

FIRST REPORT of Injury or Occupational Disease

Montana Schools Group

WCRRP

Workers' Compensation Risk Retention Program

Send Completed form to:

MTSBA Insurance Services

PO Box 7029

Helena, MT 59604

Toll Free: 1-877-667-7392

Fax: 406-457-4505

Worker

LAST NAME		FIRST NAME		M.I.	DATE OF BIRTH (m/d/yyyy)		SOCIAL SECURITY NUMBER	
HOME ADDRESS				CITY		STATE	POSTAL CODE	
PHONE NUMBER	EDUCATION ☐ LESS THAN HIGH SCHOOL ☐ GED OR HIGH SCHOOL DIPLOMA ☐ BEYOND HIGH SCHOOL		GENDER ☐ MALE ☐ UNKNOWN ☐ FEMALE		MARITAL STATUS ☐ MARRIED ☐ SEPARATED ☐ SINGLE ☐ UNKNOWN		NUMBER OF DEPENDANTS	

Wages

DATE HIRED	GROSS EARNINGS FOR FOUR PAY PERIODS PRECEDING THE INJURY	DATE/AMOUNT /	DATE/AMOUNT /	DATE/AMOUNT /	DATE/AMOUNT /
EMPLOYMENT STATUS ☐ FULL TIME ☐ PART TIME ☐ SEASONAL ☐ VOLUNTEER		NUMBER OF DAYS WORKED PER WEEK:	WAGE: ☐ HOUR ☐ WEEK ☐ MONTH ☐ OTHER: ☐ DAY ☐ BI-WEEKLY ☐ YEAR		
IN ADDITION TO GROSS EARNINGS CITED ABOVE WORKER RECEIVED: ☐ OVERTIME ☐ BONUS ☐ OTHER ESTIMATED VALUE:					HOURS WORKED PER DAY:
WORKED NEXT SCHEDULED SHIFT ☐ YES ☐ No	OFF WORK MORE THAN 4 WORK DAYS ☐ YES ☐ No ☐ NOT SURE	DATE LAST WORKED	DATE OF RETURN TO WORK	FULL WAGES PAID FOR DATE OF INJURY? ☐ YES ☐ No	SALARY CONTINUED? ☐ YES ☐ No
OCCUPATION OF INJURED WORKER	INJURED ASSIGNED TO: ☐ ELEMENTARY ☐ MIDDLE ☐ HIGH SCHOOL ☐ AMIN.		SCHOOL SITE/BUILDING WHERE INJ. EMP. WORKS	PAYROLL CLASSIFICATION CODE: ☐ 8868 ☐ 9101	

Accident Description

DESCRIPTION OF ACCIDENT:						
CAUSE OF INJURY	CAUSE CODE	PART OF BODY	PART CODE	NATURE OF INJURY	NATURE CODE	DATE AND TIME OF INJURY /
DATE DISABILITY BEGAN:	DATE OF DEATH:		NAMES OF WITNESSES:	1)	2)	3)
ACCIDENT ON EMPLOYER'S PREMISES? ☐ YES ☐ No	ACCIDENT ADDRESS OR LOCATION IF OFF PREMISES: ADDRESS: CITY: STATE: POSTAL CODE:					
DATE EMPLOYER NOTIFIED:	ACCIDENT REPORTED TO:			SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ No		SAFETY EQUIPMENT USED? ☐ YES ☐ No

Medical

ATTENDING PHYSICIAN'S NAME:	ADDRESS:	CITY	STATE/ZIP	PHONE NUMBER:
HOSPITAL NAME:	ADDRESS:	CITY	STATE/ZIP	PHONE NUMBER:
TYPE OF INITIAL MEDICAL TREATMENT RECEIVED: ☐ NO TREATMENT ☐ EMERGENCY ROOM ☐ TREATMENT ON-SITE BY EMPLOYER OR MEDICAL STAFF ☐ CLINIC/DR. OFFICE ☐ HOSPITAL				

Signature

- This is my claim for workers' compensation benefits due to the on-the-job injury, occupation disease or death of the above named worker. **I understand** that signing this claim for compensation authorizes the release of rehabilitation records, Social Security records and health care information (medical records) relevant to this claim to the workers' compensation insurer and the insurer's agents. **I also understand** that if I obtain or exert unauthorized control over workers' compensation benefits, I may be fined and/or imprisoned.

Signature of Injured Worker or Beneficiary: _____ Date: _____

Employer

EMPLOYER NAME: HAVRE SCHOOL DISTRICT 16A		DOING BUSINESS AS:		FEDERAL EMPLOYER IDENTIFICATION NUMBER (TAX I.D.) 81-6000499	
MAILING ADDRESS: 425 6 TH STREET	CITY: HAVRE	STATE: MT	POSTAL CODE: 59501	PHONE NUMBER: (406)265-4356	
LOCATION OF OPERATION, IF DIFFERENT FROM MAILING ADDRESS:			NATURE OF BUSINESS OR SIC CODE: SCHOOL DISTRICT		SELF-INSURED? ☐ YES ☒ NO
DO YOU HAVE ANY REASON TO QUESTION THIS ACCIDENT? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN FULLY. USE SEPARATE SHEET IF YOU NEED ADDITIONAL SPACE.					WAS WORKER INJURED WHILE IN YOUR EMPLOY? ☐ YES ☐ NO
PREPARED BY:		OFFICIAL TITLE:			DATE:
AUTHORIZED EMPLOYER'S SIGNATURE:				TITLE:	DATE:

Insurer

CLAIM ADMINISTRATOR'S CLAIM NUMBER:	DATE REPORTED TO CLAIM ADMINISTRATOR:	THE ABOVE INFORMATION IS CORRECT WITH THE FOLLOWING EXCEPTIONS: ☐ (ATTACH EXTRA SHEETS IF BOX AT RIGHT IS CHECKED)	
CLAIM ADMINISTRATOR'S NAME: MTSBA INSURANCE SERVICES	CLAIM ADMINISTRATOR'S ADDRESS: PO Box 7029, HELENA, MT 59604		FEIN: 81-0460841
INSURANCE COMPANY NAME: MONTANA SCHOOLS GROUP INSURANCE AUTHORITY/ WCRRP	POLICY NUMBER:	POLICY EFFECTIVE DATE:	POLICY EXPIRATION DATE: