



PMA's Enhanced Online Report a Claim Solution
Claim Reporting Guide

July 2025
Version 1.02



OLD REPUBLIC INSURANCE GROUP

Welcome to RADIUS^R

PMA's Enhanced Online Report a Claim Solution featuring

- New look and feel to PMA's online claim reporting functionality
- User self-registration
- Multi-factor authentication for greater client data security
- Ability to save draft claims to complete during a later session

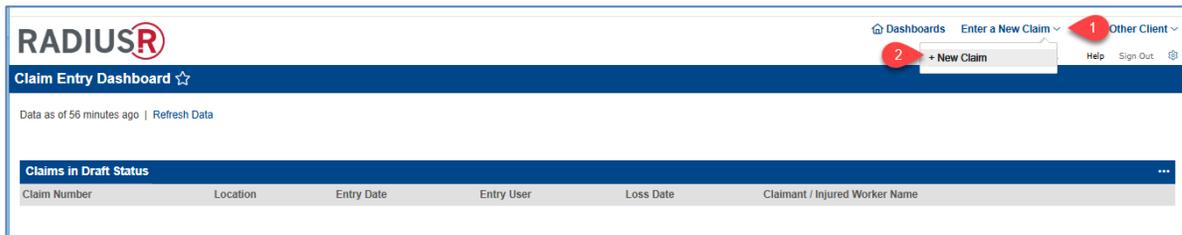
Claim Reporting Guide

Go to <https://www.pmacompanies.com/support/report-a-claim> and click on the gold "Report a claim online" button at the bottom of the page.

Report a claim online

Please review the Self Registration and Multi-factor Authentication Guide for log in assistance.

You know you have logged in successfully, when you see the Radius^R Claim Reporting Dashboard. Please note, if you have access to file claims for more than one account, you will be asked to select an account before the Radius^R Claim Reporting Dashboard is displayed.



Claim Entry Dashboard

Data as of 56 minutes ago | Refresh Data

Claim Number	Location	Entry Date	Entry User	Loss Date	Claimant / Injured Worker Name
692	0000000004 - Public Works	06/19/2025	Your Name	06/09/2025	Default

Click **Enter New Claim** in the upper right corner and then click **+ New Claim** to file a new claim. To continue working on a claim draft from a prior session, click the temporary Claim Number listed in the Claims in Draft Status list.



Draft Claim Number	Location	Entry Date	Entry User	Loss Date	Claimant / Injured Worker Name
692	0000000004 - Public Works	06/19/2025	Your Name	06/09/2025	Default

You will see the New Claim Coverage screen. Select the coverage desired. Please note, your coverage selections will be limited to the coverage available for the selected account number.

Select the coverage desired.

After selecting the coverage needed, you will see the entry screen for that coverage.

Required Fields are listed in **bold font** and contain an asterisk (*).

Please note the buttons under the **Submitter Details**.

- Click **Submission Complete** to submit your claim.
- Click **Save Progress** to save a draft of the claim. Your entry will be assigned a temporary claim number will it remains in draft status. You will be able to come back to complete the claim later. Drafts will be automatically deleted after 30 days. If your claim remains in draft status for an extended period of time, you will receive email reminders at 7 and 28 days.
- **Return to Coverage Screen** will bring you back to the coverage selection screen.

Workers' Compensation Claims

Employee Information

The screenshot shows the RADIUSR 'New Claim' form. At the top, there are navigation links for 'Dashboards', 'Enter a New Claim', and 'Select Other Client'. Below this, the user is identified as 'James Radiusar currently working in ABC COMPANY (1234567)'. The form is titled 'New Claim' and shows account details: 'Account Name: ABC COMPANY - 1234567' and 'Coverage: Workers Compensation'. The 'Submitter Details' section includes instructions to select 'Submission Complete' or 'Save Progress' and a 'Return to Coverage Screen' button. The 'Employee Information' section contains various input fields: 'Accident State' (with a magnifying glass icon), 'First Name', 'Middle Name', 'Last Name', 'Claimant Suffix' (dropdown), 'Address', 'Address 2', 'City', 'State' (with a magnifying glass icon), 'ZIP', 'Birth Date' (with a calendar icon), 'SSN', 'Occupation/Job Title', and 'Location of Loss' (with a magnifying glass icon). On the right side, there are fields for 'Sex' (dropdown), 'Home Phone', 'Work Phone', 'Mobile Phone', 'Hire Date' (with a calendar icon), 'Claimant Email', 'Marital Status' (dropdown), 'Injured Worker Employment Status Code' (dropdown), 'Number Of Dependents', and 'Employee Number'.

Complete as much information about the injured worker as possible. Adding contact information like home phone, mobile phone and email address, when available, will allow multiple options for communication between the adjuster and the injured worker.

Fields with an arrow  or a magnifying glass  icon contain a list of predefined values. Click the arrow or magnifying glass to see a list of available options for that field. Fields with a magnifying glass, like **Location of Loss**, allow you to type a portion of the name or code to narrow the list of options. For more details refer to the **Helpful Hints** section on page 24 of this guide.

A dropdown menu for 'Marital Status' is shown, with the following options: '- None Selected -', '- None Selected -', 'Common law spouse', 'Divorced', 'Married', 'Separated', 'Single', 'Spouse deceased', and 'Unknown'.

A search field for 'Location of Loss' is shown with the text 'Caro' entered. Below the search bar, a list of suggestions is displayed: 'North Carolina (NC)' and 'South Carolina (SC)'.

Occurrence Information

Occurrence Information
Date of Injury/Illness: * 
Accident Cause: * 
Injury Type: * 
Body Part: * 
Accident Description: *
Maximum 500 Characters.

Body Part (Fingers or Toes)

For claims with a Body Part of Fingers or Toes, an additional drop down will appear. Select the affected finger or toe from the list. If unknown, select one and then provide Comments on the Claim Submission page to indicate the actual toe or finger is currently unknown.

Injury Information

Injury Information			
Time Began Work:	<input type="text"/>	Time of Occurrence:	<input type="text"/>
Date Employer Notified: *	<input type="text"/> 	Last Date Worked:	<input type="text"/> 
Date Expected Return to Work:	<input type="text"/> 	Date Returned to Work:	<input type="text"/> 
Full Pay for Date of Injury:	- None Selected -	Payment Frequency:	- None Selected -
Work Week Type: *	Standard	Hours Worked per Day:	- None Selected -
If fatal, date of death:	<input type="text"/> 		
Is the injured worker losing time? *	- None Selected -		
Is the injured worker on modified duty? *	- None Selected -		

Work Week Type

Standard

The default for **Work Week Type** is Standard. Standard applies when the employee works five days per week and the work days are Monday - Friday.

Fixed

Fixed indicates that the employee works a fixed schedule, but the days worked are not Monday - Friday. When selected, **Work Days Scheduled** becomes required. The default for **Work Days Scheduled** is blank and you will need to indicate the days the employee works - for example an employee may only work Monday, Wednesday and Friday or they may work a five-day week but the days worked are Wednesday - Sunday.

Varied

When selected, the **Days Worked Per Week** field, rather than the **Work Days Scheduled** field, becomes required. Since the work days vary there is no need to complete **Work Days Scheduled**. You should indicate the number of days the employee works each week in the **Days Worked Per Week** field. If the days worked per week is not consistent, indicate the average number of days per week.

Loss Location/Primary Physical Work Location

Loss Location Address

Where did injury/illness occur?

Maximum 255 Characters.

Make Loss Location same as Claim Reporting Location:

Claim Reporting Location Name:

Address: *

City: *

ZIP: *

Primary Physical Work Location

Make Primary Physical Work Location the same as Loss Location:

Address: *

City: *

State: *

ZIP: *

Physical Work Location Unknown:

Medical Attention Required: *

Were Safeguards/Safety Equipment Used?

Was Employee injured during employment?

Is Employee Represented by Attorney?

Did Injury or Illness Occur on Employer's Premises?

Were Safeguards or Safety Equipment Provided?

Does Employer Question the Claim?

Were Drugs or Alcohol Involved?

Where did injury/illness occur? is a freeform field. Use this field to indicate the specific location of the injury such as "Rear stairwell" or "Patient Room 27A".

Check the **Make Loss Location same as Claim Reporting Location** box if the injury occurred at the same physical address as the loss location. If not, complete the address.

If the injured worker's primary physical work location is the same as the loss location address, check the box. If not, complete the address. If the primary physical work location is unknown, check the **Primary Work Location Unknown** box.

