PREFERRED INSURANCE
25 YEARS
Professional. Dependable. Knowledgeable.

First Report of Injury

Insured's Name _____

Key Contact _____ Phone _____

This form is intended to assist you in filing a claim with your appropriate carrier.

Below is the information that you should have on hand when reporting an injury:

Company tax ID number _____

Worker's Compensation policy number _____

The following information pertains to that of the injured worker:

Name, Address, Phone Number _____

Social Security Number _____

Date of Birth _____

Sex _____

Marital Status _____

Number of Dependents _____

Occupation/ Job Title & Wage Information _____

When, Where, and How the Injury Occurred _____

Type of Injury and Exact Body Part Injured _____

Date Disability Began _____

Last Full Day Paid _____

Date Employee Reported the Injury _____

Names of Any Witnesses _____

Name, Address and Phone Number of Physician or Hospital _____

Anticipated Date of Return to Work _____