7/10/2014

EASTERN KENTUCKY UNIVERSITY
521 LANCASTER AVE
RICHMOND, KY 40475

Re: Posting Notice(s) for WC 9015351

Enclosed is the Workers' Compensation posting notice for your business. Please place it in an area that is accessible by your employees.
The name, address and telephone number of your employer’s workers’ compensation insurance company, third-party administrator (TPA), or person handling workers’ compensation claims for your company, are shown below.

**Employer Name:** EASTERN KENTUCKY UNIVERSITY  

**IF INSURED:**  
(Complete all applicable spaces)

**Name of Insurance Company:** ZURICH AMERICAN INSURANCE COMPANY

**Address:**

**Telephone Number:**

**Insurer’s Bureau Code:** 0041

**Policy Number:** WC 9015351

**IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:**  
(Complete all applicable spaces)

**Name of TPA (Claims administrator):**

**Address:** P.O. Box 28777  
Baltimore, MD 21240  

**Telephone Number:** 800-987-3373

**IF SELF-INSURED:**  
(Complete all applicable spaces)

**Name of person handling claims at the self-insured:**

**Address:**

**Telephone Number:**

**Self-Insured Bureau Code:**

**IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:**  
(Complete all applicable spaces)

**Name of TPA (Claims administrator):**

**Address:**

**Telephone Number:**
DATE OF NOTICE

MM - DD - YYYY

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

MM - DD - YYYY

DATE OF INJURY

MM - DD - YYYY

WCAIS CLAIM NUMBER

EMPLOYEE

First name ____________________________

Last name ____________________________

Date of birth _________________________

Address _______________________________________________________

Address _______________________________________________________

City/Town ____________________________ State ______ ZIP ____________

County _________________________________

Telephone ____________________________

INJURY INFORMATION

Part of body injured ____________________________

Nature of injury ____________________________

Accident/injury description narrative _______________________________________

Check if occupational disease □

EMPLOYER

Name ____________________________

Address _______________________________________________________

Address _______________________________________________________

City/Town ____________________________ State ______ ZIP ____________

County _________________________________

Telephone ____________________________ FEIN _______________________

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name ____________________________

Address _______________________________________________________

Address _______________________________________________________

City/Town ____________________________ State ______ ZIP ____________

County _________________________________

Telephone ____________________________ FEIN _______________________

Contact _______________________________

NAIC code ________________________ or Insurer code ____________________

Insurer/TPA claim #_____________________

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers’ Compensation Act, 77 P.S. §1039.3, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.462.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-il-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

LIBC-800 REV 09-13