

**Claims Handling Playbook**



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What To Do in the Event of a Claim



## 

## **Introduction**

Welcome to the Claims Handling Playbook for The Insurance Center. The Insurance Center team is here to serve you and assist you in the event of a claim. This playbook is designed to help you navigate the claims process and know what to expect. It includes high-level summaries and detailed instructions by coverage type to ensure that you can handle claims with confidence.

Your insurance contract requires that you report all claims promptly. Failure to do so may impact coverage. Therefore, contact us as soon as possible after a property, liability, workers’ compensation or automobile claim. We will report your claim to the insurance company. An insurance company claims adjuster will be assigned to handle your claim. You should then be able to work directly with the adjuster to settle your claim.

If you encounter any unusual delays or problems in the handling of your claim, please contact:

Deanna Lutz, Claims Specialist at The Insurance Center, for assistance at 920.383.8205 or dlutz@ticinsurance.com.

We appreciate your business and are here to assist you.

## 

**SERVICE Team**

## **Your Licensed & Certified Service Team**

**Aaron Hutchinson** - Business Insurance Specialist

Aaron is your go-to expert for tailored insurance solutions, ensuring your property & casualty needs are met.

*Phone:* (262) 492-6021

*Email:* [ahutchinson@ticinsurance.com](mailto:ahutchinson@ticinsurance.com)

**Nita Hauser** - Customer Service Agent (CS-A)

Nita provides the exceptional service and support, confirming all your day-to-day needs and activities are handled.

*Phone:* (715) 507-5130

*Email:* [jhauser@ticinsurance.com](mailto:jhauser@ticinsurance.com)

**Deanna Lutz** -Claims Specialist

Deanna is responsible for assessing, verifying, and efficiently processing claims, ensuring they are handled fairly and in line with guidelines.

*Phone:* (920) 383-8205

*Email:* [dlutz@ticinsurance.com](mailto:dlutz@ticinsurance.com)

## **Auto Claims**

**AUTO** Claims

* If anyone in the accident is injured, seek immediate medical attention
* Report the accident to the police
* Cooperate with the police, but do not make any statements about your legal liability
* If there are other drivers involved in the accident, exchange names, addresses, and insurance information. Write down the following information:
  + Date, Time and Place of accident
  + Names, addresses, and phone numbers of passengers and witnesses
  + License plate numbers and vehicle descriptions of all vehicles involved
* Take photos of any damage to your vehicle and any other damage caused by the accident
* Take photos of the scene, vehicle placement after impact, etc.
* If you have a dash cam, preserve the video footage and send it to the claim adjuster when their information is available
* Report the claim to The Insurance Center as soon as possible

|  |  |
| --- | --- |
| **Insurance Company** | Integrity Insurance |
| **Policy Number** | CA2861471 |
| **Integrity Website Information** | Online Portal:  <https://www.integrityinsurance.com/login?returnUrl=%2Fclaims>  How Claims Work: <https://www.integrityinsurance.com/claims/how-claims-work>  To locate a recommended repair shop in your area [click here](https://www.integrityinsurance.com/claims/locate-a-repair-shop). |
| **Claims Reporting** | Fill out the Auto Claim form in Appendix A page 11 and notify Aaron and Nita with The Insurance Center. They will file a claim with Integrity on your behalf.  You may also file a claim directly with Integrity:   1. Contact Integrity at [(800) 445-3030](tel:18004453030) 2. Sign up or sign in to [your Integrity account](https://account.integrityinsurance.com/claims) to report your claim online 3. If you only have glass damage, [click here](https://soar.glassclaim.com/v1/Default.aspx?ClientTag=FDCC1205-3999-491F-AAEA-3DBEFBF0B089) to report your claim online or contact Safelite at [(800) 951-9734](tel:18009519734). |

