HARFORD MUTUAL
INSURANCE GROUP

Workers' Compensation First Notice of Injury or Illness

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

GENERAL INFORMATION

Employer Name _____ Employer FEIN _____

Employer Address _____ City _____ State _____ Zip _____

Phone # _____ Contact Email _____

Industry Code _____ Carrier/Administrator Claim Number _____

OSHA Log Case # _____ Report Purpose Code _____

Jurisdiction _____ Jurisdiction Claim Number _____ Insured Report Number _____

Employer's Location Address (if different) _____ Location # _____

City _____ State _____ Zip _____

CARRIER/CLAIMS ADMINISTRATOR

Carrier Name _____ Carrier Phone # _____ Carrier FEIN _____

Carrier Address _____ City _____ State _____ Zip _____

Policy Period _____ to _____ Self-Insured? __ Yes __ No Policy/Self-Insured Number _____

Claims Admin Name _____ Admin Phone # _____ Admin FEIN _____

Claims Admin Address _____ City _____ State _____ Zip _____

EMPLOYEE/WAGE

Name (Last, First, Middle) _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone _____ Social Security Number _____ Sex __ Male __ Female __ Unknown

Marital Status __ Single __ Divorced __ Married __ Separated __ Unknown # Of Dependents _____

Occupation/Job Title _____

Date Hired _____ State of Hire _____ Employment Status _____ NCCI Class Code _____

Rate _____ Per __ Day __ Week __ Month __ Other _____ Days Worked/Week _____

Full Pay for Day of Injury? __ Yes __ No Did Salary Continue? __ Yes __ No

OCCURRENCE/TREATMENT

Contact Name _____ Contact Phone _____

Time Employee Began Work _____ __ AM __ PM

Date of Injury/Illness _____ Time of Occurrence _____ __ AM __ PM __ Cannot be Determined

Did Injury/Illness/Exposure Occur On Employer's Premises? __ Yes __ No

Last Day Worked _____ Date Employer Notified _____ Date Disability Began _____

Type of Injury/Illness _____ Injury/Illness Code _____

Part(s) of Body Affected _____ Part of Body Code _____

Department Or Location Where Accident Or Illness Exposure Occurred _____

List All Equipment, Materials, or Chemicals Employee was Using When Accident or Illness Exposure Occurred

_____

Specific Activity the Employee was Engaged in When The 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 _____ Phone _____

Address _____ City _____ State _____ Zip _____

Hospital Or Off Site Treatment Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Initial Treatment: __ No Medical Treatment __ Minor: By Employer __ Minor: Clinic/Hosp

__ Emergency Care __ Hospitalized > 24 Hours __ Future Major Medical/Lost Time Anticipated

OTHER

Witness 1: Name _____ Phone _____

Witness 2: Name _____ Phone _____

Date Administrator Notified _____ Date Prepared _____

Preparer's Name _____ Phone Number _____

Preparer's Title _____ Preparer's Signature _____