

Worker

LAST NAME		FIRST NAME		M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
HOME ADDRESS				CITY	STATE	POSTAL CODE	
PHONE NUMBER	EDUCATION	GENDER		MARRITAL STATUS		NUMBER OF DEPENDANTS	
	<input type="checkbox"/> LESS THAN HIGH SCHOOL <input type="checkbox"/> GED OR HIGH SCHOOL DIPLOMA <input type="checkbox"/> BEYOND HIGH SCHOOL	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED, DIVORCED, SINGLE, UNMARRIED <input type="checkbox"/> UNKNOWN				

Wages

DATE HIRED	GROSS EARNINGS FOR FOUR PAY PERIODS PRECEDING THE INJURY			ESTIMATED VALUE IF ANY		TIME EMPLOYEE BEGAN WORK	
	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"/> SEASONAL <input type="checkbox"/> PIECE WORKER <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> OTHER					<input type="checkbox"/> HOUR <input type="checkbox"/> WEEK <input type="checkbox"/> MONTH <input type="checkbox"/> OTHER <input type="checkbox"/> DAY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> YEAR		
IN ADDITION TO GROSS EARNINGS CITED ABOVE WORKER RECEIVED							
<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	SALARY CONTINUED		
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE			DATE OF INJURY	<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 or its agent, rehabilitation records, Social Security records and 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 ID)		
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		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"/> 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 OR PARTNER) FAMILY LIVING IN THE EMPLOYER'S HOUSEHOLD				
DO YOU HAVE ANY REASON TO QUESTION THIS ACCIDENT?				WAS WORKER INJURED WHILE IN YOUR EMPLOY		
IF YES, PLEASE EXPLAIN FULLY. USE SEPARATE SHEET IF YOU NEED ADDITIONAL SPACE				<input type="checkbox"/> YES <input type="checkbox"/> NO		
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'S NAME		CLAIM ADMINISTRATOR FEIN	
CLAIM ADMINISTRATOR ADDRESS			
INSURER NAME		INSURER FEIN	
POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	