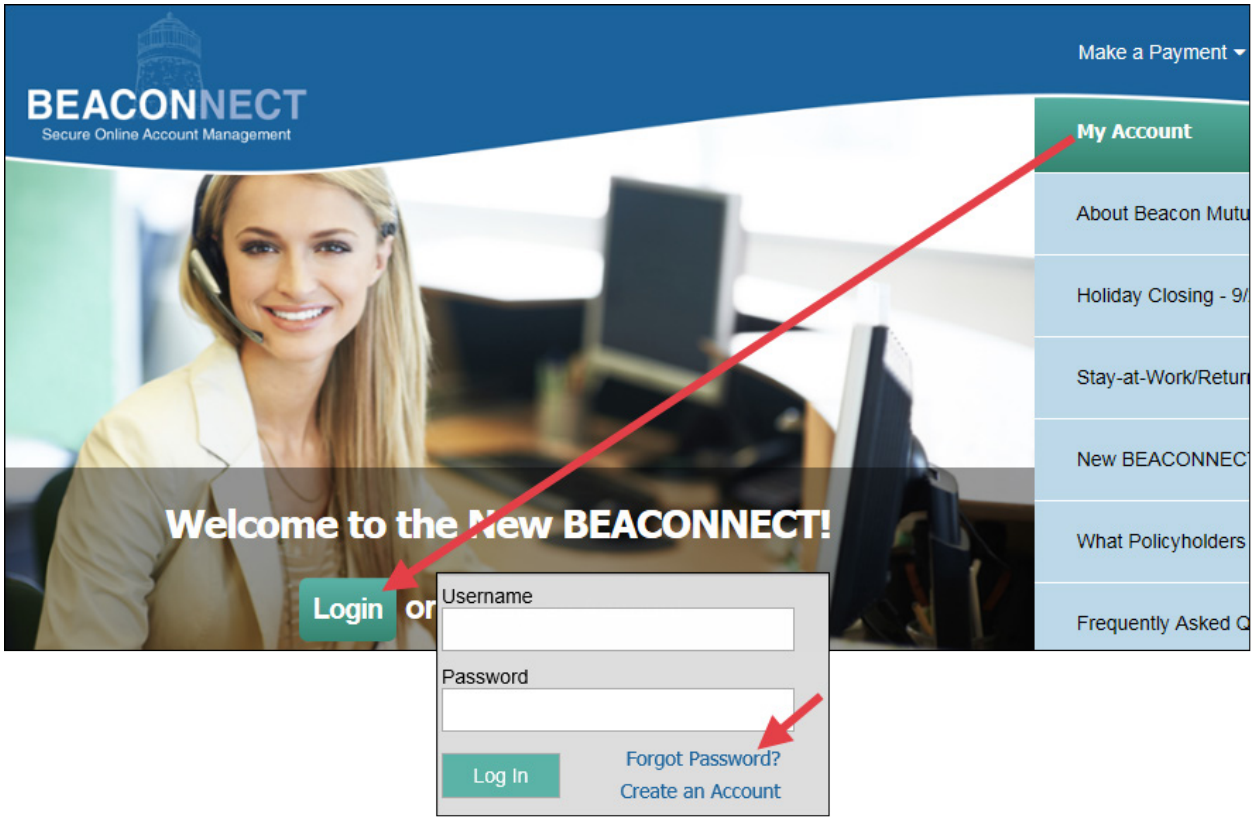
Section 1: Sign in to BEACONNECT

1. Go to the BEACONNECT website:
    a. https://beaconnect.beaconmutual.com/Pages/Default.aspx

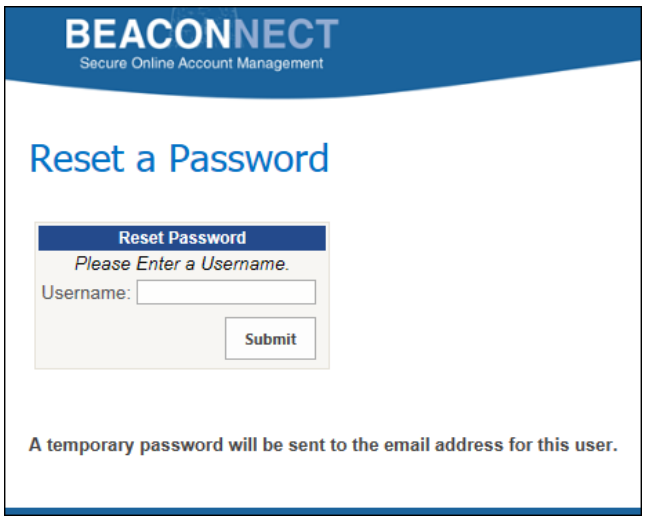
2. Enter your username and password:

    a. If you do not remember your username:
        - Usernames include the first letter of your first name and your last name. For example: Mary Smith would be msmith.
        - If you are still unable to determine your username, please contact your company's key contact.

