Claims

GENERAL CASUALTY

Worker's Compensation
First Report of Injury or Loss

Reference

Policy number | Loss date | Loss time ☐ AM ☐ PM

Agent/Branch

Employer information

Name | Insured report number

Address | Employer Federal ID number

City | State | Zip

Employer's location address, if different

Name | Phone

Address | Location no. | County occurred

City | State | Zip

Employee information

Employee name | Last date employee worked

Employee address | Employee SSN

City | State | Zip

Employee job title | Employee date of birth

Job status | Hire date | Wage

Married: ☐ Yes ☐ No

Dependent information

Other comments

Occurrence

Injury/Illness type | Employee injury date

Body part affected | Date employer notified

Contact name | Contact phone

Occur on premises: ☐ Yes ☐ No Safeguards provided: ☐ Yes ☐ No Safeguards used: ☐ Yes ☐ No

Nature of injury

Cause of injury

Department or location where accident or illness or exposure occurred

Describe all equipment, materials or chemicals employee was using when it happened.

Describe activity employee was engaged in at time of accident/illness exposure.

Describe work process employee was engaged in at the time.

Describe sequence of events/objects that directly injured the employee or made the employee ill.

Witness information

Name | Home phone

Address | Work phone

City | State | Zip

Hospital/Clinic information

Name

Address

City | State | Zip

Physician information

Name

Address

City | State | Zip

Reported by

Name | Date reported | Time reported | AM ☐ | PM ☐

Loss information taken by

Name | ☐ | ☐