Workers Compensation Claim

Begin Your Claim

Asterisk (*) indicates required field

Name of Person Reporting Claim:

Company Name

* First Name * Last Name

Address

City State Zip Code

* Work Phone 000 - 000 - 0000 ext 00000 Cell Phone 000 - 000 - 0000

E-mail

Are you a party to the claim? Yes No

What is your relationship to the claim?

We appreciate the time you are taking to complete this claim. Entering as much information as you can provide will expedite handling. For questions or problems, please contact us.

Workers Compensation Claim

Policyholder/Employer

Asterisk (*) indicates required field

Insurer/Carrier Name:

Address

City | State | Zip Code

Carrier FEIN | Policy # or Self Insured #

Insured Name | Self Insured ◯ Yes ◯ No

Insured FEIN

Policy Effective Date MM / DD / YYYY | Policy Expiration Date MM / DD / YYYY

Employer

* Company Name

Physical Address

City | State | Zip Code

* Work Phone 000 - 000 - 0000 ext 00000 | Cell Phone 000 - 000 - 0000 *One phone number required.*

Mailing Address: ◯ Same as above

Street Address

City | State | Zip Code

Employer FEIN

Employer SIC/NAICS Code | Location Code # | Division #

Employer Contact Name

First Name | Last Name

Work Phone 000 - 000 - 0000 | Cell Phone 000 - 000 - 0000

E-mail

Employer Nature of Business

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Workers Compensation Claim

Injured Party

Asterisk (*) indicates required field

Injured Employee Name:

First Name | Last Name

Date of Birth (MM / DD / YYYY) | Social Security # (000 - 00 - 0000)

Date of Hire (MM / DD / YYYY) | Green Card or Employment Visa #

* Home Phone (000 - 000 - 0000) | Cell Phone (000 - 000 - 0000) | *One phone number required.

Home Physical Address

City | State | Zip Code

Home Mailing Address: ◯ Same as above

Street Address

City | State | Zip Code

Work Phone (000 - 000 - 0000) | E-mail

Gender: ◯ M ◯ F

Marital Status: ◯ Single ◯ Married ◯ Separated ◯ Unknown

Occupation/Job Title

Employment Status

NCCI Class Code

Wage Rate ($) ◯ Day ◯ Week ◯ Month Other

Days Worked Per Week | Hours Worked Per Day

Full Pay for Date of Injury ◯ Yes ◯ No | Did Salary Continue? ◯ Yes ◯ No

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Claim Details

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Time Employee began work 00 : 00 AM

* Date of Injury or Illness MM / DD / YYYY

Time of Injury or Illness 00 : 00 AM

Last Work Date MM / DD / YYYY

Date Employer Notified MM / DD / YYYY

Date Disability Began MM / DD / YYYY

* Accident Description

If Fatal, Date of Death MM / DD / YYYY

Occurrence on Insured Premises? Yes No

– If "No," please enter Accident Location:

Address

City

* State

Zip Code

– If "Yes," enter Location or Department where Accident, Injury, Illness exposure occurred:

List Equipment, Materials, or Chemicals used by Employee when the incident occurred:

Specific Activity the Employee was engaged in when the incident occurred:

Work process the Employee was engaged in when incident occurred:

Were Safeguards or Safety Equipment provided? Yes No

Type of Illness/Injury

Cause of Injury/Illness

Part of Body Affected

Initial Treatment

- No Medical Treatment
- Minor Treatment by Employer
- Minor Treatment at Clinic/Hospital
- Emergency Care
- Hospitalized/24 hours
- Future Major Medical/ Lost Time Anticipated

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Other Information

Asterisk (*) indicates required field

Medical Provider Name:

Address

City State Zip Code

Phone # 000 - 000 - 0000

Add Another Medical Provider

Hospital Name:

Address

City State Zip Code

Phone # 000 - 000 - 0000

Witness to Incident:

First Name Last Name

Address

City State Zip Code

Phone # 000 - 000 - 0000 Cell Phone 000 - 000 - 0000 *One phone number required.

E-mail

Add Another Witness Name

Is this OSHA Reportable? Yes No

OSHA log #

We appreciate the time you are taking to complete this claim. Entering as much information as you can provide will expedite handling. For questions or problems, please contact us.

Workers Compensation Claim
Summary

Asterisk (*) indicates required field

Your claim is now ready for submission.
Please review all claim information and make any changes needed before submitting.

Is there anything else that you would like to note?

When you have completed this form, please save a copy for yourself and email the form and any attachments to reportaclaim@narisk.com. We will send you an acknowledgment electronically that we have received it.

We appreciate the time you are taking to complete this claim. Entering as much information as you can provide will expedite handling. For questions or problems, please contact us.