    b. If you do not remember your password:
        - Click the Forgot Password link:



This link opens the Reset Password window:

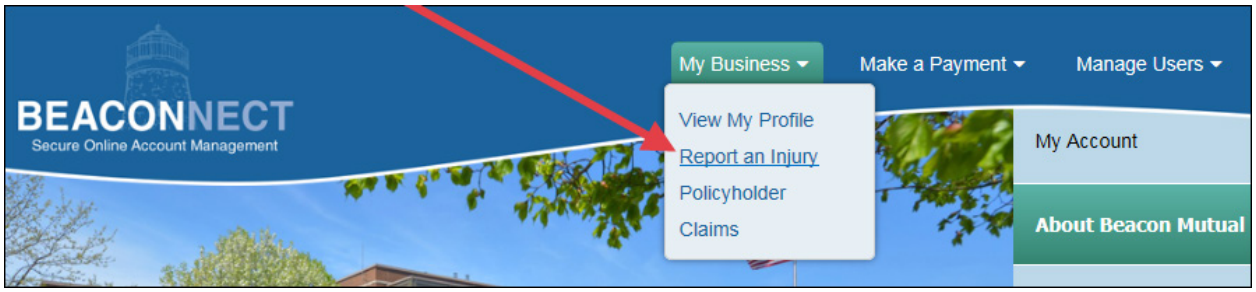


c. Enter your username and select **Submit**.
   An email with a temporary password will be sent to your email address on file.

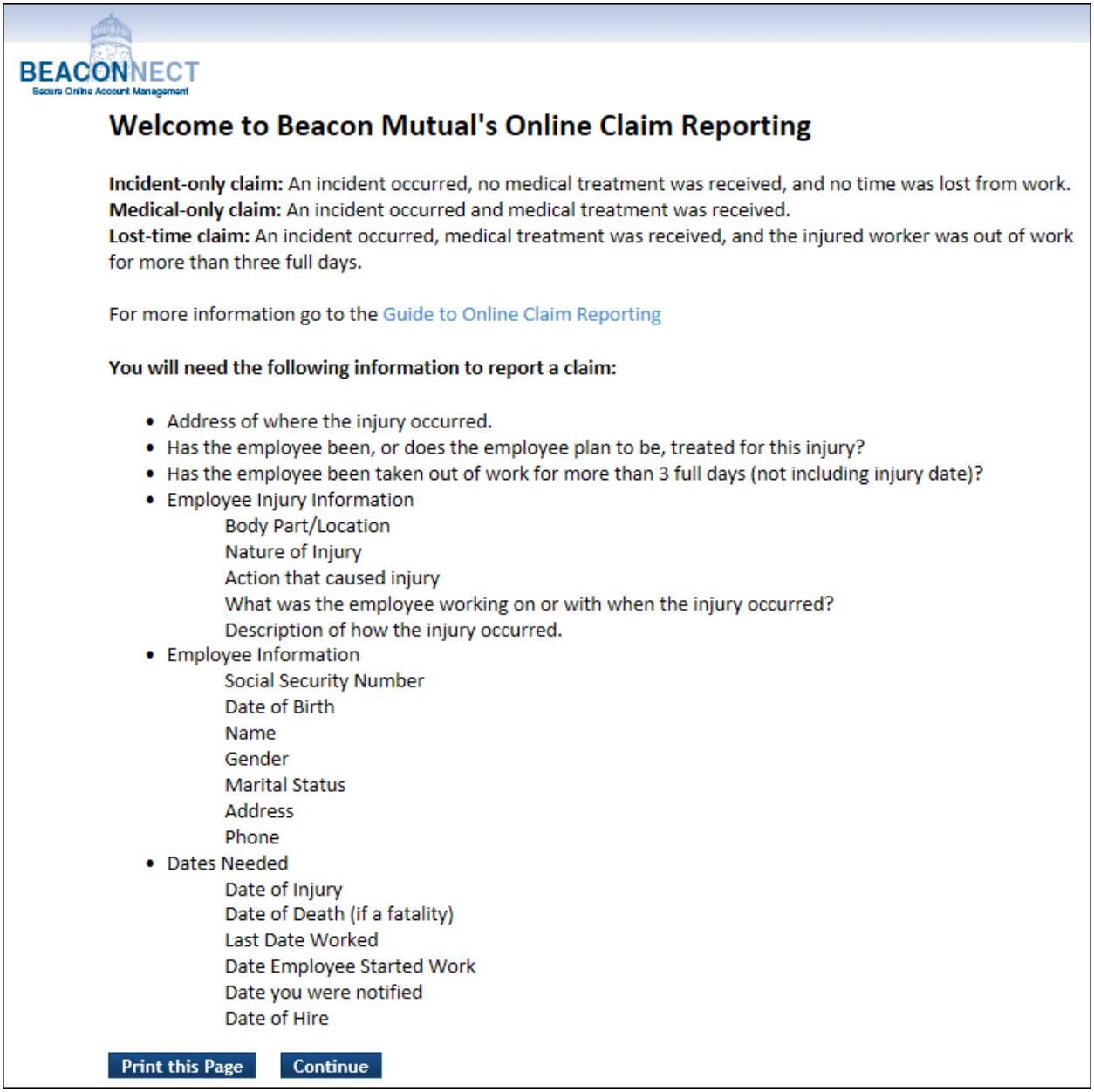
d. If you do not receive an email within the day, please notify your key contact to ensure your email address is correct.

