WORKERS COMPENSATION CLAIMS REPORTING CHECKLIST

Please Note: Report all workers compensation injuries to Intact Insurance. The Intact Claims Service Center is open for claim intake 24/7. For more efficient service, please have the information on this checklist available for your Loss Representative. To report a claim, call 1-877-248-3455 or email wclosses@intactinsurance.com

EMPLOYER INFORMATION

POLICY #:	EMPLOYER NAME:
ACCIDENT DATE:	EMPLOYER PHONE #:
EMPLOYER EMAIL ADDRESS:	

ADDRESS

STREET:		
CITY:	STATE:	ZIP CODE:
LOCATION #:	INTERNAL REPORT #:	
ID # (FEIN):		
ACCIDENT ON EMPLOYER'S PREMISES? ☐ YES ☐ NO		
NATUREOF BUSINESS:		

ACCIDENT LOCATION

STREET:		
CITY:	STATE:	ZIP CODE:
COUNTY:	STATE IAB TO WHICH REPORTED:	

EMPLOYEE INFORMATION

LAST NAME:	
FIRST NAME:	M.I.:
EMAIL ADDRESS:	

ADDRESS

STREET:		
CITY:	STATE:	ZIPCODE:

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PHONE #:	SOC. SEC. #:
D.O.B.	DATE OF HIRE:
AVG. WEEKLY WAGE:	MARITAL STATUS:
SEX:	OCCUPATION:
EMPLOYMENT STATUS:	
# OF DEPENDENTS:	# DAYS SCHEDULED PER WEEK:

INJURY INFORMATION

DID EMPLOYEE LOSE 1 OR MORE DAYS OF WORK? ☐ YES ☐ NO	DID EMPLOYEE RETURN TO WORK? ☐ YES ☐ NO
DATE LAST WORKED:	DATE INCAPACITATED:
DATE RETURNED:	DATE OF DEATH:
FULL PAY ON INJURY DATE? ☐ YES ☐ NO	EST. # OF SCHEDULED LOST TIME DAYS:
SALARY CONTINUED? ☐ YES ☐ NO	

DESCRIBE HOW INJURY/EXPOSURE OCCURRED:

SOURCE OF INJURY:

WITNESS INFORMATION

NAME:	PHONE #:

STATE INFORMATION

INJURY CODE:	DESCRIPTION:
BODY PART CODE:	DESCRIPTION:

EQUIPMENT, MATERIALS, OR CHEMICALS USED:

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SPECIFIC ACTIVITY EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OCCURRED:
WORK PROCESS EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OCCURRED:

CAUSE OF INJURY CODE:	TIME WORK BEGAN: ☐ A.M. ☐ P.M.
	TIME INJURY OCCURRED: ☐ A.M. ☐ P.M.
SAFEGUARDS AND SAFETY EQUIPMENT:	
WERE THEY PROVIDED? ☐ YES ☐ NO	WERE THEY USED? ☐ YES ☐ NO
COUNTY EMPLOYEE LIVES IN:	
EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ SEASONAL ☐ VOLUNTEER	

MEDICAL INFORMATION

HOSPITAL NAME:	
STREET:	
CITY:	STATE:
ZIPCODE:	PHONE #:
PHYSICIAN NAME:	
STREET:	
CITY:	STATE:
ZIPCODE:	PHONE #:

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INITIAL EMPLOYER CONTACT

TARGET RTW DATE:	DID EMPLOYER DIRECT EMPLOYEE TO PHYSICIAN? ☐ YES ☐ NO
EMPLOYER WILLINGNESS/ABILITY TO PROVIDE MODIFIED DUTY:	
EMPLOYER ADDITIONAL COMMENTS:	

PREPARER'S NAME:	
TITLE:	PHONE #:
EMAIL ADDRESS:	