

SB 1159 COVID-19 REPORTING FORM 1- CA

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

1111 Ashworth Rd West Des Moines, IA 50265 **GuideOne.com**

<u>IMPORTANT NOTICE</u>: If you have a California 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. <u>You are required to report this information to us no later than 30 business days after law effective date.</u> 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 <u>GuideOneCACovid19@guideone.com</u>.

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.

1.	Employer name:Employer Street Address:				
	Employer Street Address:		State Abbraviation:	Zin Codo:	
	City: GuideOne policy number:		State Appreviation	2ip Code	
2.	If available, please provide the employee ID number: (Note: This is your internal ID number, not a SSN or driver's license number.)				
				(B 4B 4/DD 2 () 0 0 () 1	
3.	(Note: The testing date is the date that PCR/Viral Test? (Choose one)	ease identify the testing date for the employee who tested positive: (MM/DD/YYYY) ote: The testing date is the date that a specimen was collected from the employee for testing.) CR/Viral Test? (Choose one) Yes No I don't know			
4.	Please provide the information below for <u>each</u> 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		Total Employee Count for this	S	
	specific location only:		specific location only:		
	Identify the last day the employee worked at this location:		Identify the last day the employers worked at this location:	oyee	
	What is the highest number of		What is the highest number o	f	
	employees who reported to work		employeeswho reported to w		
	at this specific location from July		at this specific location from J	luly	
	6, 2020 to September 16, 2020?		6, 2020 to September 16, 202	20?	
	Has this location ever been		Has thislocation ever been		
	ordered to close due to a risk of infection with COVID-19?		ordered to close due to a risk infection with COVID-19?	OT	
	If YES, please explain:		If YES, please explain:		
5.	Has the employee filed a WC claim or alleged the illness is work-related? (<i>Choose one</i>)YesNo lf yes:				
	Employee First Name	Employee Last Name Clai		aim 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		le	
	Email address:		Phone number:		
	Date:				
			SIGNATURE		

¹ If the testing date ison 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.