THE RESEARCH FOUNDATIO N
The State University of New York

WORKERS' COMPENSATION-DIRECT LOSS REPORTING GUIDE
1-800-699-9916 (CHUBB*First*)
Fax: 1-800-884-3946

Things to remember when reporting a Workers Compensation Claim:
Use this Report of Injury Worksheet as a reference for collecting details. It is not necessary to write in answers to questions you know when calling us. If you plan to fax us, you should fill in the worksheet. However, whether you are calling or faxing, do not delay in reporting the claim if you do not have answers to every question.

Location Code		State	
Date of Accident		Employer's FEIN #	

Employers Name		Mail Address (Street)	
Phone # (Area Code First)		Nature of Business	
Preparer's Name		Preparer's Title	
Days Open		Policy Number	

Employee Name (Last, First)				Mail Address				
City/County/ Parish				State/Zip				
Phone # (Area Code First)		Social Security #			Sex		Age	
Date of Birth		Marital Status (S,M,D,W)			Occupation			
Regular Dept		Hire Date		Length Employed	Yrs.		Mos.	Dys
Date in Job		Length in Job		Yrs.		Mos.		Dys
Date Inj reported to employer				Estimated/Actual Days Off				

Injury/Illness Description

Employment Status (F,P,S,V)				Is the employee owner/officer, partner?			
Wage Class		Paid Day Inj?		(Y/N/U)		Piece/Time	
Hrs./Day		Days/Wk		Hrs/Wk		Wages/Hr$	
Wages/Day$			Avg. Wage/Wk$			Salary/MO$	
Reg Days Off				Per (W/M/Y)			

Accident LOC (Street Address)		City		Zip	
County		St		Zip		On Premises (Y/N)	

Injury/Disease (I/D)		Time of Inj		A/P		Time Shift Begins		A/P		Ends		A/P	

Supervisor		Time Reported		A/P		Last Worked	
Time Left		A/P		Lost Time (Y/N)		First Off		# of Employees Inj	
Fatal (Y/N)		Date of Death		What was the employee doing?	
Nature of Injury/Body Part		Objects/Substance Involved	

How could employer prevent?	
How could employee prevent?	
Who caused the accident if not the employee?	
Address of the person who caused the accident	

Returned (Y/N)		Date		Time		A/P		Reg ( )	Light ( )	Duty (X)	Return Wage	$
Return Occupation		Paid while injured? (Y/N)	

Reason to doubt validity of claim?	
Witness Name(s)		Address	City	State	Zip
Doctor's Name		Address	City	State	Zip
Doctor's Phone #		Hospitalized (Y/N)	

Hospital Name		Address	City	State	Zip
Hospital Phone #		Total Depend. #		Minor Depend.#	

Death-If Yes, next of Kin name and address

Preparer's Phone Number		Mail Instructions	

The address the employer would like the first report of injury mailed to	
Additional address employer would like the first report of injury mailed to	

Your Claim #____________________

Revised 7/9/01