Complete the **Medical Attention Required** field. If you are unsure, select Unknown.

Physician/Health Care Provider and Hospital/Provider Information

If you know the injured work was treated at an occupation health center, clinic or hospital, expand the appropriate section and complete the provider information. Any information you can provide will be helpful.

▼ Physician / Health Care Provider Name and Address			
Name:	<input type="text"/>	Address:	<input type="text"/>
Telephone:	<input type="text"/>	City:	<input type="text"/>
		State:	<input type="text"/> Q
		ZIP:	<input type="text"/>
▼ Hospital / Provider Information			
Name:	<input type="text"/>	Address:	<input type="text"/>
Telephone:	<input type="text"/>	City:	<input type="text"/>
		State:	<input type="text"/> Q
		ZIP:	<input type="text"/>

Preparer and Contact Information

Other Information	
Date Prepared:	<input type="text" value="06/10/2025"/>
Preparer's Information	
First Name: *	<input type="text" value="John"/>
Last Name: *	<input type="text" value="Smith"/>
Telephone: *	<input type="text" value="(999) 555-1212"/>
Employer Contact Information (If different than Preparer)	
First Name:	<input type="text"/>
Last Name:	<input type="text"/>
Telephone:	<input type="text"/>

Your name and phone number will prefill in the Preparer section. Please complete the **Employer Contact Information** if we should reach out to someone other than you to discuss the claim.

Witness Information

Please expand and complete the witness information section if there were witnesses to the injury.

▼ Witness Contact Information			
First Name:	<input type="text"/>	Telephone:	<input type="text"/>
Middle Name:	<input type="text"/>	Occupation:	<input type="text"/>
Last Name:	<input type="text"/>		
▼ Additional Witness Contact Information			
First Name:	<input type="text"/>	Telephone:	<input type="text"/>
Middle Name:	<input type="text"/>	Occupation:	<input type="text"/>
Last Name:	<input type="text"/>		

Claim Submission

Claim Submission

Comments (Intake)

Maximum 900 Characters.

Record Only (no medical treatment and no lost time)

Type any additional information about the claim in the **Comments** box. Your comments will become the first log note in the file. Treat this information as legally discoverable.

Check the **Record Only** box when the claim is for informational purposes only. Record Only claims will not be assigned to an adjuster.

For Workers' Compensation, this means an injured worker will not be seeking medical treatment and will not be losing any time from work. If you submit a Record Only claim, and the situation changes, please contact us at 888-476-2669 to have the claim assigned to an adjuster.

Claim Information Email

Claim Information Email

Additional Emails to copy on Notification:

Distribution list - Account Level:

Location Distribution List:

You will automatically receive an email copy of the claim information provided. This email will include our claim number. If you would like to send a copy of the claim information to someone else, enter the email address in the **Additional Emails to copy on Notification** field. Your employer may have a standard distribution list for these new claim emails. If so, you will see email address(es) in the Account Level or Location Distribution List.

Claim Submission and Uploading Documents

Claim Submission

When you are finished, click **Submission Complete** at the top or bottom of the page.

Files and other documents can be attached on the next page at the top of the page.

Submitter Details

Select **Submission Complete** After you have confirmed that all information on your submission looks correct
Select **Save Progress** If you'd like to save your progress on the form

Submission Complete Save Progress
Return to Coverage Screen

After clicking **Submission Complete**, you may see a notification indicating missing required fields. If so, complete the missing information and click Submission Complete to file the claim.

New Claim

Please correct the following errors.

- **Address:** A value is required.
- **City:** A value is required.
- **ZIP:** A value is required.
- **Date of Injury/Illness:** A value is required.
- **Date Employer Notified:** A value is required.
- **SSN:** A value is required.

Address: * A value is required.
Address 2:
City: * A value is required.
State: * A value is required.
ZIP: * A value is required.
Birth Date: * A value is required.
SSN: * A value is required.

You will see a notification that your claim was saved successfully. To view the PMA claim number, click the **Click Here to obtain the PMA Claim Number** button. The claim number will appear in the blue banner next to the account name and number. Please note, even if you do not click that button, the PMA Claim Number will be assigned and will be included in the email notification.