3. Once you sign in successfully, the Beaconnect "Home" page will redisplay with a new slider and additional options in the top menu. Options include Report an Injury as well as links to other pages depending on your access permission in BEACONNECT.

4. Select My Business > **Report an Injury** to continue and place a claim:



The Online Claim Reporting window will open, which lists all the information you need to report a claim. Click the **Print this Page** button for reference if necessary:



5. Select **Continue**, and you will be prompted to enter the injury information.

   The Claim "Wizard" will navigate you through the process to report your claim.

   A red asterisk (*) indicates required information.
   You will be prompted to enter all required information before you can continue.

Section 2: When did the injury occur?

1. Enter the Date and Time of Injury.

2. Question 1 – Did the injured employee receive or intend to receive medical treatment? Select Yes or No.

    a. Selecting No for question 1 automatically defaults No to question 2 and sets the claim type to incident only.

3. Question 2 – Did a medical provider take the employee out of work for more than 3 full days (excluding date of injury)? – Select Yes or No.

    a. Selecting Yes for question 2 sets the claim type to Lost Time.
    Worked Started Date and Time and Last Date Worked are required for a Lost Time claim.

    b. Selecting No for question 2 sets the claim type to Medical Only.

4. Hire Date is required.

5. Hire State defaults to RI but can be changed and is required.

6. Enter the date you learned of the injury.

7. If the injury was a fatality, click the check box next to the question "Is this a Fatality?" The Date of Death field will display and you will be required to enter the date of death:

Section 3: Employee Work Location and Title

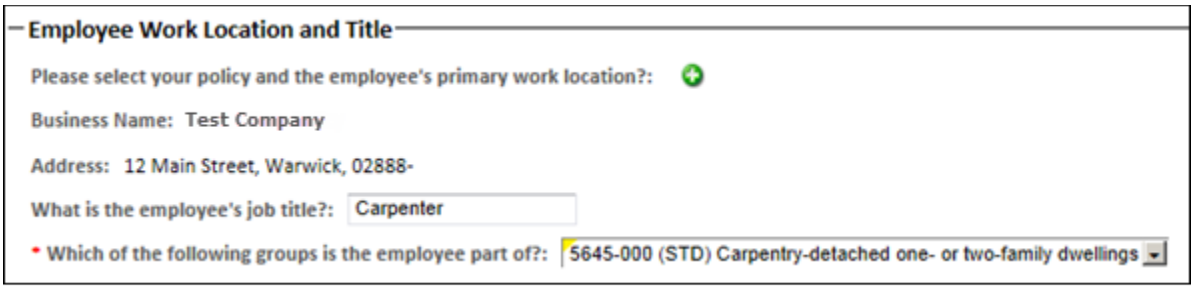
1. Click the green plus sign to display your policy and risk locations:

2. A popup window displays a list of policy periods and risk locations for the last three years. The first column Cov? displays Yes or No to indicate if the injury date is covered for the policy period:

3. Highlight the policy and risk location, and click the **Select** button. The popup will close and your policy information and risk location will be entered in the form window.

