



Insurance Agency

WORKERS COMPENSATION LOSS

DATE ____/____/____

Date of Loss ____/____/____ Reported by _____

Employers Name _____

Employers Federal ID # _____

Employees Name _____

Address of Employee _____

City _____ State ____ Zip _____ Phone # _____

Location of Injury _____

Claims Administrator _____

Date of Injury ____/____/____ Time of Injury _____:____ am/pm

What part of the employee body was injured?

Complete Description of Incident:

Any lossed time potential? Yes No Explain: _____

Did injury occur on employers premises? Yes No

Any witnesses to the incident: Name _____

Phone # (home) _____ (work) _____

Physician or Health Care Provider? _____

Hospital taken to? _____

Completed by _____ Date ____/____/____

Please fax completed form to (574) 252-2109