

* Denotes required field

Please note: The fields highlighted in grey are pre-populated in the online system.

Date of injury: *	Policy number:	Policy name:	Case # from OSHA Log (if applicable):
Filing date:	Claim type: * <input type="checkbox"/> Incident <input type="checkbox"/> Indemnity <input type="checkbox"/> Medical only		Jurisdiction:

What is your name? *	What is your job title?		
What is your telephone number? *	What is your fax number?	What is your email address?	
Are you the contact for this claim? <input type="checkbox"/> No <input type="checkbox"/> Yes		If no, who should we contact for additional information?	
What is the contact's phone number?		What is the contact's email?	
Is this a Federal Longshore (USL&H) claim? <input type="checkbox"/> No <input type="checkbox"/> Yes		Are you reporting a fatality? <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of death: *
Date of injury/date of last exposure: *		What is your policy number? *	
What is the employee's ID type? *	<input type="checkbox"/> Employment Visa number <input type="checkbox"/> Green Card number <input type="checkbox"/> Passport number <input type="checkbox"/> Social Security number	ID number: *	
What is the employee's name?	First: *	MI:	Last: * Suffix:
What is the employee's mailing address? Street/P.O. Box: *			
Zip: *	City: *	State: *	Country:
What is the employee's physical address? Street/P.O. Box:			
Zip:	City:	State:	Country:
What is the employee's primary telephone number?		What is the employee's alternate telephone number?	
What is the employee's regular work schedule?			

What is the employee's date of birth? *	Gender: * <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		
Marital status: * <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Common law <input type="checkbox"/> Unknown			
What is the industrial code? *	What is the job title? *		
Description of employee's job and regular duties:			

POLICY / DEMOGRAPHIC QUESTIONS

DEMOGRAPHIC / WAGE QUESTIONS

What is the employee's hire date? *		What is the state of hire for this employee?	
Employment type: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Volunteer		Is the employee: An officer? <input type="checkbox"/> No <input type="checkbox"/> Yes An owner/part owner? <input type="checkbox"/> No <input type="checkbox"/> Yes	
What is the hourly rate of pay for this employee?		What are the number of hours worked per week for this employee?	
What is the daily rate of pay for this employee?	How many hours per day did the employee work?	How many days per week did the employee work?	
Is there any additional wage information not included in the daily rate (i.e. commissions, etc.)?			
Is the employee continuing to receive full wages? <input type="checkbox"/> No <input type="checkbox"/> Yes			

What is the primary work location? *			
Name:			
Address: *			Country:
Zip: *	City: *	State: *	
What is the reporting location?			
Did the accident occur on the employer's property? * <input type="checkbox"/> No <input type="checkbox"/> Yes			
If no, where did the accident occur? *		Address:	
Name: *			
Zip:	City:	State:	Country:
Was this the employee's regular department? <input type="checkbox"/> No <input type="checkbox"/> Yes		In what department did the accident occur?	
Was injury the result of a motor vehicle accident? <input type="checkbox"/> No <input type="checkbox"/> Yes		Was any equipment involved in the injury? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what equipment?	
What was the employee doing just before the incident occurred?			
How did the accident occur? *			
What object or substance directly harmed the employee?			
Was safety equipment provided? <input type="checkbox"/> No <input type="checkbox"/> Yes		Was safety equipment used? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, what type?			
What was the injured body part(s)? *			
What is the body part location? * <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Lower <input type="checkbox"/> Middle <input type="checkbox"/> Right <input type="checkbox"/> Upper <input type="checkbox"/> Not applicable			
What is the nature of the injury (sprain, strain, etc.)? *			
What was the cause of injury? *			
Are you aware of a previous injury to this body part? * <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain: *			
Do you have knowledge of pre-existing disability, industrial or non-industrial? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain: *			
Are there outside activities or medical conditions that would affect this injury? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain: *			

List all **others** involved in the accident with contact information:

1.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
2.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
3.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			

List all **witnesses** to the accident (or enter "none"):

1.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
2.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			
3.	First name:	MI:	Last name:	
	Address:			
	Zip:	City:	State:	Country:
	Phone:			

RETURN-TO-WORK QUESTIONS

What time did the employee begin work? * (Include a.m. or p.m.)	
What time did the accident occur? * (Include a.m. or p.m.)	Who was notified of the accident?
When did the injured worker notify the employer? * (Date)	Did the claimant stop work? <input type="checkbox"/> No <input type="checkbox"/> Yes
What is the loss type? <input type="checkbox"/> Incident only <input type="checkbox"/> Indemnity <input type="checkbox"/> Medical only <input type="checkbox"/> Modified duty with no wage loss <input type="checkbox"/> Modified duty with wage loss	
What was the last date worked?	What time did the employee stop work? (Include a.m. or p.m.)
Has the employee returned to work? <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of return to work?
Did/will the claimant return to full duty? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have transitional/modified work available? <input type="checkbox"/> No <input type="checkbox"/> Yes
Number of hours per week?	Modified daily rate of pay?

MEDICAL QUESTIONS

Was medical treatment provided? <input type="checkbox"/> No <input type="checkbox"/> Yes		Name of medical provider:	
Medical facility/provider's address:			
Zip:	City:	State:	Country:
Was employee treated in an emergency room? <input type="checkbox"/> No <input type="checkbox"/> Yes		Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> No <input type="checkbox"/> Yes	
What was the method of transportation? <input type="checkbox"/> Helicopter <input type="checkbox"/> Ambulance <input type="checkbox"/> Personal vehicle <input type="checkbox"/> Other			
Do you require your employees to be drug tested? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, when was the employee last tested?	
Was an incident report completed? * <input type="checkbox"/> No <input type="checkbox"/> Yes		Do you have any reason to question this injury? * <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have any comments for the record?			