First Report

of Injury or Occupational Disease
MACO CLAIMS DEPARTMENT
PO Box 7059, Helena, MT 59604-7059

Adjuster Date Stamp

Highlighted areas are mandatory fields

Worker

Last Name	First Name	M.I.	Date of Birth	Social Security Number
Home Address	City	State	Postal Code	
Phone Number	Education ☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	Gender ☐ Male ☐ Female ☐ Unknown	Marital Status ☐ Married ☐ Separated ☐ Not Married ☐ Unknown	Number of Dependants

Wages

Date Hired	**Gross earnings for <u>four</u> pay periods preceding the injury** Date/Amount / Date/Amount / Date/Amount / Date/Amount /		
Employment Status ☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Volunteer	Number of Days worked per week	Wage	☐ Hour ☐ Week ☐ Month ☐ Other ☐ Day ☐ Bi-Weekly ☐ Year
In addition to gross earnings cited above worker received ☐ Room & Board ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other:	Estimated value if any		Time Employee began work

Worked next scheduled shift ☐ Yes ☐ No	Off work more than 4 work days ☐ Yes ☐ No ☐ Not Sure	Date Last Worked	Date of Return to Work	Full wages paid for date of injury ☐ Yes ☐ No	Salary Continued ☐ Yes ☐ No

Accident Description

Job Title	Description of Accident

Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	**Date of Injury**	Time of Injury

Date Disability Began	Date of Death	Names of Witnesses 1) 2) 3)
Accident on Employer's Premises ☐ Yes ☐ No	Accident Address or Location City State Postal code	

Date Employer Notified	**Accident Reported to**	Safety Equipment Provided ☐ Yes ☐ No	Safety Equipment Used ☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code	Phone Number
Hospital Name	Address	State	Postal Code	Phone Number

Type of initial medical treatment received ☐ No Treatment ☐ Emergency Room ☐ Treatment on-site by Employer or Medical Staff ☐ Clinic/Dr. Office ☐ Hospital

Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. <u>I understand</u> that signing this claim for compensation authorizes the release to the workers' compensation insurer or its agent, rehabilitation records, Social Security records and health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA) that are directly relevant to the claimed injury, disease or death. <u>I also understand</u> that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signature of Injured Worker or Beneficiary **Date**:

Employer

Employer Name	Doing Business as	Federal Employer Identification Number (Tax I.D)		
Mailing Address	City	State	Postal Code	Phone Number

Location of operation, if different from mailing address	Nature of Business SIC/NAICS Code	Self-Insured ☐ Yes ☐ No

Employer is a ☐ Sole Proprietorship ☐ Partnership ☐Corporation ☐ Limited Liability Company	Injured worker is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ A member of the employer's (sole proprietor) family living in the employer's household.

Do you have any reason to question this accident? ☐ Yes ☐ No If yes, please explain fully. Use separate sheet if you need additional space	Was worker injured while in your employ ☐ Yes ☐ No

Prepared By	**Official Title**	Phone Number	Date

Payroll Classification Code under which you report Employee's wages	**Authorized Employer's Signature** ______________ **Date** ______

Insurer

Claim Administrator Claim Number	Date Reported to Claim Administrator:	The above information is correct with the following exceptions ☐ (Attach extra sheets if box at right is checked)
Third Party Administrator Name	Claim Administrator Address	Insurer FEIN
Insurer Name	Third Party Administrator FEIN	
Policy Number	Policy Effective Date	Policy Expiration Date