4. Enter the employee's job title (if available).

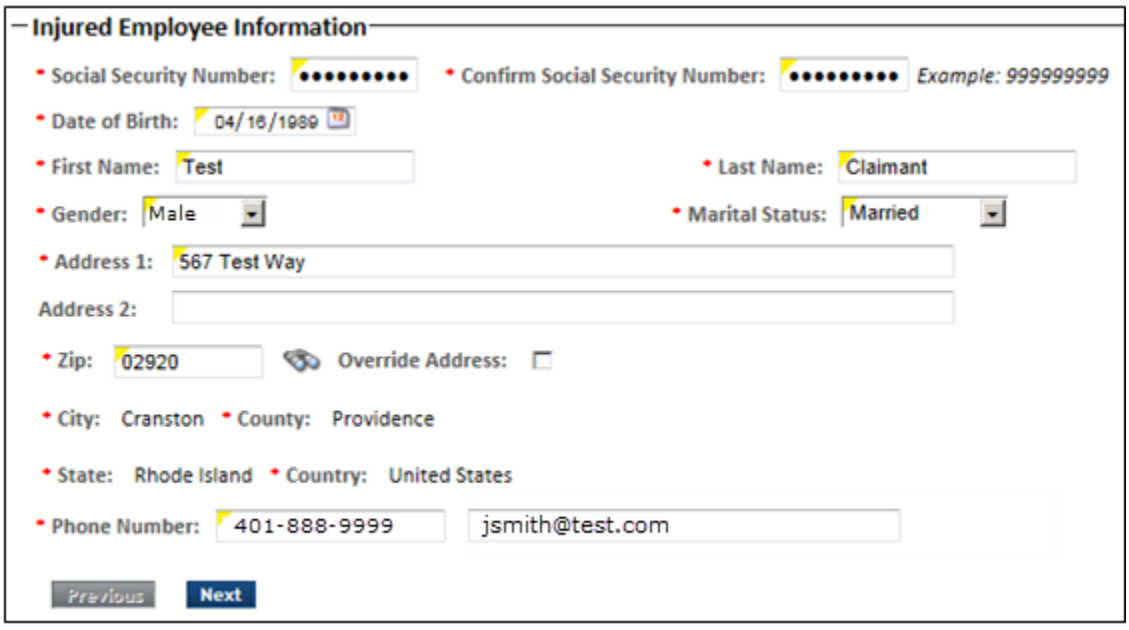
5. Answer the question "Which of the following groups is the employee part of? This is the class code for the employee.



Section 4: Injured Employee Information

1. Social Security Number
    a. Enter the employee's Social Security Number.
    b. Enter the employee's Social Security Number a second time in the Confirm Social Security Number field.
    c. SSN fields are masked so you will not see the data you are entering.
    d. Social Security Numbers must match for you to continue.

2. Enter the following data about the employee:
    a. Date of Birth
    b. First Name
    c. Last Name
    d. Gender
    e. Marital Status
    f. Address
    g. Zip Code (City and State will default from zip code)
    h. Phone number
    i. Email address

