WORKERS COMPENSATION CLAIMS REPORTING FORM

Please Note: All workers' compensation injuries should be reported to Intact Insurance. The Intact Insurance Claims Service Center is open for claim intake 24/7. To report a claim, call 800-203-9600. For more efficient service, please have the information on this form available for your Loss Representative.

Other methods of claim reporting: by e-mail to wclosses@intactinsurance.com; by fax to 800-224-4416; or online at www.intactspecialty.com

EMPLOYER INFORMATION		
PREPARER'S NAME:		
TITLE:	PHONE NUMBER:	
EMAIL ADDRESS:		
EMPLOYER NAME:		
EMPLOYER PHONE NUMBER:	POLICY NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
ID # (FEIN):		
UNEMPLOYMENT INSURANCE (UI) NUMBER:		
EMPLOYER CONTACT FOR CLAIM: ☐ ***Check box if the Preparer is the employer contact.***		
TITLE:	PHONE NUMBER:	
EMAIL ADDRESS:		

DATE OF LOSS AND ACCIDENT LOCATION		
DATE OF ACCIDENT:	TIME INJURY OCCURRED: ☐A.M. ☐P.M	
DATE REPORTED TO EMPLOYER:	ACCIDENT ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	
STREET:		
CITY:	STATE:	ZIP:
COUNTY:		
LOCATION CODE (*IF APPLICABLE*):		

WORKERS COMPENSATION CLAIMS REPORTING CHECKLIST

EMPLOYEE INFORMATION

LAST NAME:			
FIRST NAME:			M.I.:
STREET ADDRESS:			
CITY:	STATE:	ZIP CODE:	COUNTY:
EMAIL ADDRESS:		PHONE NUMBER:	
SOC. SEC. #:		D.O.B.	
GENDER:		MARITAL STATUS:	
# OF DEPENDENTS:		AVG. WEEKLY WAGE:	
DATE OF HIRE:		OCCUPATION:	
DEPARTMENT:		TIME WORK BEGAN: ☐A.M. ☐ P.M.	
EMPLOYMENT STATUS:		# OF DAYS SCHEDULED PER WEEK:	
DIRECT SUPERVISOR:		PHONE NUMBER:	

ACCIDENT AND INJURY INFORMATION

ACCIDENT DETAILS-DESCRIBE HOW INJURY/EXPOSURE OCCURRED:
(PLEASE INCLUDE SPECIFIC ACTIVITY & WORK PROCESSES EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OCCURRED. IF APPLICABLE ALSO INCLUDE EQUIPMENT, MATERIALS, CHEMICALS, SAFEGUARDS AND/OR SAFETY EQUIPMENT USED.)

INJURY DETAILS- Type of injury and Body Part

☐ Check box if FATALITY DATE OF DEATH: _____

WORKERS COMPENSATION CLAIMS REPORTING CHECKLIST

EMPLOYER WILLINGNESS/ABILITY TO PROVIDE MODIFIED DUTY:		
DID EMPLOYEE LOSE 1 OR MORE DAYS OF WORK? ☐ YES ☐ NO		DATE LAST WORKED:
DATE RETURNED:		EST. # OF SCHEDULED LOST TIME DAYS:
FULL PAY ON INJURY DATE? ☐ YES ☐ NO		DATE INCAPACITATED:
SALARY CONTINUED? ☐ YES ☐ NO		TARGET RTW DATE:
MEDICAL INFORMATION		
HOSPITAL NAME:		PHONE:
STREET:		
CITY:	STATE:	ZIP
PHYSICIAN NAME:		PHONE:
STREET:		
CITY:	STATE:	ZIP:
WITNESS INFORMATION		
WITNESS #1		
NAME:		PHONE:
WITNESS #2		
NAME:		PHONE:
ADDITIONAL COMMENTS:		