MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

SIC CODE

EMPLOYER FEIN

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ MALE (M)

☐ FEMALE (F)

☐ UNKNOWN (U)

MARITAL STATUS

☐ UNMARRIED/SINGLE/DIVORCED (U)

☐ MARRIED (M)

☐ SEPARATED (S)

☐ UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER:

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

NO MEDICAL TREATMENT (0) ☐

MINOR: BY EMPLOYER (1) ☐

MINOR CLINIC/HOSP (2) ☐

EMERGENCY CARE (3) ☐

HOSPITALIZED > 24 HRS (4) ☐

FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) ☐

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

SEE BACK FOR INSTRUCTIONS

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Immediately after an accident fill out this form and send to:

GALLAGHER BASSETT SERVICES, INC.

LOCATION
THIS ACCIDENT RESULTED IN:
☐ BODILY INJURY
☐ PROPERTY DAMAGE ONLY

ACCIDENT REPORT — GENERAL/PRODUCTS LIABILITY

(DO NOT USE FOR AUTO)

CLIENT

NAME		PHONE
ADDRESS		
CITY	STATE	ZIP

ACCIDENT

DATE OF LOSS	TIME OF LOSS	LOCATION OF LOSS	CITY	STATE	ZIP

OFFICIALS CALLED TO SCENE ☐ POLICE ☐ FIRE DEPT. ☐ AMBULANCE IF SO, IDENTIFY

CLAIMANT (PROPERTY DAMAGE)

NAME	ADDRESS	CITY	STATE	ZIP	PHONE
DESCRIBE DAMAGED PROPERTY	LOCATION OF PROPERTY	CITY	STATE	EXTENT OF DAMAGE	

CLAIMANT (BODILY INJURY)

NAME	AGE	ADDRESS	CITY	STATE	ZIP	PHONE
OCCUPATION		DESCRIBE EXTENT OF INJURY				

DESCRIPTION OF LOSS

WITNESS

NAME	ADDRESS	CITY	STATE	ZIP	PHONE
NAME	ADDRESS	CITY	STATE	ZIP	PHONE

IMPORTANT: HAS THIS ACCIDENT BEEN REPORTED TO OUR LOCAL EMERGENCY ADJUSTER? ☐ YES ☐ NO

IF REPORTED, NAME OF FIRM __________

ADDRESS __________

DATE ASSIGNED __________

DATE OF REPORT	SIGNATURE AND TITLE

LOCATION CODE
THIS ACCIDENT RESULTED IN: ☐ BODILY INJURY ☐ PROPERTY DAMAGE ONLY

Immediately after an accident fill out this form and send to:

GALLAGHER BASSETT SERVICES, INC.

ACCIDENT REPORT, AUTO AND TRUCK

(FOR BODILY INJURY OR DAMAGE TO ANOTHER'S PROPERTY OR FOR DAMAGE TO YOUR VEHICLE)

CLIENT

NAME / PHONE	DRIVER NAME / PHONE	DATE OF BIRTH
ADDRESS	ADDRESS	NUMBER OF YEARS WITH COMPANY
CITY / STATE / ZIP	CITY / STATE / ZIP	DRIVER'S LICENSE NO.

VEHICLE

MAKE OF YOUR VEHICLE	YEAR	MODEL	SERIAL NUMBER	LICENSE NUMBER	WHERE VEHICLE CAN BE SEEN
TRAILER (IF APPLICABLE)	YEAR	MODEL	AREA OF DAMAGE	USED FOR BUSINESS ☐ YES ☐ NO	ESTIMATED COST TO REPAIR $

ACCIDENT

DATE OF LOSS	TIME OF LOSS	LOCATION (STREET OR HIGHWAY)	CITY	STATE

WERE POLICE CALLED TO SCENE? ☐ YES ☐ NO	POLICE DEPT. CALLED	DRIVER	ARRESTED	TICKETED	VIOLATION
NAME OF OFFICER	BADGE NUMBER				
STATION ADDRESS					

