CHUBB®

Chubb Workers Compensation Report of Injury Worksheet

Internet: www.chubb.com • Phone: 1.800.699.9916

Things to remember when reporting a Workers Compensation Claim:
Use this Report of Injury Worksheet as a reference for collecting details. It is not necessary to write in answers to questions you know when calling us. If you plan to fax us, you should fill in the ***2 page*** worksheet. However, whether you are calling or faxing, do not delay in reporting the claim even if you do not have answers to every question.

Location/Site Code:	State:
Date of Accident:	

Employers Name: Mail Address (street):

Phone # (area code first): Nature of Business:

Preparer's Name: Preparer's Title:

Days Open: **Policy Number:**

Employee Name (Last, First): Mail Address:

City/County/Parish: State: Zip:

Phone # (Area Code First): Social Security # Sex Age

Date of Birth: Marital Status (S,M,D,W): Occupation

Regular Dept: Hire Date: Length Employed: Yrs. Mos. Dys.

Date in Job: Length in Job: Yrs. Mos. Dys.

Date Injury Reported to Employer: Estimated/Actual Days off:

Injury/Illness Description:

Employment status: (F,P,S,V)		Is the Employee Owner/Officer, Partner?	
Wage Class:	Paid Day INJ?	(Y/N/U)	Piece/Time:
Hrs/Day:	Days/Wk:	Hrs/wk:	Wages/Hr:
Wages/Days:		Avg. Wage/Wk:	Salary/Mos:
Reg Days Off:		Per (W/M/Y):	

Accident Loc (Street Address): City: State

County: State: Zip: On Premise (Y/N):

Injury/Disease (I/D): Time of Injury: Time Shift Begins: A/P: Ends: A/P:

Supervisor: Time reported: A/P: Last Worked:

Time Left: A/P: Lost time (Y/N): First Off: # Of Employees Injured

Fatal (Y/N): Date of Death: What was the employee doing?

Nature of Injury/Body Part: Object/Substance Involved:

How could employer prevent?

How could employee prevent?

Who caused the accident if not the employee?

Address of the person who caused the accident:

Returned (Y/N): Date: Time: AP REG ( ) Light ( ) Duty ( ) Return Wage:

Return Occupation: Paid while injured? (Y/N):

Reason to doubt validity of claim?

Witness Name(s): Address City State Zip

Doctor's Name: Address City State Zip

Doctor's Phone #: Hospitalized (Y/N)?

Hospital Name: Address City State Zip

Hospital Phone #: Total Depend. #: Minor Depend. #:

Death-if yes, next of kin name & address:

Preparer's phone number: Mailing instructions:

The address the employer would like the first report of injury mailed to:

Additional address employer would like the first report of injury mailed to:

Your Claim # _____

Phone: 1.800.699.9916 **Internet:** www.chubb.com **Fax:** 1.800.884.3946