FIRST REPORT of Injury or Occupational Disease

Montana Schools Group
WCRRP
Workers' Compensation Risk Retention Program

Send Completed form to:
MTSBA Insurance Services
PO Box 7029
Helena, MT 59604

Toll Free: 1-877-667-7392
Fax: 406-457-4505

Worker

Last Name	First Name	M.I.	Date of Birth (m/d/yyyy)	Social Security Number

Mailing Address	City	State	Postal Code

Contact Number	Education	Gender	Marital Status	Number of Dependants
	☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	☐ Male ☐ Unknown ☐ Female	☐ Married ☐ Separated ☐ Single ☐ Unknown	

Wages

Date Hired	Gross earnings for four pay periods preceding the injury	Date/Amount	Date/Amount	Date/Amount	Date/Amount
		/	/	/	/

Employment Status	Number of days worked per week:	Wage:
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer		☐ Hour ☐ Week ☐ month ☐ Other: ☐ Day ☐ Bi-weekly ☐ year

In addition to Gross Earnings cited above worker received: ☐ Overtime ☐ Bonus ☐ Other	Estimated Value:	Hours worked per day:

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

Occupation of injured worker	Injured assigned to:	School site/Building where inj. emp. works	Payroll classifcation code:
	☐ Elementary ☐ Middle ☐ High school ☐ Amin.		☐ 8868 ☐ 9101

Accident Description

Description of Accident:

Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	Date and Time of Injury
						/

Date Disability Began:	Date of Death:	Names of witnesses:	1)	2)	3)

Accident on employer's premises?	Accident address or location if off premises: Address:	City:	State:	Postal Code:
☐ Yes ☐ No				

Date employer notified:	Accident Reported to:	Safety equipment provided?	Safety Equipment used?
		☐ Yes ☐ No	☐ Yes ☐ No

Medical

Attending Physician's Name:	Address:	City	State/Zip	Phone Number:

Hospital Name:	Address:	City	State/Zip	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. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer (and its agents) and to the Montana Uninsured Employers' Fund of: Social Security records; rehabilitation records; and all 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. I also understand 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:
		MT		(406)

Location of operation, if different from mailing address:	Nature of Business or SIC Code:	Self-Insured?
	School District	☐ Yes ☐ No

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:	Date:

Authorized Employer's Signature:	Title:	Date:

Insurer

Claim Administrator's 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)

Claim Administrator's Name:	Claim Administrator's Address:	FEIN:
MTSBA INSURANCE SERVICES	PO Box 7029, Helena, MT 59604	81-0460841

Insurance Company Name:	Policy Number:	Policy Effective Date:	Policy Expiration Date:
Montana Schools Group Insurance Authority/ WCRRP			