CLAIMANT 1

OWNER OF OTHER VEHICLE	AGE	ADDRESS	CITY	STATE	ZIP	PHONE
DRIVER, IF OTHER THAN ABOVE	AGE	ADDRESS	CITY	STATE	ZIP	PHONE

MAKE OF VEHICLE	YEAR	MODEL	LICENSE NO.	AREA OF DAMAGE	ESTIMATE OF DAMAGE $	WHERE CAN VEHICLE BE SEEN

CLAIMANT 2

OWNER OF OTHER VEHICLE	AGE	ADDRESS	CITY	STATE	ZIP	PHONE
DRIVER, IF OTHER THAN ABOVE	AGE	ADDRESS	CITY	STATE	ZIP	PHONE

MAKE OF VEHICLE	YEAR	MODEL	LICENSE NO.	AREA OF DAMAGE	ESTIMATE OF DAMAGE $	WHERE CAN VEHICLE BE SEEN

PROPERTY DAMAGE—OTHER THAN AUTO (ie. FENCE, CANOPY)

OWNER OF PROPERTY	ADDRESS	CITY	STATE	ZIP	PHONE
DESCRIBE DAMAGED PROPERTY	LOCATION OF PROPERTY	CITY	STATE	EXTENT OF DAMAGE	

WITNESS INFORMATION

NAME	ADDRESS	CITY	STATE	ZIP	PHONE
NAME	ADDRESS	CITY	STATE	ZIP	PHONE

NOTE: PLEASE COMPLETE REVERSE SIDE.

PERSONS INJURED (USE ADDITIONAL SHEET IF NECESSARY)

NAME	AGE	NAME	AGE
ADDRESS	PHONE	ADDRESS	PHONE
CITY STATE	ZIP	CITY STATE	ZIP
OCCUPATION	WHERE TAKEN	OCCUPATION	WHERE TAKEN

☐ FATALITY ☐ PEDESTRIAN
☐ BLEEDING OR DISTORTED WOUND ☐ IN YOUR VEHICLE
☐ UNCONSCIOUSNESS ☐ IN CLAIMANT VEHICLE
☐ NO VISIBLE INJURY — COMPLAINED OF PAIN
☐ OTHER ____________

☐ FATALITY ☐ PEDESTRIAN
☐ BLEEDING OR DISTORTED WOUND ☐ IN YOUR VEHICLE
☐ UNCONSCIOUSNESS ☐ IN CLAIMANT VEHICLE
☐ NO VISIBLE INJURY — COMPLAINED OF PAIN
☐ OTHER ____________

ADDITIONAL REMARKS

DESCRIBE ACCIDENT

VEHICLES 1 2 PEDESTRIAN

ACCIDENT DIAGRAM

INDICATE NORTH BY ARROW

WHAT STREET WERE YOU ON?	CLAIMANT 1	CLAIMANT 2
WHAT DIRECTION WERE YOU TRAVELING?	CLAIMANT 1	CLAIMANT 2

WEATHER CONDITIONS: ☐ DRY ☐ WET ☐ ICY ☐ FOGGY ☐ SNOWY

TRAFFIC CONDITIONS: ☐ LIGHT ☐ MODERATE ☐ HEAVY

SPEED LIMIT	WERE YOU FAMILIAR WITH AREA ☐ YES ☐ NO	TRAFFIC CONTROLS

THIS SECTION MUST BE COMPLETED BY SUPERVISOR

1. DO YOU THINK A CLAIM WILL BE MADE AGAINST YOU? ☐ YES ☐ NO
2. IN MY OPINION WE ARE AT FAULT FOR THIS ACCIDENT? ☐ YES ☐ NO

IMPORTANT: HAS THIS ACCIDENT BEEN REPORTED TO OUR LOCAL EMERGENCY ADJUSTER? ☐ YES ☐ NO

IF REPORTED, NAME OF FIRM ____________
ADDRESS ____________
DATE ASSIGNED ____________

DATE OF THIS REPORT	SIGNATURE AND TITLE