Workers' Compensation Claims Submission

Insured Name: ____

Policy#: ____

Address: ____

Main Contact Person: ____

Main Contact Phone#: ____

Main Contact Email: ____

Injured Employee Name: ____

Date of Birth of Injured Employee: ____

Social Security Number of Injured Employee: ____________________________________

Date of Hire of Injured Employee: ____

Date of Incident: ____

Time of Incident: ____

Description of Incident: ____

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Description of Injury: ____

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Medical Treatment Involved: ____

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Name and Address of Medical Facility where treatment took place: ______________________

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Phone# of Medical Facility: ____