

REQUEST FOR CLAIM CAPTURE LOGIN

Purpose and Directions – For Authorized State Employees Only! Complete this form to report Workers Compensation or GL claims. Send completed form by email to SolaSecurityRequest@sedgwickcms.com Your login name and initial password will be emailed to you within 3 business days. Do not share your login info. For login information or password resets please call 866-647-7610.

Legal Notice - By applying for and using your assigned login credentials, you agree to not disclose the information presented on screens and in system generated reports to any other person without a clear need or right to know. Information within this system may be protected by Federal and State privacy laws. Before sharing any information about a specific claim, person, or event, check with your supervisor or the claims adjuster assigned to the claim.

Select the line of coverage:

Claim Capture – Internet Claim Reporting: **for Reporting Workers Compensation Claims
for Reporting GL Claims**

Monthly Reports: Form is located on the Loss Analysis tab: <http://laorm.com/analysis.html>

Today's Date: **First Name:** **Last Name:**
Email Address: **Job Title:**

Telephone Number: **Address:**

Your Agency's ORM 4 Digit Location Code(s) – To view an agency location code listing, please visit <http://doa.louisiana.gov/orm/PDF/ORMLocListing.pdf>

List D location/s if you need access to all S and L locations under the D level.

List S location/s if you need access to all L locations under the S level.

Otherwise, list each L location you need access to.

D Location Level:

S Location Level:

L Location Level:

Department Name:

Agency/Division Name:

Agency/Division Name:

Additional locations needed: (attach a separate list if needed)

LEVEL (D,S,or L) LOCATION CODE (4 DIGITS) DEPARTMENT OR AGENCY/DIV NAME

Requested by @ _____
(Signature of Person Requesting Access)

Your Supervisor's Name: **Email:**
Job Title: **Telephone Number:**

Authorization: (system access must be approved by your agency's appointing authority) 'I verify that the above named individual is currently employed at the agency listed and I authorize this employee to report claims. I understand that should this person leave the agency or is assigned to another duty station, I am to email SOLAsecurityRequest@sedgwickcms.com within one working day of the employee's change in status.'

Authorized by @ _____
(Signature of Authorized Agency Representative)

This section reserved for security use

(22) GROUP - LA State Agencies General Access Level

Verified by _____

Audited by _____ on _____

ORM State Agency Version 2.9 (Valid as of 11/22/13)