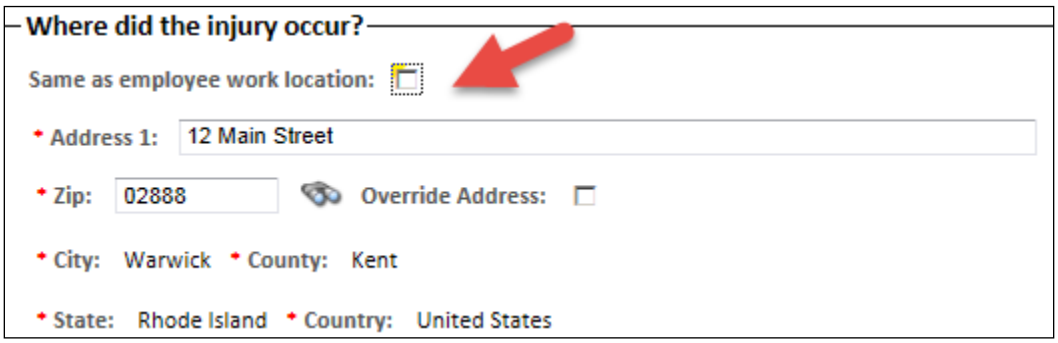


3. Select **Next** to continue.

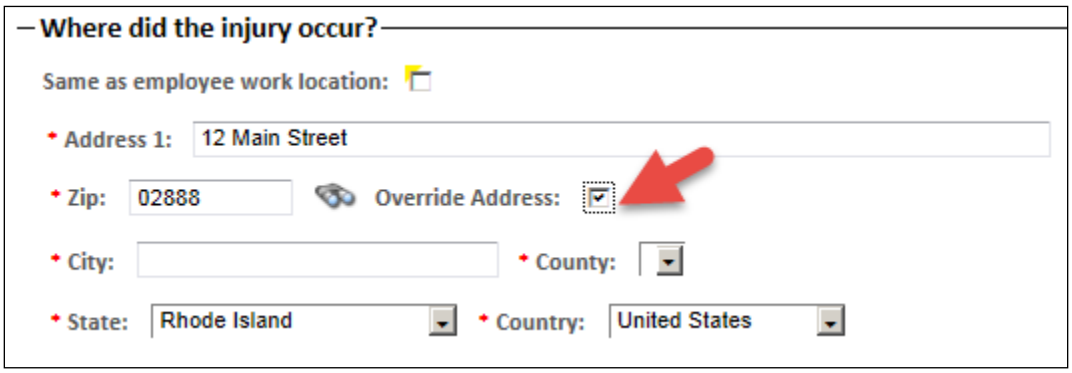
Section 5: Where did the injury occur?

1. Check the box next to the "Same as employee work location" if the injury occurred at the employee's primary work location:

2. If the injury occurred at a different work location, do not check the "Same as employee work location". Leave the box unchecked and enter the address where the injury occurred:



3. Click the Override Address check box if the system prefills any location information, which you believe to be incorrect. For example: If you enter a zip code and the wrong city or county appears, click the Override Address check box and enter the correct information.:

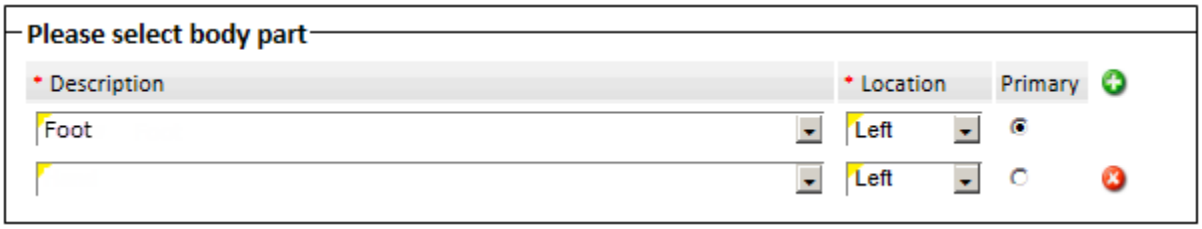


Section 6: Please select body part

1. Select the primary body part from the description drop-down list.

2. Select the location for that body part.

3. You can enter more than one body part/location and change the primary body part if needed.



Section 7: Please tell us about the injury

1. What was the nature of the injury? For example: Cut, Burn, Fracture

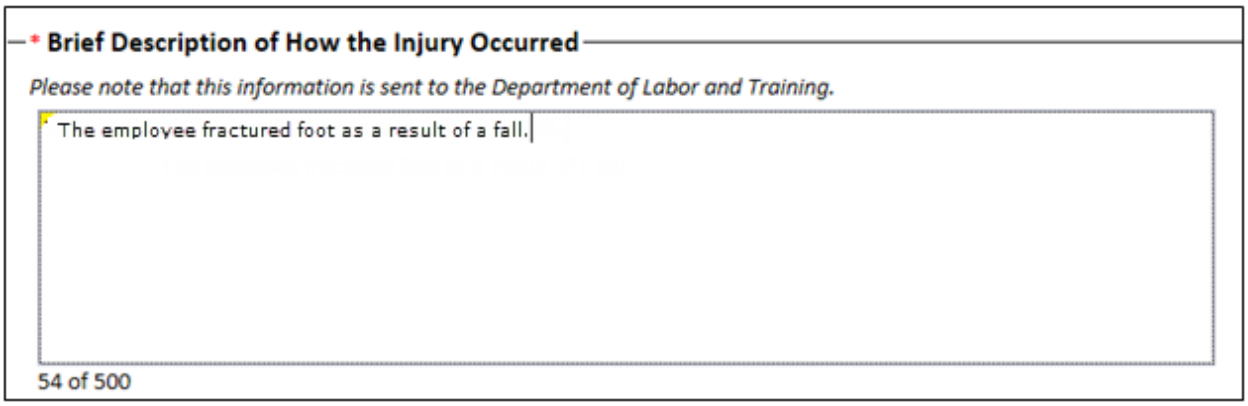
2. What action caused the injury? For example: Slip, Fall

3. What was the employee working on or with when the injury occurred?
   For example: Hand Tool or Machine in use.

Section 8: Brief Description of How the Injury Occurred

Enter a brief description. This is a required field.

