First Report of Injury or Illness Form

CLAIM REPORTING INSTRUCTIONS

1. Fill out this First Report of Injury or Illness form in its entirety, with the injured employee if possible.

2. Send an email to **NewWCClaims@protectiveinsurance.com** listing the policy number, insured name, claimant name and date of injury. Include the following attachments:
    - Completed First Report of Injury or Illness Form
    - Copy of the **Authorization to Release Information** form, signed by the injured employee
    - Completed **Wage Statement** form
    - Copy of the injured employee's most recent W-2
    - Photocopy of a valid photo ID for the injured employee

3. In the subject line of the email, include the policy number, insured name, claimant name and date of injury.

4. Utilize the **First Fill Prescription Program** as needed.

Or report your claim via fax or phone:

Fax: (317) 715-9639

Phone: (800) 479-0981

WORKERS' COMPENSATION – FIRST REPORT OF INJURY OF ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	OSHA CASE NUMBER (IF APPLICABLE)	
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
	EMPLOYER'S PHONE NUMBER	EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

☐ PROTECTIVE INSURANCE ☐ SAGAMORE INSURANCE	AGENT NAME:	
	AGENT PHONE NUMBER:	POLICY NUMBER:

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS ☐ UNMARRIED/SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION/JOB TITLE	
EMAIL ADDRESS			EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO	
RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER	AVERAGE WEEKLY WAGES	# DAYS WORKED/WEEK	DID SALARY CONTINUE? ☐ YES ☐ NO	

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	TIME OF OCCURRENCE ☐ AM ☐ PM ☐ CANNOT BE DETERMINED	LAST DATE WORKED	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

DATE OF INJURY/ILLNESS	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
SUPERVISOR NAME	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	

PHONE (A/C, NO, EXT):	ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
	DATE RETURN(ED) TO WORK
HOW INJURY OR ILLNESS/ADNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL	IF FATAL, GIVE DATE OF DEATH
	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFFSITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT ☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR: CLINIC/HOSPITAL ☐ EMERGENCY CARE ☐ OVERNIGHT HOSPITALIZATION ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED
WITNESS NAME:	WITNESS NAME:	
PHONE (A/C, NO, EXT):	PHONE (A/C, NO, EXT):	
DATE ADMINISTRATOR NOTIFIED:		

EMPLOYER SIGNATURE ____________ DATE ____________ EMPLOYEE SIGNATURE ____________ DATE ____________