

FIRST REPORT of Injury or Occupational Disease**MTSBA Insurance Services**
Montana Schools Group Interlocal Authority

Send Completed form to:

MSGIA
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	
MAILING ADDRESS				CITY		STATE	POSTAL CODE	
CONTACT NUMBER	Employee Email address			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		PART OF BODY		NATURE OF INJURY		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 OR HOSPITAL		ADDRESS:		CITY	STATE/ZIP	PHONE NUMBER:
DATE OF FIRST TREATMENT						
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, occupational disease, or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer (and its agents) and to the Montana Uninsured Employers' Fund of: Social Security records; rehabilitation records; and all health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA), that are directly relevant to the claimed injury, disease, or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signature of Injured Worker or Beneficiary

Date

Employer

EMPLOYER NAME:		DOING BUSINESS AS:		FEDERAL EMPLOYER IDENTIFICATION NUMBER (TAX I.D.)		
MAILING ADDRESS:		CITY:	STATE: MT	POSTAL CODE:	PHONE NUMBER: (406)	
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.				WAS WORKER INJURED WHILE IN YOUR EMPLOY? ☐ YES ☐ NO
PREPARED BY:		OFFICIAL TITLE:		Phone Number:		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 INTERLOCAL AUTHORITY/WCRP		POLICY NUMBER:	POLICY EFFECTIVE DATE:	POLICY EXPIRATION DATE: