member INSURANCE

# Workers Compensation –First Report of Injury or Illness

| Date (MM/DD/YYYY): |
|---|

**Loss Location:**

| **Carrier:** | **Policy Number and Effective Dates:** | |
|---|---|---|
| | | |

| **Policy Type:** | **Date of Loss** | **Time:** |
|---|---|---|
| | | |
| Co-Op: | | |

**INSURED/Employer:**

| Name of Insured (Business Name): | Insured's Mailing Address: |
|---|---|
| Contact's name:<br>Contact's phone #: | Email Address: |

**Employee/Wage:**

| Name (Last, First, Middle):<br>Birthdate: | | | | Social Security No: |
|---|---|---|---|---|
| Address: | | | | Date Hired: |
| Phone: | Full day for day of injury? | Rate: | Day:<br>Week: | Employment Status: |
| | | Average weekly wages: | | |

**Injured Party/Illness Description:**

| How was the party injured? | Loss time? Please explain: |
|---|---|
| Physician/Health Care Provider (Name & Address): | Describe initial treatment:<br>Phone No: |

Record only claim (?):
Other information relevant to claim:
**Reported by; Contact phone :**
**Time:**
**FEIN:**

YORK Risk Services Group