RADIUS®

Claims >
Sample Account (1234567) - 688 - 6/12/2025 ☆

Save Successful.
Click Here to obtain the PMA Claim Number

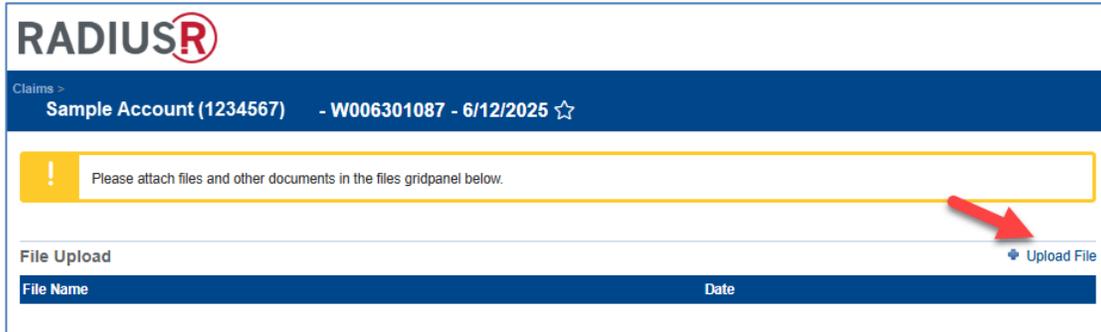
Please attach files and other documents in the files gridpanel below.

File Upload Upload File

File Name	Date
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Uploading Documents

To submit additional documentation, such as internal investigation reports, surveillance footage, medical reports or photographs, click the **Upload File** link.

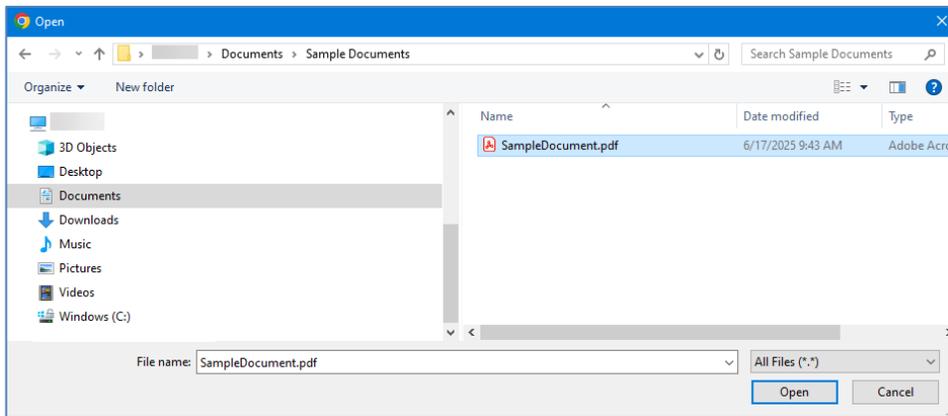


Click the **Choose File** button to upload a single document or the **Upload Multiple Files** button to attach multiple documents.

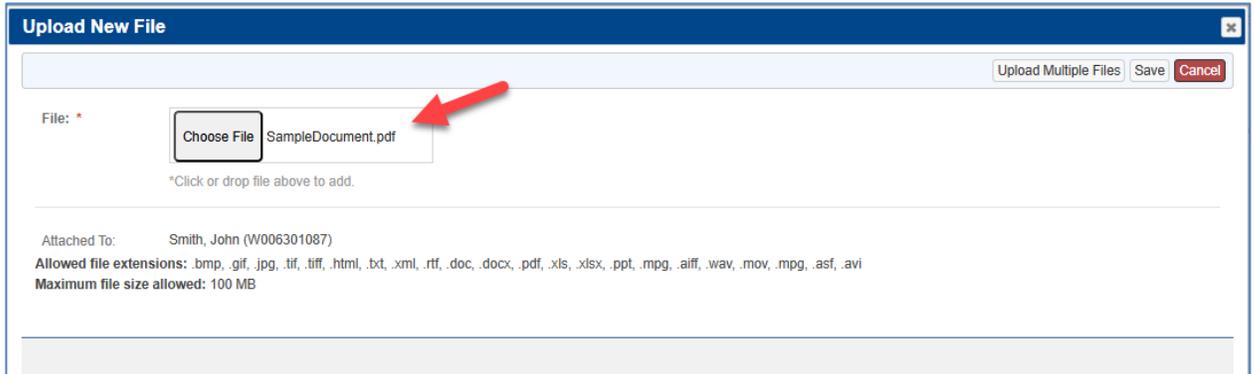


The File Explorer window will open. Navigate to the folder where you have stored the document(s) you want to upload. Select the file(s) you would like to submit and click **Open**.

