WORKERS' COMPENSATION TELEPHONE REPORTING GUIDE

Please do not delay in reporting the claim even if you do not have all the necessary information. We will produce and submit the necessary forms.

ACCOUNT/ACCIDENT INFORMATION

Caller's phone number and extension
Caller's title and name
Caller's email address
Reporting state – state where EE is permanently employed
Subsidiary name and address
Subsidiary mailing address (if different from above)
Did the accident occur at the location address? (if no, address where accident occurred)
Parent company / Insured's name
Location code
Policy symbol and number
Nature of business

EMPLOYEE INFORMATION

Employee's name
Gender
Social security number
Date of birth
Employee's mailing address
Employee's home phone number or cell number
Employee's home address (if different from mailing)

EMPLOYEE JOB INFORMATION

Employment status code (FT, PT, seasonal, volunteer, etc.)
Regular assigned department
Regular occupation
Department when injured
Occupation when injured
Employee's work schedule (regular work hours, hours per day, days per week)
Employee's wage information (hourly, annual, average weekly)
Does the employee work a varied Schedule?
Date of hire (if date of hire is unknown length of employment)
Supervisor's name, phone number and best hours to contact
Supervisor's email address

ACCIDENT INFORMATION

Date of injury
Time of injury
Date claim reported to employer
Was Injury fatal? (if yes, date of death)
Did employee lose any time from work? If yes,
What day did employee return to work?
Did Employee get paid for the date of injury?
Is the employee back at work?
Is employee on light/modified duty?
Is employee working his regular number of hours?
Accident description
Are you aware of any issues that would make you question this injury (Y/N) If YES are you questioning whether this injury is work related(Y/N)
Describe the reason why you question this injury is work related.
Cause of accident (e.g. slip/fall, lifting, and chemical)
Equipment, material, or substance involved
Names, addresses and phone numbers of witnesses

INJURY INFORMATION

Part of body injured (e.g. head, neck, arm, leg)
Nature of injury (e.g. fracture, sprain, laceration)
Prior injury or pre-existing condition(s) (if yes, describe)
Treatment - Note all that apply.
- First-aid (treatment and date of 1st treatment)
- Hospital/Clinic (name, address, phone number, physician name, treatment, date of 1st treatment, length of stay, ambulance used?)
- Was employee treated in an emergency room?
- Was employee hospitalized overnight as an inpatient?
- Physician (name, address, phone number, treatment, date of 1st treatment, specialty)
- Who is the primary contact for this claim? Name, title, phone number and email address

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STATE SPECIFIC INFORMATION

See WORKERS COMPENSATION – FIRST REPORT OF INJURY – STATE SPECIFIC QUESTIONS for your individual state.

COMMENTS