First Report of Injury Filing Guide

To report a claim please call your GCG Risk Management "First Report of Injury" response line at

1-888-785-7755, ext. 1 or ext. 2

Your GCG representative will need the information on this form to properly process your claim.
Please use this form as a guide.

CLAIMANT/EMPLOYEE:

Name_____
Home Address: _____
City, St, Zip:_____
Phone #: _____
SS#: _____
D.O.B. _____/_____/____ M☐ F☐
Job Title: _____
Related to Owner: Yes ☐ No ☐ Relationship: _____
Date Hired: ____/____/____

EMPLOYER INFORMATION:

Employer: _____
Mailing Address: _____
_____
Location (if different):_____
Nature of Business: _____
Employer Phone #: _____
Employer FEIN#: _____
NY UI Employer Reg #:_____
WC Policy #:_____

PAYROLL INFORMATION:

Amount Paid last 52 weeks:_____
Average Weekly Wage: _____
Employee's Job was (check one): Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other ☐_____
Work Week (days worked): M ☐ T☐ W ☐ TH☐ F☐ Sat ☐ Sun ☐
Was the employee paid for a full day on the day of the injury/illness? Yes ☐ No ☐
Did the employee receive lodging or tips in addition to pay Yes ☐ No ☐ If yes, describe:_____
Last date worked: ____/____/____ Last date paid: ____/____/____ In Full? Yes ☐ No ☐
Did you continue to pay the employee after the injury/illness (e.g. sick leave, vacation, disability, regular salary)? Yes ☐ No ☐
If Yes, is reimbursement requested? Yes ☐ No ☐

ACCIDENT INFORMATION:

Date of Accident:_____ Time of day employee began to work on date of injury: _____ AM ☐ PM ☐
Time of Accident:_____ AM ☐ PM ☐
Has the employee given you notice of injury/illness? Yes ☐ No ☐ Date notice provided _____/_____/_____
If Yes, Name & Title of person to whom accident was reported :_____ Oral ☐ Written ☐
His or Her Phone#_____
Address where Accident occurred: Assured address? Yes ☐ No ☐ If No, please give address where accident occurred:_____
_____ County:_____
Was this location where the employee normally worked? Yes ☐ No ☐ If No, why was employee there? _____
Employee's Supervisor: _____ Did Supervisor see injury happen? Yes ☐ No ☐ Unknown ☐
Did anyone else see injury happen? Yes ☐ No ☐ Unknown ☐ If yes, name of witness and position _____
_____
What was employee doing when injured? _____
What body parts affected? _____
Was an object (e.g. forklift, hammer, acid) involved in injury/illness? Yes ☐ No ☐ If Yes, what was it? _____
Was the injury the result of the use or operation of a licensed motor vehicle? Yes ☐ No ☐
If Yes: Employee's vehicle ☐ Employer's vehicle ☐ Other vehicle ☐ License plate number (if known) _____
Auto Insurance information: _____
Did the injury/illness result in the employee's death? Yes ☐ No ☐ If Yes, what was the date of death? ____/____/____

Are you disputing the accident? If so, why?_____ _____
_____

If Non-Work Related or You Are Disputing this claim then NYS Disability Insurance Information Required:

NYS DB Company:_____
Address:_____
City, State, Zip:_____
Policy#:_____

MEDICAL TREATMENT INFORMATION:

Date of employee's first medical treatment: ____/____/____ None received ☐ Unknown ☐
Where did the employee receive first medical treatment for this injury/illness? Onsite ☐ Doctor's office ☐ Emergency Room ☐
Clinic/Hospital/Urgent Care ☐ Hospital stay over 24 hours ☐ Unknown ☐
Who treated the employee and where?
Doctor Name: _____
Hospital/Clinic Name (if applicable): _____
Address: _____
Telephone: _____
Number of Doctor/Hospital visits to date:_____
Is the employee still being treated for this injury/illness? Yes ☐ No ☐ Unknown ☐ If Yes, name and address of treating doctor(s):
_____
_____
To your knowledge, did the employee have another work-related injury to the same body part or a similar illness while working for you?
Yes ☐ No ☐ If Yes, name of doctor(s) who treated the previous injuries/illnesses (if known): _____
Did you provide any medical care? Yes ☐ No ☐ If Yes, please describe what and when:_____

RETURN TO WORK INFORMATION:

Did the employee stop work because of his/her injury/illness? Yes ☐ No ☐ If Yes, on what date? ____/____/____
Light duty available? Yes ☐ No ☐
Is claimant/employee back to work? Yes ☐ No ☐ Date of return to work: ____/____/____
Full Pay? Yes ☐ No ☐ If No, average gross earnings?_____

COMMENTS:

_____
_____
_____
_____

Report prepared by: _____ Date: _____