GUIDEONE INSURANCE

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GuideOne.com

SB 1159 COVID-19 REPORTING FORM 2 - CA

Reporting Period: On or After 9/16/2020

IMPORTANT NOTICE: If you have a California 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 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 GuideOneCACovid19@guideone.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.

1. Employer name: _____
   Employer Street Address: _____
   City: _____ State Abbreviation: _____ Zip Code: _____
   GuideOne policy number: _____
2. If available, please provide the employee ID number: _____
   (**Note**: 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 have reported to work at this specific location in the last 45 day periods preceding the last day the employee worked at this location?		What is the highest number of employees who have reported to work at this specific location in the last 45 day periods 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:

   _____ _____ _____
   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: _____ _____
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.