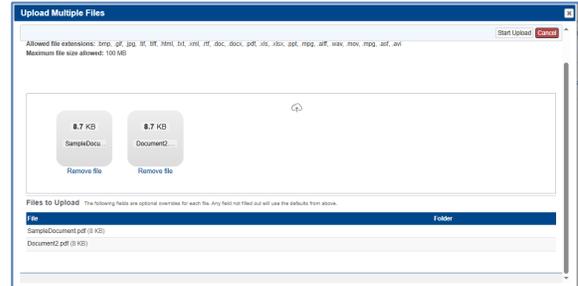
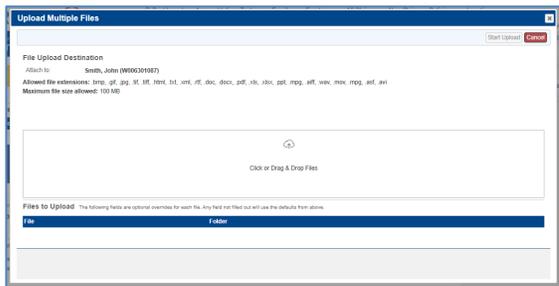
Please note, your corporate IT policy may prohibit this step. In that case, you can email your document(s) to PMA at claimsmail@pmagroup.com. Be sure to include the claim number in the subject line.



When uploading a single document, the name of the selected document will appear next to the **Choose File** button. Click **Save** to upload the document.



When uploading multiple documents, the name of the documents will appear in the list under the **Click or Drag & Drop Files** box. Click **Start Upload** to upload the documents.



When the upload is complete, you can attach more files, close the application, or enter a new claim.

Any documents uploaded will be scanned for viruses. You will see the status of the virus scan in parentheses after the file name.

File Upload		Upload File
File Name	Date	
SampleDocument.pdf (Allowed: scanned)	06/19/2025 6:19 PM	✖
Document2.pdf (Queued for scanning)	06/19/2025 6:45 PM	✖

Auto Claims

Loss Information

New Claim
Account Name: Sample Account - 1234567
Coverage: AUTO
Submitter Details
Select **Submission Complete** After you have confirmed that all information on your submission looks correct
Select **Save Progress** if you'd like to save your progress on the form
Submission Complete | Save Progress
Return to Coverage Screen
Loss Information
Date of Occurrence: * []
Time of Occurrence: []
Contact First Name: * []
Contact Last Name: * []
Location of Loss: * []
Address: []
City: []
State of Loss: * []
ZIP: []
Contact Business Phone: * []
Violations/Citations: - None Selected -
Authority Contacted: []
Report Number: []
Describe Loss: * []
Maximum 500 Characters.

Insured Vehicle/Insured Driver Information

Insured Vehicle Information
Make: []
Model: []
Year: - None Selected -
VIN: []
Body Type: []
Plate No. []
Vehicle No. []
State: []
Insured Vehicle Driver Information
First Name: []
Last Name: []
Address: []
City: []
State: []
Zip: []
Residence Phone: []
Business Phone: []
Check if Driver is Injured:
Description of Injury: []
Maximum 300 Characters.
Check if Driver is Owner:
Relation to Insured: - None Selected -
Date of Birth: []
Driver's License # []
License State: []
Purpose of Use: - None Selected -
Used with Permission? - None Selected -
Check if Fatal:



Insured Vehicle Owner/Insured Vehicle Damage Information

Insured Vehicle Owner Information	
First Name:	<input type="text"/>
Last Name:	<input type="text"/>
Organization Name:	<input type="text"/>
Residence Phone:	<input type="text"/>
Business Phone:	<input type="text"/>
Address:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/> <input type="button" value="Q"/>
Zip:	<input type="text"/>
Insured Vehicle Damage Information	
Describe Damage:	<input type="text"/>
	Maximum 300 Characters.
Estimate Amount:	<input type="text"/>
Where can vehicle be seen?	<input type="text"/>
When can vehicle be seen?	<input type="text"/>
Other Vehicle / Property Insurance?	<input type="text" value="- None Selected -"/>
Other Insurance on Insured Vehicle Information:	<input type="text"/>

