WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)		Carrier/Administrator Claim Number	Report Purpose Code
		Jurisdiction	Jurisdiction Claim No.
		Insured Report No.	
		Employer's Location Address (if different)	Location No.
Sic Code	Employer FEIN		Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)		Policy Period	Claims Admin (Name, Address & Phone Number)
		To	
		☐ Check if self insured	
Carrier FEIN	Policy Number or Self-Insured Number		Administrator FEIN
Agent Name & Code Number			

Legal Name (Last, First, Middle)	Birth Date	Social Security Number	Date Hired	State of Hire

Address (Incl. Zip)	Sex	Marital Status	Occupation/Job Title
	☐ Male	☐ Unmarried/ Single/Div.	
	☐ Female	☐ Married	Employment Status
	☐ Unknown	☐ Separated	