

Worker

Last Name		First Name		M.I.	Date of Birth	Social Security Number	
Mailing Address				City	State	Postal Code	
Phone Number	Education	<input type="checkbox"/> Less Than High School <input type="checkbox"/> GED or High School Diploma <input type="checkbox"/> Beyond High School	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed, Divorced, Single, Unmarried <input type="checkbox"/> Unknown	Number of Dependents

Wages

Date Hired	Gross earnings for <u>four</u> pay periods preceding the injury					
	Date/Amount /	Date/Amount /	Date/Amount /	Date/Amount /		
Employment Status	Number of Days worked per week		Wage	Wage Period		
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Piece Worker <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer <input type="checkbox"/> Other				<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Bi-Weekly		
In addition to gross earnings cited above worker received				Estimated value if any	Time Employee began work	
<input type="checkbox"/> Room & Board <input type="checkbox"/> Overtime <input type="checkbox"/> Bonus <input type="checkbox"/> Commissions <input type="checkbox"/> Other:						
Worked next scheduled shift	Off work more than 4 work days	Date Last Worked	Date of Return to Work	Full wages paid for date of injury	Salary Continued	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Accident Description

Job Title	Description of Accident						
Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	Date of Injury	Time of Injury
Date Disability Began	Date of Death	Names of Witnesses					
		1)	2)	3)			
Accident on Employer's Premises	Accident Address or Location						
<input type="checkbox"/> Yes <input type="checkbox"/> No	City	State	Postal code				
Date Employer Notified	Accident Reported to			Safety Equipment Provided	Safety Equipment Used		
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Medical

Attending Physician's Name	Address	State	Postal Code	Phone Number
Hospital Name	Address	State	Postal Code	Phone Number
Type of initial medical treatment received <input type="checkbox"/> No Treatment <input type="checkbox"/> Emergency Room/Urgent Care <input type="checkbox"/> Treatment on-site by Employer or Medical Staff <input type="checkbox"/> Clinic/Dr. Office				
<input type="checkbox"/> Hospital > 24 hours				

Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease, or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer (and its agents) and to the Montana Uninsured Employers' Fund of: Social Security records; rehabilitation records; and all health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA), that are directly relevant to the claimed injury, disease, or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signature of Injured Worker or Beneficiary _____ Date: _____

Employer

Employer Name	Doing Business as	Federal Employer Identification Number (Tax I.D.)		
Mailing Address	City	State	Postal Code	Phone Number
Location of operation, if different from mailing address		Nature of Business SIC/NAICS Code	Self-Insured <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer is a <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company	Injured worker is a <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company			
<input type="checkbox"/> A member of the employer's (sole proprietor) family living in the employer's household.				
Do you have any reason to question this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			Was worker injured while in your employ <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain fully. Use separate sheet if you need additional space				
Prepared By	Official Title	Phone Number	Date	
Payroll Classification Code under which you report Employee's wages	Authorized Employer's Signature _____ Date _____			

Insurer

Claim Administrator Claim Number	Date Reported to Claim Administrator:	The above information is correct with the following exceptions <input type="checkbox"/> (Attach extra sheets if box at right is checked)
Claim Administrator Name	Claim Administrator Address	Claim Administrator FEIN
Insurer Name	Insurer FEIN	
Policy Number	Policy Effective Date	Policy Expiration Date