SB 1159 COVID-19 REPORTING FORM 2
Reporting Period: On or After 9/17/2020

TheZenith®
A FAIRFAX Company

IMPORTANT NOTICE: If you have an employee that has tested positive for COVID-19 **on or after September 17, 2020**, you are required to promptly notify us with the information required in this form. **You are required to report this information to us within three business days of knowledge of the employee's status.** 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.

1. Please provide insured name: _____
   Insured address: _____ Zenith policy number: _____

2. If available, please provide the employee ID number_____. This is your internal ID number, not a SSN or driver's license number.

3. 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

4. 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 in the 45-day period preceding the last day the employee worked at this location?		What is the highest number of employees who reported to work at this specific location in the 45-day period preceding the last day the employee worked at this location?	
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:	

5. Has the employee filed a WC claim or alleged the illness is work-related? (*Choose one*) _____Yes _____ No
   If yes, please specify the employee name and 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.

_____
PRINT FULL NAME/TITLE

Email address: _____

Phone number: _____

Date: _____

_____
SIGNATURE

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