## **Property Claims**

**PROPERTY** Claims

* Take all necessary and appropriate steps to protect the property from further damage
* Take photos of the damaged property before having emergency repairs made, such as boarding up windows or covering holes in the roof.
* For theft or vandalism, notify the police right away. Then take care of securing your building. Carefully take an inventory of your property that was stolen or damaged. Finally, speak with your bank or credit card company if any debit or credit cards are missing.
* For fire damage, reach out to a contractor to secure your property and disconnect utilities. It’s important to save any items with fire damage.
* When you’ve had water damage, be sure to turn off the main water supply. Do not attempt potentially dangerous repairs. Watch out for submerged appliances, chemicals or electrical outlets that may be in standing water. Consult a plumber if you have any questions.
* If you had to close your business and take emergency steps to re-open, your policy may cover those costs. Be sure to save your receipts.
* Separate damaged contents from undamaged contents. Do not discard any items until the claims adjuster gives you the authority to do so.
* Keep records of expenses if you are forced to temporarily relocate your business.
* Do not authorize repairs until the claims adjuster has given you the authority to do so.
* Report the claim to The Insurance Center as soon as possible

|  |  |
| --- | --- |
| **Insurance Company** | Integrity Insurance |
| **Policy Number** | CPP2861470 |
| **Integrity Website Information** | Online Portal:  <https://www.integrityinsurance.com/login?returnUrl=%2Fclaims>  How Claims Work:  <https://www.integrityinsurance.com/claims/how-claims-work#homebusiness>  If you have personal property damage, you will need to fill out the [Integrity Property Loss Inventory Sheet](https://www.integrityinsurance.com/-/media/files/claims/integrity%20property%20loss%20inventory%20sheet.pdf) to share details about your items. |
| **Claims Reporting** | Fill out the Property Claim form in Appendix B Page 13 and notify Aaron and Nita with The Insurance Center. They will file a claim with Integrity on your behalf.  You may also file a claim directly with Integrity:   1. Contact Integrity at [(800) 445-3030](tel:18004453030) 2. Sign up or sign in to [your Integrity account](https://account.integrityinsurance.com/claims) to report your claim online |

**Workers’ Compensation Claims**

**WORKERS’ COMPENSATION** Claims

In the event an employee is injured on the job, follow these steps:

1. Attend to the injured employee:
   1. If it’s a serious injury, send the employee to an Emergency Room or call an ambulance right away.
   2. If injured but not serious, direct the employee to a respective urgent care facility or hospital, or utilize the Insurance Company’s Nurse Triage Hotline for guidance on care.
   3. If employee seeks treatment, obtain and send physicians assessment with any work restrictions
2. Complete the Employer’s [First Report of Injury or Disease form](https://dwd.wisconsin.gov/dwd/forms/wkc/wkc-12-e.htm) for all claims. Either use the “call in” reporting system, online portal, or fax the original form to the insurance company.
3. Report the claim to The Insurance Center as soon as possible. Forward a copy of the First Report to us in the event of a disabling injury or death claim. We will follow up with the insurance company for their prompt handling of the claim.
4. Maintain open, regular communication with the injured employee and the claim adjuster.
5. Keep meticulous records of all communication, treatments, RTW, and transactions related to workers’ compensation claims. Document any disputes or issues that arise during the claim process.
6. Obtain a Return to Work Evaluation Form if applicable. The employee’s medical provider must complete the Return to Work Evaluation Form for each visit to evaluate the employee’s impairment. It is the employee’s responsibility to inform of his or her medical status after each doctor visit. This applies to both work-related and non-work-related injuries and illnesses that interfere with work assignments.
7. If you experience delays or have questions, please contact The Insurance Center for assistance.

|  |  |
| --- | --- |
| **Insurance Company** | Integrity Insurance |
| **Policy Number** | WCP2861472 |
| **Integrity Website Information** | Online Portal:  <https://www.integrityinsurance.com/login?returnUrl=%2Fclaims>  How Claims Work:  <https://www.integrityinsurance.com/claims/how-claims-work#workerscomp> |
| **Claims Reporting** | Fill out the [FROI](https://dwd.wisconsin.gov/dwd/forms/wkc/wkc-12-e.htm) (First Report of Injury Form, Appendix C Page 15). Notify Aaron and Nita, they will file a claim with Integrity on your behalf.  You may also file a claim directly with Integrity:   1. Contact Integrity at [(800) 445-3030](tel:18004453030) 2. Sign up or sign in to [your Integrity account](https://account.integrityinsurance.com/claims) to report your claim online |

**Failure to Report**

If an employer intentionally fails to file a report of injury, the employer may be assessed a penalty for bad faith up to $30,000 or 200 percent of compensation due. An employer may be assessed a 10 percent penalty for delay in reporting an injury with the delay causing an untimely payment to the employee. If the penalty amount is not paid by the designated date, a default order may be issued.

**Workers Compensation Timeline Requirements**

24 Hours After Fatal Incident

* All employers must report all work-related fatalities to the Worker's Compensation Division, Madison Office, within 24 hours of the incident. Work related fatalities can be phoned in by calling (608) 266-1340 or faxed in at (608) 267-0394.