Property Damage Information

To report property damage, select Property Damage

Damage Information (Select One)	
Indicate vehicle or property damage:	<input checked="" type="radio"/> Property Damage <input type="radio"/> Vehicle Damage
Describe Property	
Describe Property:	<input type="text"/>
	Maximum 300 Characters.
Property Owner Information	
Owner First Name:	<input type="text"/>
Last Name:	<input type="text"/>
Organization Name:	<input type="text"/>
Residence Phone:	<input type="text"/>
Check if Property Owner is Injured:	<input type="checkbox"/>
Description of Injury:	<input type="text"/>
	Maximum 300 Characters.
Address:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/> <input type="button" value="Q"/>
Zip:	<input type="text"/>
Business Phone:	<input type="text"/>
Check if Injury is Fatal:	<input type="checkbox"/>

Property Damage Information

To report other vehicle damage, select Vehicle Damage

Damage Information (Select One)

Indicate vehicle or property damage: Property Damage Vehicle Damage

Describe Vehicle

Make:	<input type="text"/>	Body Type:	<input type="text" value="- None Selected -"/>
Model:	<input type="text"/>	Plate No.:	<input type="text"/>
Year:	<input type="text"/>	Vehicle No.:	<input type="text"/>
VIN:	<input type="text"/>	State:	<input type="text" value="- None Selected -"/>

Other Driver Information

Check if Driver is Owner:	<input type="checkbox"/>	Address:	<input type="text"/>
First Name:	<input type="text"/>	City:	<input type="text"/>
Last Name:	<input type="text"/>	State:	<input type="text"/>
Residence Phone:	<input type="text"/>	Zip:	<input type="text"/>
Business Phone:	<input type="text"/>	Check if Fatal:	<input type="checkbox"/>
Check if Driver is Injured:	<input type="checkbox"/>	Description of Injury: <input type="text"/> Maximum 300 Characters.	

Property/Other Vehicle Damage Information

Describe damage to the property or other vehicle and include estimate information if available.

Property / Other Vehicle Damage Information

Describe Damage:	<input type="text"/> Maximum 300 Characters.	Estimate Amount:	<input type="text"/>
		Where can damage be seen:	<input type="text"/>
		When can damage be seen:	<input type="text"/>

Party Information

Expand and complete information for Party 1 and Party 2, if details are available.

▼ **Party 1**

First Name:	<input type="text"/>	Address:	<input type="text"/>
Last Name:	<input type="text"/>	City:	<input type="text"/>
Phone:	<input type="text"/>	State:	<input type="text"/> <input type="button" value="Q"/>
Description of Injury:	<input type="text"/>		

Maximum 300 Characters.

Injury is Fatal:

Passenger in which Vehicle? Passenger in Insured Vehicle Passenger in Other Vehicle

Passenger in Vehicle Information: Injured in the accident Witness to the accident

> **Party 2**

Witness Information

Expand and complete information for Witness 1 and Witness 2, if details are available.

▼ **Witness 1**

First Name:	<input type="text"/>	Address:	<input type="text"/>
Last Name:	<input type="text"/>	City:	<input type="text"/>
Phone:	<input type="text"/>	State:	<input type="text"/> <input type="button" value="Q"/>
		ZIP:	<input type="text"/>

> **Witness 2**

Reporting Party Information

Complete reporting party information, if available.

Reporting Party Information

Reported by First Name:

Reported by Last Name:

Remarks:

Maximum 500 Characters.

Reported To:

Claim Submission

Claim Submission

Comments (Intake)

Maximum 900 Characters.

Record Only:

Type any additional information about the claim in the **Comments** box. Your comments will become the first log note in the file. Treat this information as legally discoverable.

Check the **Record Only** box when the claim is for informational purposes only. Record Only claims will not be assigned to an adjuster.

Claim Information Email

Claim Information Email

Additional Emails to copy on Notification:

Distribution list - Account Level:

Location Distribution List:

You will automatically receive an email copy of the claim information provided. This email will include our claim number. If you would like to send a copy of the claim information to someone else, enter the email address in the **Additional Emails to copy on Notification** field. Your employer may have a standard distribution list for these new claim emails. If so, you will see email address(es) in the Account Level or Location Distribution List.