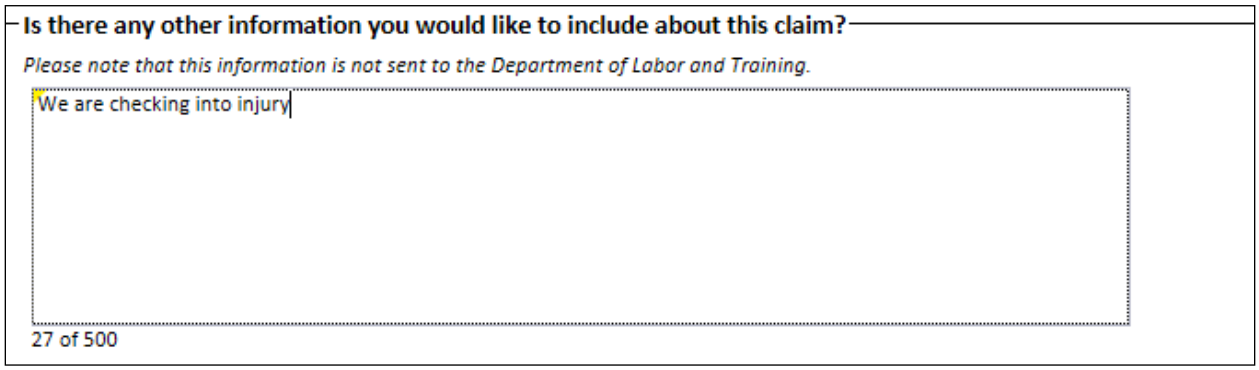
- The information entered in this section will be sent to the Department of Labor and Training.
- The description can be up to 500 characters:



Section 9: Is there any other information you would like to include about this claim?

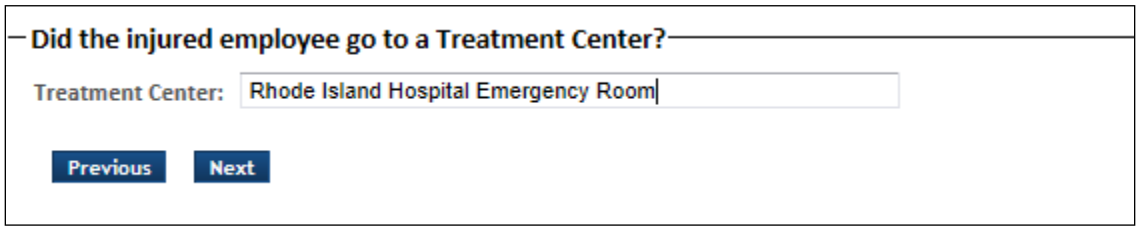
Enter additional information in the field following this question. This is Not a required field

- The information entered in this field will NOT be sent to the Department of Labor and Training.
- The description can be up to 500 characters.



Section 10: Did the injured employee go to a Treatment Center

1. Enter the hospital, walk-in treatment center, or facility where the employee was treated:



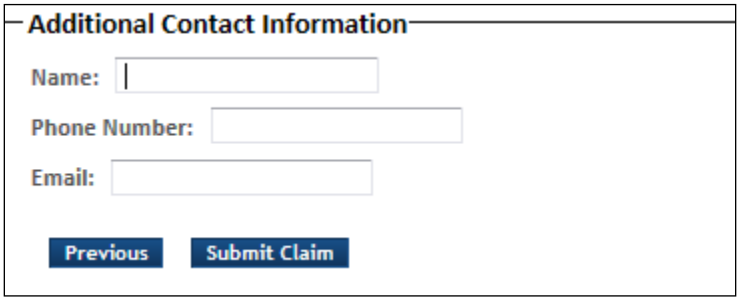
2. Select **Next** to continue.

Section 11: Contact Information

1. This section will display your contact information from BEACONNECT:

Section 12: Additional Contact Information

You can add another contact person's information. This section is not required.