7 Days After Injury

* Insured employers must report any claim of an injury to their insurance carrier within 7 days.

**OSHA Requirements**

As of Jan. 1, 2015, the Occupational Safety and Health Administration (OSHA) required employers to report any work-related employee fatality within **eight hours,**and any inpatient hospitalization, amputation or loss of an eye within **24 hours.**

OSHA defines an inpatient hospitalization as “a formal admission to the inpatient service of a hospital or clinic for care or treatment.” Hospitalizations for observation or diagnostic testing are not reportable events. An amputation is the traumatic loss of a limb or other external body part. Amputations can be full or partial, and they can happen with or without bone. Amputations do not include avulsions, enucleations, deglovings, scalpings, severed ears or broken (or chipped) teeth. Employers must submit these reports to OSHA:

* By telephone at 1-800-321-OSHA (6742);
* By calling or visiting the nearest area office during normal business hours; or
* By using the [online form.](https://www.osha.gov/pls/ser/serform.html)

The reporting clock does not begin until the employer or its agents learn about the reportable event.

Employers are not required to notify OSHA of a reportable event if the event is the result of a motor vehicle accident on a public street or highway, unless the accident took place in a construction work zone. However, unless an exemption applies, employers will need to keep a record of the incident. The same is true for incidents that occur on commercial or public transportation systems.

**Additional Requirements / Helpful Hints**

* An [**Early Return to Work Plan**](https://dwd.wisconsin.gov/wc/employers/early-rtw.htm)can help injured employees return to work sooner, increasing your company’s productivity and your employee’s wellbeing.
* Any employee injured or potentially injured at work should be reported immediately to the insurance company. They will conduct a detailed investigation into the claimed injury.
* Failure to report any claim in a timely manner may result in financial penalties. Additionally, delayed reporting hinders the insurance company’s ability to complete a full and timely investigation.
* If you have video footage of the loss, be sure to preserve the file and send it to the claim adjuster.
* If you suspect fraud, notify the adjuster right away.
  + <https://dwd.wisconsin.gov/wc/fraud/questionable-claims.htm>
* Please provide information of any possible witnesses to the claimed injury.
* Additional resources are available upon request including:
  + Supervisor and Injured Employee Report
  + Attending Physicians Report
  + Authorization for Medical and/or Employment Information Form
  + Job Analysis
* To request a copy of any of these forms or for general questions, please contact the adjuster assigned to the relevant claim.

## **Liability Claims**

**LIABILITY** Claims

In the event of injuries or damage to the property of others which you allegedly caused, follow these steps:

1. Call us to report the claim.
2. Forward any correspondence, including a summons from an attorney representing the other party.
3. Do not discuss the claim with the other party or their attorney. Refer them to your insurance company’s claims adjuster or to us.
4. Document all important facts, including names and best phone/e-mail contact for all parties involved
5. Take photos of the loss location
6. Gather any damaged property for potential inspection
7. Secure and retain surveillance video of the loss (if available)

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| **Insurance Company** | Integrity Insurance |
| **Policy Number** | CPP2861470 |
| **Integrity Website Information** | Online Portal:  <https://www.integrityinsurance.com/login?returnUrl=%2Fclaims>  How Claims Work:  <https://www.integrityinsurance.com/claims/how-claims-work#liability> |
| **Claims Reporting** | Fill out the Liability Claim form from Appendix D Page 19 and notify Aaron and Nita with The Insurance Center. They will file a claim with Integrity on your behalf.  You may also file a claim directly with Integrity:   1. Contact Integrity at [(800) 445-3030](tel:18004453030) 2. Sign up or sign in to [your Integrity account](https://account.integrityinsurance.com/claims) to report your claim online |

## **Other Resources**

**OTHER RESOURCES** & **CONCLUSION**

* Zywave
* Workers’ Compensation:
  + [Wisconsin Department of Workforce Development (DWD)](https://dwd.wisconsin.gov/): Offers resources and information on workers' compensation.
  + [Workers’ Compensation Division](https://dwd.wisconsin.gov/wc/): Provides assistance with claims, appeals, and disputes.
  + Legal Aid Services: Can help with legal advice and representation in workers' compensation cases.
* OSHA recording and reporting [website](https://www.osha.gov/recordkeeping/)

## **Conclusion**

The Insurance Center team is here to serve you and assist you in the event of a claim. By being familiar with and following the guidelines outlined in this playbook, you will be better prepared when a claim arises.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **LOSS**  Date: | | |  | | |
| Location: | | |
| City: | | | State: | | |
| Police Dept. Involved: | | | Ticket Issued: | | |
| **DESCRIPTION OF ACCIDENT** | | | | | |
|  | | | | | |
| **INSURED VEHICLE** | | | | | |
| Year: | Make: | | | Model: | |
| VIN: | | Plate: | | | |
| Extent of Damages: | | | | | |
| Present Location: | | | | | |
| Driver: | | | | | (ASK IF OFFICER OF CO) |
| Date of Birth: | License #: | | | | State: |
| **OTHER VEHICLE** | | | | | |
| Year: | Make: | | | Model: | |
| Extent of Damages: | | |  | | |
| Owner: | | | Phone: | | |
| Address: | | |  | | |
| City: | State: | | | Zip: | |
| **OTHER VEHICLE INSURANCE INFORMATION** | | | | | |
| Company Name: | | | Policy #: | | |
| Agent Name: | | | Phone: | | |
| **INJURED** | | |  | | |
| Name: | | | Phone: | | |
| Address: | | |  | | |
| City: | State: | | | Zip: | |
| Extent of Injury: | | | | | |
| **WITNESSES** | | | | | |
| Name: | | | Phone: | | |
| Address: | | | | | |
| City: | State: | | | Zip: | |
| **IMPACT** | | | | | |
| Is damaged auto essential to business? | | | | | |
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**Appendix A – Auto Claim Incident Report**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **LOSS**  Date: | | |  | | |
| Location: | | |
| City: | | | State: | | |
| Police Dept. Involved: | | | Ticket Issued: | | |
| **DESCRIPTION OF ACCIDENT** | | | | | |
|  | | | | | |
| **INSURED PROPERTY** | | | | | |
| Location (Street Address, City, State): |  | | |  | |
| Extent of Damages: | |  | | | |
|  | | | | | |
|  | | | | | |
| Impact / Effect on Business: | | | | |  |
|  |  | | | |  |
| **RESPONSIBLE PARTY (WHO CAUSED THE PROPERTY DAMAGE)** | | | | | |
| Name: |  | | |  | |
| Address (Street Address, City, State Zip): | | |  | | |
| Phone: |  | | |  | |
| **RESPONSIBLE PARTY INSURANCE INFORMATION (IF APPLICABLE)** | | | | | |
| Company Name: | | | Policy #: | | |
| Agent Name: | | | Phone: | | |
| **INJURED** | | |  | | |
| Name: | | | Phone: | | |
| Address: | | |  | | |
| City: | State: | | | Zip: | |
| Extent of Injury: | | | | | |
| **WITNESSES** | | | | | |
| Name: | | | Phone: | | |
| Address: | | | | | |
| City: | State: | | | Zip: | |
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**Appendix B - Property Claim Incident Form**

