



Workers Compensation Claim Reporting Worksheet and Guide

We will produce and submit the necessary state forms and filings.



DO NOT DELAY IN REPORTING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.
PLEASE EMAIL YOUR COMPLETED FORM TO first.report@travelers.com OR CALL 1.800.238.6225.

ACCOUNT / ACCIDENT INFORMATION			
PREPARER'S PHONE NUMBER	PREPARER'S TITLE	PREPARER'S NAME	EMPLOYMENT STATE
SUBSIDIARY (COMPANY) NAME	SUBSIDIARY (COMPANY) ADDRESS (STREET, CITY, STATE & ZIP)	SUBSIDIARY (COMPANY) MAILING ADDRESS (STREET, CITY, STATE & ZIP) <input type="checkbox"/> SAME	
DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED			
PARENT COMPANY / INSURED'S NAME			
LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS	
DATE OF INJURY	TIME OF INJURY		
ACCIDENT DESCRIPTION			
EMPLOYEE INFORMATION			
INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	PRIMARY LANGUAGE
DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS		
EMPLOYEE'S PHONE NUMBER	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)	EMPLOYEE'S EMAIL ADDRESS	

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> OTHER	REGULAR ASSIGNED DEPARTMENT	REGULAR OCCUPATION
--	-----------------------------	--------------------

OCCUPATION WHEN INJURED

EMPLOYEE'S WORK SCHEDULE

REGULAR WORK HOURS	HOURS/DAY	DAYS/WEEK
_____	_____	_____

EMPLOYEE'S WAGE INFORMATION:

\$ _____ HOUR OR \$ _____ / ANNUAL OR _____ / WEEKLY OVERTIME: \$ _____ ADD'L BENEFITS: \$ _____

DATE OF HIRE OR LENGTH OF EMPLOYMENT

SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER:	SUPERVISOR'S EMAIL ADDRESS:	BEST HOURS TO CONTACT
_____	_____	_____	_____

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK OR ARE THEY WORKING MODIFIED DUTY BEYOND THE DATE OF THE INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THE EMPLOYEE BACK AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE RETURNED TO WORK? IS THERE AN ANTICIPATED RETURN TO WORK DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, ANTICIPATED RETURN DATE?
----------------------------------	---	---

RETURN TO WORK STATUS <input type="checkbox"/> LIGHT <input type="checkbox"/> MODIFIED <input type="checkbox"/> REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH <input type="checkbox"/> YES <input type="checkbox"/> NO
--	---------------------------	---

DO YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT ARE YOU QUESTIONING? <input type="checkbox"/> INJURY WORK RELATED <input type="checkbox"/> EXTENT OF INJURY <input type="checkbox"/> OTHER
---	--

WITNESS INFORMATION

NAME (FIRST, MI, LAST)	PHONE NUMBER
_____	_____

ADDRESS

NAME (FIRST, MI, LAST)	PHONE NUMBER
_____	_____

ADDRESS

NAME (FIRST, MI, LAST)	PHONE NUMBER
_____	_____

ADDRESS

INJURY INFORMATION	
CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)	
PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)	
NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION)	
PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, PLEASE DESCRIBE) <input type="checkbox"/> YES <input type="checkbox"/> NO	
TREATMENT (“X” ALL THAT APPLY)	
<input type="checkbox"/> UNKNOWN <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> FIRST AID/MINOR ON SITE TREATMENT <input type="checkbox"/> DOCTOR’S OFFICE/WALK-IN CLINIC <input type="checkbox"/> EMERGENCY ROOM <input type="checkbox"/> HOSPITAL/CLINIC – ADMITTED >24 HOURS	
DESCRIPTION OF TREATMENT AND DATE OF 1st TREATMENT	
NAME, ADDRESS, PHONE NUMBER OF TREATING FACILITY	
PHYSICIAN NAME	
INSURED CONTACT INFORMATION	
CONTACT NAME	PHONE NUMBER
EMAIL ADDRESS	BEST TIME TO CONTACT AND WHERE TO CONTACT
ADDITIONAL NOTES/COMMENTS OR CUSTOMER SPECIFIC INFORMATION	



travelers.com

The Travelers Indemnity Company and its property casualty affiliates. One Tower Square, Hartford, CT 06183

This material is for informational purposes only. All statements herein are subject to the provisions, exclusions and conditions of the applicable policy. For an actual description of all coverages, terms and conditions, refer to the insurance policy. Coverages are subject to individual insureds meeting our underwriting qualifications and to state availability.

CE-10347 New 12-17