

# Labor Claims - External

## Filing a Claim

Once the Labor Claim process has been initiated, the Start Form will display, enter some preliminary information and then you can start filing the Claim

The screenshot shows a web form titled "Start New Action" with a sub-section "Start a Worker's Compensation Labor Claim". Below this is a "Claim Information" section with the following fields: First Name, Last Name, Date Of Birth, Email, Date of Accident, Middle Name, Suffix, and SSN. The Date Of Birth and Date of Accident fields have a date format of MM/dd/yyyy. The Suffix field is a dropdown menu with "Please select..." as the current selection. There are help icons (question marks) next to several fields.

**1** Enter the Labor Claim information on the Start Form. If the user is found to be registered to CompHub, the Claimant Contact information will be pulled directly from their profile

**2** If necessary, enter the Contact Information in the proper section.

The screenshot shows the "Claimant" section of the form. The "Claimant" section is pre-filled with the following information: First Name: Zoraida, Middle Name: (empty), Last Name: Suarez, Suffix: Please select..., Date of Birth: 01/01/1980, SSN: 123456789. The "Claimant Contact Information" section is also pre-filled: Email: zoraida.suarez@wcc.invalid.com, Phone Number: (empty), Ext: (empty), Country Code: 1, Address: Country: US, Address Line 1: 10 E BALTIMORE ST, State: AL, Address Line 2: (empty), Postal Code: 21202-1630, Address Line 3: (empty), City: BALTIMORE. There is an "Edit Address" button at the bottom left.

**Claimant Contact Info. Prefilled**

The screenshot shows the "Claimant" section of the form. The "Claimant" section is pre-filled with the following information: First Name: Kimberly, Middle Name: (empty), Last Name: Weeden, Suffix: Please select..., Date of Birth: 01/02/1960, SSN: (empty). The "Claimant Contact Information" section is blank: Email: (empty), Phone Number: (empty), Ext: (empty), Country Code: 1, Address: Country: US, Address Line 1: (empty), State: MD, Address Line 2: (empty), County: Please select..., Address Line 3: (empty), City: (empty). There is a "Verify Address" button at the bottom right and a red text prompt "Please verify this address with USPS" below it.

**Claimant Contact Info. Blank**

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## Filing a Claim (Cont.)

Fill out the remainder of the Claim Form using the various textboxes, dropdowns, and checkboxes provided.

1 Enter the Claim Information in the textbox provided.

▼ Claim Information

Date of Accident: 05/04/2023

Other Information

2 Click Advanced Search to open the Search form and find the proper Employer.

▼ Employer

**REQUIRED:** Select Advanced Search to provide the details of the employer for whom the claimant was working at the time of the accident. If the employer is not already located in Commission records, also use the Advanced Search button to enter the new employer.

**Advanced Search**

To delete / edit a particular row, select the corresponding row and then click on the appropriate icon (delete / edit).

▼ Employer

No records			
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Search Criteria

Location Name: FLASHPOINT LLC

Registered Name:

FEIN:

Location Address

Street:

City:

Postal Code:

If in case your business is not found, please add your business details

▼ Please select an item

Registered Name	FEIN	Location Name	Address
FLASHPOINT LLC	272092349	FLASHPOINT LLC	6436 RUXTON DR ELKRIDGE MD 21075-6309

Search Cancel

▼ Attachments

Please click + icon below to add new supporting document(s)

All attachments should be converted to PDF format before uploading

To delete / edit a particular row, select the corresponding row and then click on the appropriate icon (delete / edit).

3 Add any attachments using the Attachments table.

▼ Attachments

Document Type	Description
Supporting Documents	Labor Claim-Discharge Summary

4 Don't forget to Sign & Certify

▼ Certifications and Signature

I HEREBY CERTIFY that on June 2, 2023, that service of the foregoing was made in accordance with COMAR 14.09.01.03.

By checking this box, I affirm this is the electronic signature of the submitter for all purposes under the Maryland Workers' Compensation Law, Title 9 of the Labor & Employment Article of the Annotated Code of Maryland and the Maryland Uniform Electronic Transactions Act, Title 21 of the Commercial Law Article of the Annotated Code of Maryland.

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## Filing a Claim (Cont.)


Once the Claim has been successfully submitted, CompHub presents a three(3)-tab form; The PDF view tab allows a user to view/print/download the PDF copy of the form, Labor Claim shows a read-only version of the submission, and Claim Documents displays all documents in the Claim File.

To print or download the document use the icons in the top right hand corner.

PDF View Labor Claim Claim Documents

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**NOTICE OF LABOR CLAIM**  
**WORKERS' COMPENSATION COMMISSION**  
10 E. Baltimore St., Baltimore, MD 21202-1641  
Baltimore, Maryland 21202-1641  
BALTIMORE PHONE 410-864-5100  
Toll Free (MD): 1-800-492-0479  
TTY USERS CALL VIA MARYLAND RELAY



CLAIM NUMBER  
**L400373**

DATE STAMP RECEIVED  
06/02/2023

CLAIM STATUS  
Submitted

**CLAIMANT INFORMATION**

Claimant's Name	Zoraida Suarez	SS#	***-**-6789
Mailing Address	10 E BALTIMORE ST BALTIMORE AL 21202-1630	Date of Birth	01/01/1980
Email	zoraida.suarez@wcc.invalid.com	Phone	

**CLAIM INFORMATION**

Date of Accident	05/17/2023
Other Information	

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