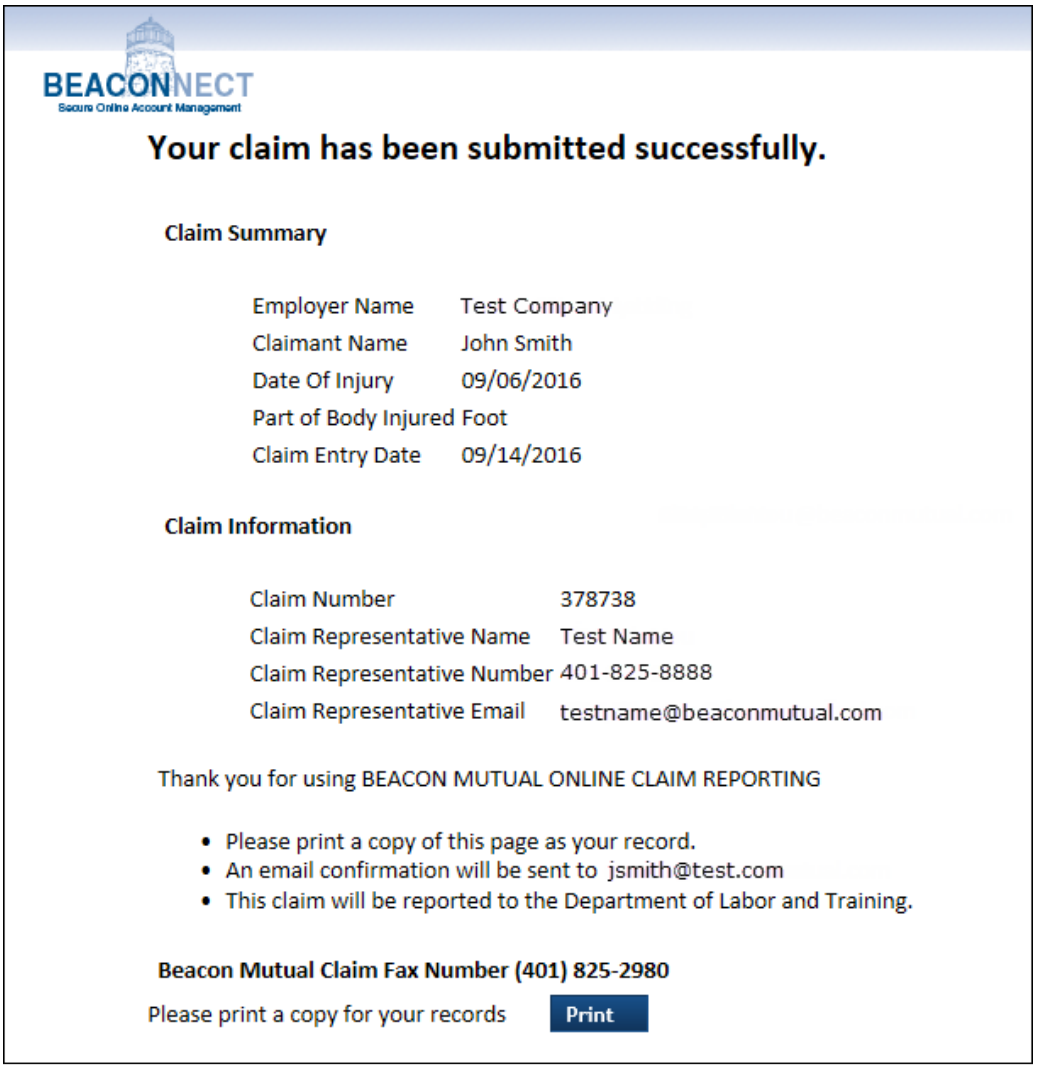
Select **Submit Claim**.

Section 13: Claim Confirmation Page

1. The Claim Summary section includes information about the claimant and the injury.

2. The Claim Information section includes the Claim Number, Claim Representative assigned, Claim Representative Phone and Email Address.

3. You have the option of printing the Claim Confirmation:


BEACONNECT
Secure Online Account Management

Your claim has been submitted successfully.

Claim Summary

Employer Name	Test Company
Claimant Name	John Smith
Date Of Injury	09/06/2016
Part of Body Injured	Foot
Claim Entry Date	09/14/2016

Claim Information

Claim Number	378738
Claim Representative Name	Test Name
Claim Representative Number	401-825-8888
Claim Representative Email	testname@beaconmutual.com

Thank you for using BEACON MUTUAL ONLINE CLAIM REPORTING

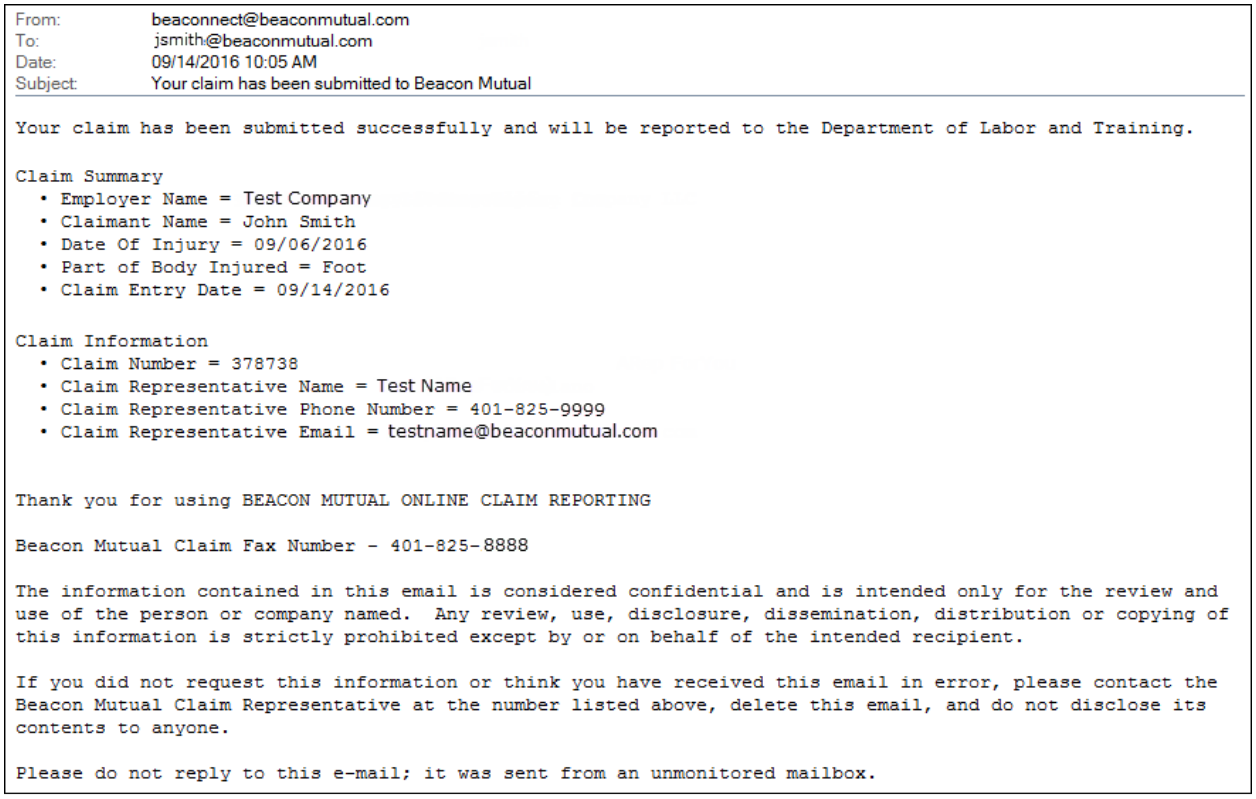
- Please print a copy of this page as your record.
- An email confirmation will be sent to jsmith@test.com
- This claim will be reported to the Department of Labor and Training.

Beacon Mutual Claim Fax Number (401) 825-2980

Please print a copy for your records Print

Section 14: Claim Confirmation Email

A copy of the Claim Confirmation will be sent to the email address associated to your BEACONNECT account.



From: beaconnect@beaconmutual.com
To: jsmith@beaconmutual.com
Date: 09/14/2016 10:05 AM
Subject: Your claim has been submitted to Beacon Mutual

Your claim has been submitted successfully and will be reported to the Department of Labor and Training.

Claim Summary
- Employer Name = Test Company
- Claimant Name = John Smith
- Date Of Injury = 09/06/2016
- Part of Body Injured = Foot
- Claim Entry Date = 09/14/2016

Claim Information
- Claim Number = 378738
- Claim Representative Name = Test Name
- Claim Representative Phone Number = 401-825-9999
- Claim Representative Email = testname@beaconmutual.com

Thank you for using BEACON MUTUAL ONLINE CLAIM REPORTING

Beacon Mutual Claim Fax Number - 401-825-8888

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If you did not request this information or think you have received this email in error, please contact the Beacon Mutual Claim Representative at the number listed above, delete this email, and do not disclose its contents to anyone.

Please do not reply to this e-mail; it was sent from an unmonitored mailbox.

Note: This claim confirmation will not be sent immediately if the claim was submitted between 8:30pm and midnight. You will receive the information on the next business day.