

Worker

Form for Worker information including Last Name, First Name, M.I., Date of Birth, Social Security Number, Mailing Address, City, State, Postal Code, Phone Number, Education, Gender, Marital Status, and Number of Dependents.

Wages

Form for Wages information including Date Hired, Gross earnings for four pay periods preceding the injury, Employment Status, Number of Days worked per week, Wage, Wage Period, and other details.

Accident Description

Form for Accident Description including Job Title, Description of Accident, Cause of Injury, Part of Body, Nature of Injury, Date Disability Began, Date of Death, Names of Witnesses, Accident on Employer's Premises, Accident Address or Location, Date Employer Notified, and Safety Equipment Provided/Used.

Medical

Form for Medical information including Attending Physician's Name, Address, State, Postal Code, Phone Number, Hospital Name, Address, State, Postal Code, Phone Number, and Type of initial medical treatment received.

Signature

Signature section containing a legal disclaimer: "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..."

Employer

Form for Employer information including Employer Name, Doing Business as, Federal Employer Identification Number (Tax I.D.), Mailing Address, City, State, Postal Code, Phone Number, Location of operation, Nature of Business SIC/NAICS Code, Self-Insured status, and other details.

Insurer

Form for Insurer information including Claim Administrator Claim Number, Date Reported to Claim Administrator, Claim Administrator Name, Claim Administrator Address, Claim Administrator FEIN, Insurer Name, Insurer FEIN, Policy Number, Policy Effective Date, and Policy Expiration Date.