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:
FAX # 1-855-792-3665; EMAIL WCFNOLGROUP@ERIEINSURANCE.COM
THIS FORM IS STRICTLY FOR INFORMATIONAL PURPOSES

Erie Insurance®

Company Name	
Policy # (must be provided)	
Date of Loss (must be provided)	
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 Address
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 Time ☐ Seasonal ☐ Temp ☐
	Retired ☐ Apprentice ☐ Other
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	
Returned to work	Yes ☐ No ☐
Full pay for last day worked	Yes ☐ No ☐
Hours worked per day	
Days worked per week	
Pay period (weekly/biweekly/other)	
Ambulance	
Police department	
Miscellaneous	