When you are finished, click **Submission Complete** at the top or bottom of the page. You will then receive the PMA claim number and have the opportunity to upload documents.

Property Claims

Loss Information

New Claim

Account Name: Sample Account - 1234567
Coverage: Property

Submitter Details
Select **Submission Complete** After you have confirmed that all information on your submission looks correct
Select **Save Progress** If you'd like to save your progress on the form

Loss Information

Date of Occurrence: *	<input type="text"/>	Estimated Loss Amount:	<input type="text"/>
Time of Occurrence:	<input type="text"/>	Kind of Loss:	<input type="text"/>
Contact First Name: *	<input type="text"/>	Describe Loss: *	<input type="text"/>
Contact Last Name: *	<input type="text"/>		Maximum 500 Characters.
Contact Business Phone: *	<input type="text"/>		
Location of Loss: *	<input type="text"/>	Description of Damage:	<input type="text"/>
Address:	<input type="text"/>		Maximum 500 Characters.
City:	<input type="text"/>		
State of Loss: *	<input type="text"/>		
Zip:	<input type="text"/>		

Claim Submission

Claim Submission

Comments (Intake)

Maximum 900 Characters.

Record Only:

Type any additional information about the claim in the **Comments** box. Your comments will become the first log note in the file. Treat this information as legally discoverable.

Check the **Record Only** box when the claim is for informational purposes only. Record Only claims will not be assigned to an adjuster.

Claim Information Email

Claim Information Email

Additional Emails to copy on Notification:

Distribution list - Account Level:

Location Distribution List:

You will automatically receive an email copy of the claim information provided. This email will include our claim number. If you would like to send a copy of the claim information to someone else, enter the email address in the **Additional Emails to copy on Notification** field. Your employer may have a standard distribution list for these new claim emails. If so, you will see email address(es) in the Account Level or Location Distribution List.

When you are finished, click **Submission Complete** at the top or bottom of the page. You will then receive the PMA claim number and have the opportunity to upload documents.

General Liability Claims

Loss Information

New Claim Cancel

Account Name: Sample Account - 1234567
Coverage: General Liability

Submitter Details
Select **Submission Complete** After you have confirmed that all information on your submission looks correct
Select **Save Progress** if you'd like to save your progress on the form

Loss Information

Date of Occurrence: *	<input type="text"/>	Contact Business Phone: *	<input type="text"/>
Time of Occurrence:	<input type="text"/>	Authority Contacted:	<input type="text"/>
Contact First Name: *	<input type="text"/>		
Contact Last Name: *	<input type="text"/>		
Location of Loss: *	<input type="text"/>	Describe Loss: *	<input type="text"/>
Address:	<input type="text"/>		Maximum 500 Characters.
City:	<input type="text"/>		
Zip:	<input type="text"/>		
State of Loss: *	<input type="text"/>		

Claimant Information

Claimant Information

First Name:	<input type="text"/>	Address:	<input type="text"/>
Last Name:	<input type="text"/>	City:	<input type="text"/>
Organization:	<input type="text"/>	State:	<input type="text"/>
Birth Date:	<input type="text"/>	Zip:	<input type="text"/>
Social Security:	<input type="text"/>		
Phone:	<input type="text"/>		

Check if Injury is Fatal:

Description of Injury:
Maximum 1000 Characters.

Where was Injured Person Taken:
Maximum 500 Characters.

What was Injured Person Doing Prior to Injury:
Maximum 500 Characters.



Property Damage Information

To report property damage, select Property Damage

Indicate Damage to Vehicle or Property (SELECT ONE) Property Damage Vehicle Damage

Describe Property

Describe Property:

Vehicle Damage Information

To report property damage, select Property Damage

Indicate Damage to Vehicle or Property (SELECT ONE) Property Damage Vehicle Damage

Describe Vehicle

Make:

Model:

Year:

VIN:

Property/Vehicle Damage Information

Describe damage to the property or other vehicle and include estimate information if available.

Property/Vehicle Damage Information

Estimate Amount:

Where can property be seen:

When can property be seen:

Witness Information

Expand and complete information for Witness 1 and Witness 2, if details are available.

