## First Report of Injury Filing Guide

To report a claim please call your <u>GCG Risk Management "First Report of Injury"</u> 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.

Mailing Address:   City, St, Zip:   City, St, Zip:   Location (if different):   SS#;   Nature of Business:   Employer Phone #:   Location (if different):   SS#;   Nature of Business:   Employer Phone #:   Job Title:   Employer FEIN#:   NY UI Employer Reg #:   WC Policy #:	CLAIMANT/EMPLOYEE:	EMPLOYER INFORMATION:
Mailing Address:	Name	
Do.B.	Home Address:	Mailing Address:
Do.B.	City, St, Zip:	
No. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10	Phone #:	Location (if different):
Employer FEIN#:   Related to Owner: Yes   No   Relationship:   NY UI Employer Reg #:   WC Policy #:   WC Poli	SS#:	Nature of Business:
Employer Reg #:	D.O.B/ ML FL	Employer Phone #:
PAYROLL INFORMATION:  Amount Paid last 52 weeks:  Average Weckly Wage:  Employee's Job was (check one): Full Time	Job Title:	Employer FEIN#:
PAYROLL INFORMATION:  Amount Paid last 52 weeks:  Average Weekly Wage:  Employee's Job was (check one): Full Time   Part Time   Seasonal   Volunteer   Other    Was the employee paid for a full day on the day of the injury/illness? Yes   No    Id day worked:   /   Last date paid:   In Full? Yes   No    If yes, describe:  Last date worked:   /   Last date paid:   In Full? 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    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      Has the employee given you notice of injury/illness? 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   Did anyone else see injury happen? Yes   No   Unknown   Did yes, name of witness and position    What was employee doing when injured?      Was this body parts affected?      Was the injury her result of the use or operation of a licensed motor vehicle? Yes, what was the date of death?   /    Auto Insurance information.      If Yes, Employee's vehicle   Employer's vehicle   Other vehicle   License plate number (if known)    Auto Insurance information.      Auto Bustrace information      If Non-Work Related or You Are Disputing this claim then NYS Disability Insurance Information Required:    NYS DB Company:      Address:	Related to Owner: Yes $\square$ No $\square$ Relationship	p: NY UI Employer Reg #:
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   T H   D   Stat   Stan    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:	Date Hired:/	WC Policy #:
Average Weekly Wage: Employee's 150 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, sescribe: Last date worked:	PAYROLL INFORMATION:	
Average Weekly Wage: Employee's 150 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, sescribe: Last date worked:	Amount Paid last 52 weeks:	
Work Week (days worked): M   TH   F   Sat   Sun   Was the employee paid for a full day on the day of the injuncy/illness? Yes   No   If yes, describe:   Last date worked:	Average Weekly Wage:	
Work Week (days worked): M   TH   F   Sat   Sun   Was the employee paid for a full day on the day of the injuncy/illness? Yes   No   If yes, describe:   Last date worked:	Employee's Job was (check one): Full Time	☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other ☐
Did the employee receive lodging or tips in addition to pay Yes No If yes, describe:  Last date worked:	Work Week (days worked): M ☐ T☐ W ☐ T	I'H∟ F∟ Sat ∟ Sun ∟
Last date worked:	Was the employee paid for a full day on the d	lay of the injury/illness? Yes $\square$ No $\square$
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:	Did the employee receive lodging or tips in a	ddition to pay Yes L No L If yes, describe:
ACCIDENT INFORMATION:  Date of Accident: Time of day employee began to work on date of injury: AM	Last date worked:/ Last dat	te paid:/ In Full? Yes $\square$ No $\square$
Date of Accident: Time of day employee began to work on date of injury: AM		
Date of Accident: Time of day employee began to work on date of injury: AM	If Yes, is reimbursement requested? Yes □	No L
Date of Accident: Time of day employee began to work on date of injury: AM	ACCIDENT INFORMATION:	
Has the employee given you notice of injury/illness? Yes \  \text{No} \  \text{Date notice provided} \ /	recibert ha ordination.	
Has the employee given you notice of injury/illness? Yes \  \text{No} \  \text{Date notice provided} \ /	Data of Assidant:	Time of day ampleyee began to week an data of injum.
Has the employee given you notice of injury/illness? Yes \  \text{No} \  \text{Date notice provided} \ /	Date of Accident:	Time of day employee began to work on date of injury: AM \(\sigma\) PM \(\sigma\)
His or Her Phone#  Address where Accident occurred: Assured address? Yes	Has the employee given you notice of injury/	FIN L
His or Her Phone#  Address where Accident occurred: Assured address? Yes	If Vas Name & Title of person to whom again	dent was reported:
Address where Accident occurred: Assured address? Yes	His or Her Phone#	dent was reported Orai 🗆 written 🗅
