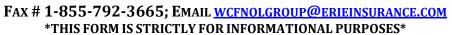
WORKERS' COMPENSATION INJURY REPORTING FORM

ALL CLAIMS MUST BE REPORTED TO THE FNOL GROUP PHONE # 1-855-492-3665

FAX OR EMAIL COMPLETED FORM TO:





Company Name						
Company Name						
Policy # (must be provided)	-					
Date of Loss (must be provided)	Vac	No				
Uncertain Date of Loss	Yes	No				
Time of Loss (provide approximation if uncertain)						
If there are multiple locations, from which does						
the employee report?						
Claim Reporter Name & Title						
Preferred Contact for Reporter (circle one)	Work	Home	Mobile	Phone #		
	Email Address			Fax		
Injured Worker Name						
Preferred Contact for Injured Worker	Work	Home	Mobile	Phone #		
	Email Add	dress				
Physical Address	-					
City						
State						
Zip Code	'					_
County						
SS#						
Date of Birth						
Gender:	Male	Female				
Marital Status	•					
Occupation	-					_
Date of Hire						
Employment Status	Full Time	Part Tir	ne	Seasonal	Temp	
F - 7	Retired	Appren		Other	- 1	
Incident Only						
Injury Description Details (specific body part/how						
did the injury occur)						
Time Shift Started						
Date Employer Notified						
Injured on Employer's Premises	Yes	No				
If NO, address where injury occurred						
Treatment	Yes	No				
If yes, Provider Name, Address, PH #						
If yes, Hospital Name, Address, PH #						
Lost time	Yes	No				
Average weekly wage	103	110				
Returned to work	Yes	No				
Full pay for last day worked	Yes	No				
·	162	INO				
Hours worked per day	-					
Days worked per week						
Pay period (weekly/biweekly/other)						
Ambulance						
Police department						
Miscellaneous						