ACORD ™ WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	REPORT PURPOSE CODE
Affiniti Golf Partners, LLC DBA: Bobby Jones Links 6716 Jamestown Drive Alpharetta, GA 30005	JURISDICTION / JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER	

SIC CODE	EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	LOCATION #
	263671531		PHONE # COUNTY

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Technology Insurance Company, Inc. 800 Superior Avenue East, 21st Floor Cleveland, OH 44114	3/18/2025 TO 3/18/2026 CHECK IF APPROPRIATE ☐ SELF INSURANCE	To Report a Claim By Phone: 1-866-272-9267 To Report a Claim By Fax: 1-877-669-9140 To Report a Claim My Email: WorkersCompClaimReport@AmTrustgroup.com

CARRIER FEIN	POLICY / SELF INSURED NUMBER	ADMINISTRATOR FEIN
02-0449082	TWC4595163	

AGENT NAME & CODE NUMBER

Baldwin Krystyn Sherman Partners, LLC -# 162152

EMPLOYEE / WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE

ADDRESS (INCL ZIP)	SEX	MARITAL STATUS	OCCUPATION / JOB TITLE
	☐ MALE ☐ FEMALE ☐ UNKNOWN	☐ UNMARRIED (SNGL/DIV) ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	EMPLOYMENT STATUS
PHONE HOME WORK	# OF DEPENDENTS		NCCI CLASS CODE

RATE PER:	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? / DID SALARY CONTINUE
☐DAY ☐MONTH ☐WEEK ☐OTHER:		☐ YES ☐ NO ☐ YES ☐ NO

OCCURRENCE / TREATMENT

TIME EMPLOYEE BEGAN WORK	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME / PHONE NUMBER	TYPE OF INJURY / ILLNESS	PART OF BODY AFFECTED
DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY / ILLNESS CODE	PART OF BODY AFFECTED

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECT OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? / WERE THEY USED?
		☐ YES ☐ NO ☐ YES ☐ NO

	HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT
WITNESS (NAME & PHONE)		☐ NO MEDICAL TREATMENT ☐ MINOR BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HRS ☐ FUTURE MAJOR MED/LOST TIME ANTICIPATED

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER