Workers Compensation
First Notice of Loss Questions

Mandatory questions are marked with an asterisk *

Initial Information		
*Is this a Notice Only Claim?	*Date of Incident	Time of Incident
Date Insured Notified	*Benefit State	*Insured Name
Business Location		
*Location Name	*Address 1	Address 2
*City	*State	*Zip
County	*Country	Telephone Number
Extn	Fax Number	
Is the mailing address the same?	Address 1	Address 2
City	State	Zip
County	Country	Federal ID Number
SIC/NAICS Code	Nature of Business	Employer Unemployment Number
Policy		
Policy Number	Policy Name	Policy Effective Date
Policy Expiration Date		
Location Code		
Location Code Level 1	Location Code Level 2	Location Code Level 3
Location Code Level 4	Location Code Level 5	Location Code Level 6
Employee Information		
Social Security Number	Employee ID	First Name
Last Name	Address 1	Address 2
City	*State	Zip
County	Country	Home Phone Number
Date of Birth	Age	Gender
Number of Dependents		
Employment Information		
Employee Regular Occupation	Job Class Code (NCCI)	Date of Hire
State of Hire	Pay Rate/Per	Did employee receive full pay for the day of the incident?
Has pay continued?		
Shift Information		
Number of hours worked per day	Number of days worked per week	Number of hours worked per week
Time employee began work on date of incident	Date last worked	Did the employee miss any work?
Do you expect the employee to be back to work on their next scheduled workday?	What date did the employee start missing work?	Is the date the employee started missing work unknown?
What date did the employee return to work?	Is the date the employee returned to work unknown?	What is the employee's return to work status?
Incident Information		
Did the employer become aware of the incident after the end of the worker's employment, during a strike or after the worker was notified of his/her layoff?		Does the employer question the validity of the incident?
*Did the incident occur on the Insured premises?	Location Name	Address 1
Address 2	City	*State
Zip	County	Country
*Provide a brief description of the incident	Specific activity the employee was engage in when the accident or illness exposure occurred.	Work process the employee was engaged in when accident or illness exposure occurred
Describe the equipment, materials, or chemicals in use at time of Incident/Exposure?	Were safeguards or safety equipment provided?	If so, were they in use?

Injury-Disease Details		
Describe the Injury	Main Cause of Injury	Sub Cause of Injury
Nature of Injury	Body Part	Is there any indication the worker had a seizure or stroke?
Was the injury fatal?	Date of death	
Medical Care		
What was the initial treatment received?	Hospital Name	Address 1
Address 2	City	State
Zip	County	Country
Telephone Number	Extn	Treating Physician Name
Address 1	Address 2	City
*State	Zip	County
Country	Telephone Number	Extn
Has the employee been directed to a medical provider?	Would you like a local provider for the employee?	
Witness		
Were there any Witnesses to the incident?	First Name	Last Name
Address 1	Address 2	City
State	Zip	County
Country	Telephone Number	Extn
Report Information		
*Are you the contact for this incident?	First Name	Last Name
Business Phone Number	Cell Number	Fax Number
Email Address	What is the best time of contact From/To?	What are the best days to contact you?
What is your preferred method of contact?	Do you have any additional comments regarding this incident?	