PINNACOL ASSURANCE

FIRST REPORT OF INJURY
To report a claim:
Call 303.361.4000 or 800.873.7242
Or Fax to 303.361.5000 or 888.329.2251
Or, go to www.pinnacol.com
PLEASE PRINT CLEARLY

Early reporting can save you money. Report all injuries immediately!
The information below allows Pinnacol Assurance's customer service representatives to quickly and accurately process your claim. Use the completed form as a guide when reporting by phone or online to save you time. Don't wait to report if you don't have all the answers.

POLICY INFORMATION

Policy Number: ____________________ Company Name: ____________________

Address or Location (if different than mailing address): ____________________

Prepared by: ____________________ (Please Print) Title: ____________________

E-mail: ____________________ Fax: (_____) _______-_________

Phone: (_____) _______-_________ Date Completed: _______/_______/_______

INJURED WORKER INFORMATION

Injured Worker's Social Security Number: _______-_______-_______ Date of Injury: _______/_______/_______

First Name: ____________________ M.I. ____ Last Name: ____________________

Home/Mailing Address: ____________________ City State Zip Code Phone: (_____) _______-_________

Date of Birth: _______/_______/_______ ☐ Male ☐ Female Martial Status: ____________________

Language: ☐ English ☐ Spanish ☐ Other: ____________ E-mail: ____________________

Occupation: ____________________ Date Hired: _______/_______/_______

Employee Status: ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Volunteer ☐ Independent Contractor

Days Worked per Week: __________ Hours Worked per Day: __________

Pay Rate: __________ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ Other: __________

ACCIDENT / INJURY INFORMATION

Fatal Injury: ☐ Yes ☐ No If Fatal Injury: Date of Death _______/_______/_______

Time of Injury: __________ ☐ am ☐ pm Time Work Began: __________ Last Day Worked: _______/_______/_______

Full Pay on Date of Injury: ☐ Yes ☐ No

Accident Occurred on Employers Premises: ☐ Yes ☐ No If Applicable: Location Code: __________ Dept Code: __________

Accident Location: ____________________ City State Zip Code

Name of Employer Representative Notified: ____________________ Date Notified: _______/_______/_______

Witnesses: ____________________ Name(s) and Phone Number(s)

How Did the Injury Occur: ____________________ Attach Additional Information if Necessary

Specific Activity the Employee Was Engaged In: ____________________ What Equipment Was Being Used: __________

Body Part(s) Injured: ____________________ ☐ Right ☐ Left ☐ Not Applicable

Type of Injury Sustained: ____________________

☐ Safety Equipment Provided ☐ Safety Equipment Used ☐ Possible Drug/Alcohol Involved ☐ Employer Questioning Liability

RETURN TO WORK INFORMATION

Has the Injured Worker Returned to Work? ☐ Yes ☐ No

Date Returned to Work: _______/_______/_______ Estimated Return to Work Date: _______/_______/_______

Is this a lost time Claim? ☐ Yes ☐ No (Claim is lost time if there is a loss of more than three scheduled work days due to the injury).

MEDICAL PROVIDER INFORMATION: Where Was Your Employee Treated?

☐ No Medical Treatment ☐ Treated by Employer ☐ 911 Called ☐ Walk-In Clinic

☐ Emergency Room ☐ Hospitalized > 24 hrs/Overnight ☐ Possible Surgery

Medical Provider Name | Street Address | City | State | Zip Code | Phone