▼ **Witness Information 1**

First Name:	<input type="text"/>	Address:	<input type="text"/>
Last Name:	<input type="text"/>	City:	<input type="text"/>
Residence Phone:	<input type="text"/>	State:	<input type="text"/> Q
Business Phone:	<input type="text"/>	Zip:	<input type="text"/>

► **Witness Information 2**

Reporting Party Information

Reporting Party Information

Reported by First Name:

Reported by Last Name:

Remarks:

Maximum 500 Characters.

Reported To:

Claim Submission

Claim Submission

Comments (Intake)

Enter miscellaneous claim details in the comments box

Maximum 900 Characters.

Record Only:

Type any additional information about the claim in the **Comments** box. Your comments will become the first log note in the file. Treat this information as legally discoverable.

Check the **Record Only** box when the claim is for informational purposes only. Record Only claims will not be assigned to an adjuster.

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Claim Information Email

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When you are finished, click **Submission Complete** at the top or bottom of the page. You will then receive the PMA claim number and have the opportunity to upload documents.

Helpful Hints

Claim Reporting

Fields with an arrow or a magnifying glass icon contain a list of predefined values.

For fields with an arrow, click the arrow to display a list of options.

Marital Status:

- None Selected -
- Common law spouse
- Divorced
- Married
- Separated
- Single
- Spouse deceased
- Unknown

To search for a value in a field with the magnifying glass, click the magnifying glass to view the full list of options and click the blue item desired.

Accident State	
Code	Description
AK	Alaska
AL	Alabama
AR	Arkansas
AZ	Arizona
CA	California
CO	Colorado
CT	Connecticut
DC	District of Columbia

For a smaller list of options, type a portion of the name or code and select the value desired.

Employee Information

Accident State: *

- Connecticut (CT)
- District of Columbia (DC)

Location of Loss: *

Date fields are indicated by a calendar icon. You can click on the calendar icon to select a date or, if you prefer, you can enter the date manually using the 4-digit year.

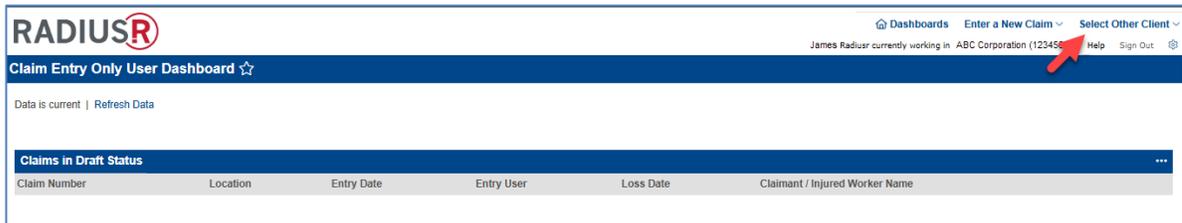
Date of Injury/Illness: *

Jun 2025

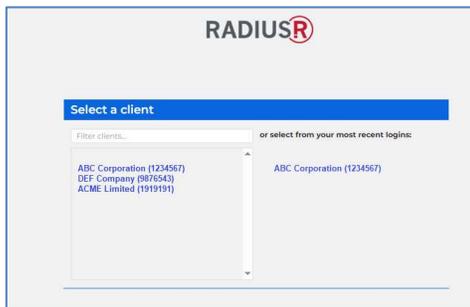
Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	1	2	3	4	5

Multiple Accounts

If you have access to multiple accounts and would like to switch to a different account, click Select Other Client on the upper right side of the screen. You will return to the Client Selection screen.



The screenshot shows the RADIUS user dashboard. At the top left is the RADIUS logo. The top right navigation bar includes 'Dashboards', 'Enter a New Claim', and 'Select Other Client'. Below this, a status bar indicates 'James Radius currently working in ABC Corporation (1234567)'. A red arrow points to the 'Select Other Client' dropdown menu. Below the navigation is a 'Claim Entry Only User Dashboard' header with a 'Refresh Data' link. The main content area is titled 'Claims in Draft Status' and contains a table with columns: Claim Number, Location, Entry Date, Entry User, Loss Date, and Claimant / Injured Worker Name.



The screenshot shows a 'Select a client' dialog box. It features a search input field labeled 'Filter clients...' and a list of client options. The list includes 'ABC Corporation (1234567)', 'DEF Company (9876543)', and 'ACME Limited (1919191)'. To the right of the list, there is a section titled 'or select from your most recent logins:' which also displays 'ABC Corporation (1234567)'.