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 ☐ LESS THAN HIGH SCHOOL ☐ GED OR HIGH SCHOOL DIPLOMA ☐ BEYOND HIGH SCHOOL	GENDER ☐ MALE ☐ UNKNOWN ☐ FEMALE	MARITAL STATUS ☐ MARRIED ☐ SEPARATED ☐ SINGLE ☐ UNKNOWN	NUMBER OF DEPENDANTS

Wages

DATE HIRED	GROSS EARNINGS FOR FOUR 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: ☐ OVERTIME ☐ BONUS ☐ OTHER	ESTIMATED VALUE:	HOURS WORKED PER DAY:

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

OCCUPATION OF INJURED WORKER	INJURED ASSIGNED TO: ☐ ELEMENTARY ☐ MIDDLE ☐ HIGH SCHOOL ☐ AMIN.	SCHOOL SITE/BUILDING WHERE INJ. EMP. WORKS	PAYROLL CLASSIFCATION CODE: ☐ 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? ☐ YES ☐ NO	ACCIDENT ADDRESS OR LOCATION IF OFF PREMISES: ADDRESS: 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:	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: MT	POSTAL CODE:	PHONE NUMBER: (406)

LOCATION OF OPERATION, IF DIFFERENT FROM MAILING ADDRESS:	NATURE OF BUSINESS OR SIC CODE: SCHOOL DISTRICT	SELF-INSURED? ☐ 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: MTSBA INSURANCE SERVICES	CLAIM ADMINISTRATOR'S ADDRESS: PO BOX 7029, HELENA, MT 59604	FEIN: 81-0460841

INSURANCE COMPANY NAME: MONTANA SCHOOLS GROUP INSURANCE AUTHORITY/ WCRRP	POLICY NUMBER:	POLICY EFFECTIVE DATE:	POLICY EXPIRATION DATE: