

**WORKER’S COMPENSATION**

***If you were injured on the job and are filing for Worker’s Compensation coverage, the following information is required:***

Date of injury: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ The State the accident occurred in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_

Name of Employer when injury occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Contact Phone #: (\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Worker’s Compensation Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Worker’s Compensation Address:

Worker’s Compensation Insurance Company Phone #: (\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Adjuster’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adjuster’s Phone #: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Case Manager’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Case Manager’s Phone #: (\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

How did this injury happen? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**I certify that the information provided by me is true, accurate, and complete.**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

**Patient / Responsible Person’s Signature Date**

Rev. 2022

Internal use – received/reviewed by: \_\_\_\_\_\_\_\_

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