PINNACOL ASSURANCE

FIRST REPORT OF INJURY
To report a claim:
Call 303-361-4000 or 1-800-873-7242
Or Fax to 303-361-5000 or 1-888-329-2251
Or, go to www.pinnacol.com
PLEASE PRINT CLEARLY

Early reporting can save you money. Report all injuries immediately!
The information below allows Pinnacol Assurance's customer service representatives to quickly and accurately process your claim. Use the completed form as a guide when reporting by phone or online to save you time. Don't wait to report if you don't have all the answers.

POLICY INFORMATION

Policy Number: _____ Company Name: _____

Address or Location (if different than mailing address): _____

Prepared by: _____ Title: _____
Please Print

E-mail: _____ Fax: (_____) _____-_____

Phone: (_____) _____-_____ Date Completed: _____/_____/_____

INJURED WORKER INFORMATION

Injured Worker's Social Security Number: _____-_____-_____ Date of Injury: _____/_____/_____

First Name: _____ M.I. ____ Last Name: _____

Home/Mailing Address: _____ Phone: (_____) _____-_____
City State Zip Code

Date of Birth: _____/_____/_____ ☐ Male ☐ Female Martial Status: _____

Language: ☐ English ☐ Spanish ☐ Other: _____ E-mail: _____

Occupation: _____ Date Hired: _____/_____/_____

Employee Status: ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Volunteer ☐ Independent Contractor

Days Worked per Week: _____ Hours Worked per Day: _____

Pay Rate: _____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ Other: _____

ACCIDENT / INJURY INFORMATION

Fatal Injury: ☐ Yes ☐ No If Fatal Injury: Date of Death _____/_____/_____

Time of Injury: _____ ☐ am ☐ pm Time Work Began: _____ Last Day Worked: _____/_____/_____

Full Pay on Date of Injury: ☐ Yes ☐ No

Accident Occurred on Employers Premises: ☐ Yes ☐ No If Applicable: Location Code: _____ Dept Code: _____

Accident Location: _____
City State Zip Code

Name of Employer Representative Notified: _____ Date Notified: _____/_____/_____

Witnesses: _____
Name(s) and Phone Number(s)

How Did the Injury Occur: _____
Attach Additional Information if Necessary

Specific Activity the Employee Was Engaged In: _____ What Equipment Was Being Used: _____

Body Part(s) Injured: _____ ☐ Right ☐ Left ☐ Not Applicable

Type of Injury Sustained: _____

☐ Safety Equipment Provided ☐ Safety Equipment Used ☐ Possible Drug/Alcohol Involved ☐ Employer Questioning Liability

RETURN TO WORK INFORMATION

Has the Injured Worker Returned to Work? ☐ Yes ☐ No

Date Returned to Work: _____/_____/_____ Estimated Return to Work Date: _____/_____/_____

Is this a lost time Claim? ☐ Yes ☐ No (Claim is lost time if there is a loss of more than three scheduled work days due to the injury).

MEDICAL PROVIDER INFORMATION: Where Was Your Employee Treated?

☐ No Medical Treatment ☐ Treated by Employer ☐ 911 Called ☐ Walk-In Clinic

☐ Emergency Room ☐ Hospitalized > 24 hrs/Overnight ☐ Possible Surgery

Medical Provider Name | Street Address | City | State | Zip Code | Phone