

SB 1159 COVID-19 REPORTING FORM 1

Reporting Period: 7/6/2020 – 9/16/2020



A FAIRFAX Company

IMPORTANT NOTICE: If you have an employee that has tested positive for COVID-19 **on or after July 6, 2020, to September 16, 2020**, you are required to promptly notify us with the information required in this form. **You are required to report this information to us no later than 30 business days after law effective date.** You must complete this form whether or not the illness is work-related and whether or not your employee has filed a claim. If your employee contends that the illness is work-related, you must report the claim in addition to completing this form. Please return this completed form as soon as possible to Covid1159reporting@thezenith.com.

If you have more than one employee who has tested positive for COVID-19, you must complete a separate form for each employee. For each employee you report, please keep internal records identifying the employee by name for future reference.

- Employer name: _____
 Employer Street Address: _____
 City: _____ State Abbreviation: _____ Zip Code: _____
 Zenith policy number: _____
- If available, please provide the employee ID number: _____
 (Note: This is your internal ID number, not a SSN or driver's license number.)
- Please identify the testing date for the employee who tested positive: _____ (MM/DD/YYYY)¹
 (Note: The testing date is the date that a specimen was collected from the employee for testing.)
 PCR/Viral Test? (Choose one) _____ Yes _____ No _____ I don't know
- Please provide the information below for each specific place of employment where the employee worked (meaning the actual address of the building, store, facility, or agricultural field where the employee performed work at employer's direction) in the 14-day period prior to the testing date. This may be a different location than the business address requested in number 1 above.

Location # 1		Location # 2	
Address:		Address:	
Total Employee Count for this specific location only:		Total Employee Count for this specific location only:	
Identify the last day the employee worked at this location:		Identify the last day the employee worked at this location:	
What is the highest number of employees who reported to work at this specific location from July 6, 2020 to September 16, 2020?		What is the highest number of employees who reported to work at this specific location from July 6, 2020 to September 16, 2020?	
Has this location ever been ordered to close due to a risk of infection with COVID-19?		Has this location ever been ordered to close due to a risk of infection with COVID-19?	
If YES, please explain:		If YES, please explain:	

- Has the employee filed a WC claim or alleged the illness is work-related? (Choose one) _____ Yes _____ No
 If yes:

Employee First Name _____ Employee Last Name _____ Claim Number _____

I hereby certify that I am an authorized representative of the insured named above and the information provided in this form is accurate and complete to the best of my knowledge.

First Name _____ Last Name _____ Title _____

Email address: _____ Phone number: _____

Date: _____

¹ If the testing date is on or after 9/17/2020, then you cannot use this reporting form. You must use SB 1159 COVID-19 Reporting Form 2 to report information about any employees who tested positive for COVID-19 on or after 9/17/2020.