Was this location where the employee normally worked? Yes \Box If No, why was employee there?  Employee's Supervisor: \Did Supervisor see injury happen? Yes \Box In the location where the employee normally worked? Yes \Box If No, why was employee there?  Did Supervisor see injury happen? Yes \Box In the location of location of the location of location of the location of location location of location of location of location locatio	Address where Assident assured: Assured a	ddragg? Var No No No nlagg give addragg where agaident accoursed:
Employee's Supervisor: Did Supervisor see injury happen? Yes		County:
Did anyone else see injury happen? Yes \Bo	Was this location where the employee normal	
Did anyone else see injury happen? Yes \ \ \ No \ \ \ Unknown \ \ \ If yes, name of witness and position \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Employee's Supervisor:	Did Supervisor see injury happen? Yes $\square$ No $\square$ Unknown $\square$
What was employee doing when injured?  What body parts affected?  Was an object (e.g. forklift, hammer, acid) involved in injury/illness? Yes \( \text{No} \) \( \text{If Yes, what was it?} \)  Was the injury the result of the use or operation of a licensed motor vehicle? Yes \( \text{No} \) \( \text{If Yes: Employee's vehicle} \) \( \text{Employer's vehicle} \) \( \text{Other vehicle} \) \( \text{License plate number (if known)} \)  Auto Insurance information:  Did the injury/illness result in the employee's death? Yes \( \text{No} \) \( \text{If Yes, what was the date of death?} \) \( /	Did anyone else see injury happen? Yes $\square$ N	o ☐ Unknown ☐ If yes, name of witness and position
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:  City, State, Zip:	What was employee doing when injured?	
Was the injury the result of the use or operation of a licensed motor vehicle? Yes \( \subseteq \text{No } \subseteq \)  If Yes: Employee's vehicle \( \subseteq \text{Employer's vehicle } \subseteq \text{Other vehicle } \subseteq \text{License plate number (if known)} \)  Auto Insurance information:  Did the injury/illness result in the employee's death? Yes \( \subseteq \text{No } \subseteq \text{If Yes, what was the date of death?} \)  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:	What body parts affected?	
Was the injury the result of the use or operation of a licensed motor vehicle? Yes \( \subseteq \text{No } \subseteq \)  If Yes: Employee's vehicle \( \subseteq \text{Employer's vehicle } \subseteq \text{Other vehicle } \subseteq \text{License plate number (if known)} \)  Auto Insurance information:  Did the injury/illness result in the employee's death? Yes \( \subseteq \text{No } \subseteq \text{If Yes, what was the date of death?} \)  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:	Was an object (e.g. forklift, hammer, acid) in	volved in injury/illness? Yes \( \subseteq \text{No} \subseteq \subseteq \text{If Yes, what was it?} \)
Auto Insurance information:  Did the injury/illness result in the employee's death? Yes \( \subseteq \text{No} \subseteq \subseteq \text{If Yes, what was the date of death?} \)	Was the injury the result of the use or operation	on of a licensed motor vehicle? Yes ☐ No ☐
Auto Insurance information:  Did the injury/illness result in the employee's death? Yes \( \subseteq \text{No} \subseteq \subseteq \text{If Yes, what was the date of death?} \)	If Yes: Employee's vehicle ☐ Employer's ve	ehicle ☐ Other vehicle ☐ License plate number (if known)
Are you disputing the accident? If so, why?	Auto Insurance information:	. , , , , , , , , , , , , , , , , , , ,
If Non-Work Related or You Are Disputing this claim then NYS Disability Insurance Information Required:  NYS DB Company:  Address:  City, State, Zip:	Did the injury/illness result in the employee's	death? Yes $\square$ No $\square$ If Yes, what was the date of death?/
NYS DB Company:Address:	Are you disputing the accident? If so, why?	
NYS DB Company:Address:	If Non-Word, Dalated V A D' C	this shains then NWC Disability Insurance L.C
Address:City, State, Zip:	•	
City, State, Zip:	NYS DB Company:	
Сиу, элан, др:	Address:	
	Daliar#	

## MEDICAL TREATMENT INFORMATION:

Date of employee's first medical treatment://	None received Unknown U	
Where did the employee receive first medical treatment for	this injury/illness? Onsite Doctor's office Emergency Room D	
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:		
Telephone:  Number of Doctor/Hospital visits to date:  Lether and the still being treated for this injury (illusers? V.		
Is the employee still being treated for this injury/illness? Ye	es $\square$ No $\square$ Unknown $\square$ If Yes, name and address of treating doctor(s):	
Yes $\square$ No $\square$ If Yes, name of doctor(s) who treated the pr	elated injury to the same body part or a similar illness while working for you revious injuries/illnesses (if known):	
RETURN TO WORK INFORMATION:		
Did the employee stop work because of his/her injury/illness Light duty available? Yes \( \subseteq \text{No} \subseteq \) Is claimant/employee back to work? Yes \( \subseteq \text{No} \subseteq \) Date of Full Pay? Yes \( \subseteq \text{No} \subseteq \subseteq \text{If No, average gross earnings?} \( \subseteq \)	return to work:/	
COMMENTS:		
Report prepared by:	Date:	