**Appendix C - General Liability Claim Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **LOSS**  Date: | |  | |
| Location: | |
| City: | | State: | |
| Police Dept. Involved: | | Case Number: | |
| **DESCRIPTION OF ALLEGED INCIDENT** | | | |
|  | | | |
| **PROPERTY DAMAGE** | | | |
| Owner: |  | | Phone: |
| Address: | |  | |
| City: | State: | | Zip: |
| Description of Damage: |  | |  |
| **INJURED** | |  | |
| Name: | | Phone: | |
| Address: | |  | |
| City: | State: | | Zip: |
| Extent of Injury: | | | |
| Attorney Information: | | | |
| **WITNESSES** | | | |
| Name: | | Phone: | |
| Address: | | | |
| City: | State: | | Zip: |
| **LAWSUIT FILED** | | | |
| County and State where filed: Date of Service: | | | |
|  | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Employee Name (First, Middle, Last)  **Appendix D – Workers’ Comp First Report of Injury Form** | | | | | | | | | | | | | | | Social Security Number\*  -  - | | | | | | | | Sex  M  F | | | | Employee Home Telephone No.  **(****)** **-** | | | |
| Employee Street Address | | | | | | | | | | | City | | | | | | | State | | | | | | Zip Code | | | | Occupation | | |
| Birthdate | | | Date of Hire | | | | | | | County and State Where Accident or Exposure Occurred? | | | | | | | | | | | | | | | | | | | | |
| Employer Name | | | | | | | | | WI Unemployment Ins. Acct No. | | | | | | | | | | Self-Insured?  Yes  No | | | | | | Nature of Business (Specific Product) | | | | | |
| Employer Mailing Address | | | | | | | | | | | | City | | | | | | | State | | | | Zip Code | | | | | Employer FEIN  - | | |
| Name of Worker’s Compensation Insurance Co. or Self-Insured Employer | | | | | | | | | | | | | | | | | | | | | | | | | | | | Insurer FEIN  - | | |
| Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer | | | | | | | | | | | | | | | | | | | | | | | | | | | | TPA FEIN  - | | |
| Wage at Time of Injury  $  . | | | | Specify per hr., wk., mo., yr., etc.  Per: | | | | | | | | | | In Addition to Wages,  Meals No. of Meals/wk.  Check Box(es) if  Room No. of Days/wk  Employee Received:  Tips Avg. Weekly Amt. $ | | | | | | | | | | | | | | | | |
| Is Worker Paid for Overtime?  Yes  No If Yes, After How Many Hours of Work Per Week? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No. of Weeks: | | Gross Amount Excluding Tips: $ | | | | | | | | | | | | | | | | | If Piece-Work, No. of Hrs. Excluding Overtime: | | | | | | | | | | | |
|  | | | | | | | | | | | | | Start Time | | | | | | | | Hours Per Day | | | | | Hours Per Week | | | | Days Per Week |
| Employee’s Usual Work Schedule When Injured: | | | | | | | | | | | | | **:**   AM  PM | | | | | | | |  | | | | |  | | | |  |
| Employer’s Usual Full-Time Schedule for This  Type of Work at Time of Employee’s Injury: | | | | | | | | | | | | |  | | | | | | | |  | | | | |  | | | |  |
| Part-Time Employment  Information: | | Are there Other Part-Time Workers Doing the Same Work With the Same Schedule?  Yes  No If Yes, how many? | | | | | | | | | | | | | | | | | | | | Number of **Full-Time** Employees Doing The  Same Type Of Work: | | | | | | | | |
| Injury Date | Time of Injury  **:**  AM  PM | | | | | | | Last Day Worked | | | | | | | | Date Employer Notified | | | | | | Date Returned to Work  Estimated Date of Return | | | | | | | | |
| Did Injury Cause Death?  Yes  No | | | | | Date of Death | | | Was This a Lost Time or Other Compensable Injury?  Yes  No | | | | | | | | | | | | Did Injury Occur Because of:  Substance  Failure to Use  Failure to  Abuse Safety Devices Obey Rules | | | | | | | | | | |
| Was Employee Treated in an Emergency Room?  Yes  No Was Employee Hospitalized Overnight as an In-Patient?  Yes  No  Name and Address of Treating Practitioner and Hospital:  Case Number from the OSHA Log: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Injury Description** - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.    What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)    What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Report Prepared By | | | | | | | Work Phone Number  **(****)** **-** | | | | | | | | | | Position | | | | | | | | | | | | Date Signed | |
| WKC-12-E (R. 10/2023) | | | | | | SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT | | | | | | | | | | | | | | | | | | | | | | |  | |

**Fatal Injuries:** Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee. **On-Fatal Injuries:** If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department. **Electronic Reporting Requirement:** All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to (608) 267-0394.\*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats.   The purpose of this form is to assist with the procurement of information related to or required by Chapter 102.  Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102.   DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

**Department of Workforce Development Worker’s Compensation Division**

201 E. Washington Ave., Rm. C100P.O. Box 7901Madison, WI 53707Imaging Server Fax: (608) 260-2503Telephone: (608) 266-1340https://dwd.wisconsin.gov/wce-mail: DWDDWC@dwd.wisconsin.gov

(**Please read the instructions on page 2 for completing this form**)

**EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS**

The employer must complete all relevant sections on this form and submit it to the employer’s worker’s compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer’s insurance carrier or the third-party claim’s administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

**MANDATORY INFORMATION**

**In order to accurately administer claims, each of the following sections of this form must be completed.** The First Report of Injury will be returned to the sender if the mandatory information is not provided.

**Employee Section:** Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the “Date of Hire” is the date the employee was hired for the job on which he or she was injured.

**Employer Section:** Provide all requested information to identify the injured worker’s employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker’s compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

**Wage Information Section:** Provide the information requested regarding the injured employee’s wage and hours worked for the job being performed at the time of injury.

**Injury Information Section:** Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.