Workers' Compensation First Notice of Loss

Telephonic Reporting: 1-800-327-3636
Fax Reporting: 1-800-347-8197
E-mail Reporting: lossconnect@thehartford.com

Please complete the following comprehensive list of questions to report your Workers' Compensation Loss. You can use this template for phone, fax or e-mail submission. Asterisks (*) denote information that is critical to proper handling office assignment. Please be sure to obtain this information prior to reporting a claim.

EMPLOYER / LOSS LOCATION INFORMATION

Policy Number: _____ Account Number: _____ IRC / Loc. Code: _____
*Filing State: _____ *Date of Loss: _____ Time of loss: _____
Account Name: _____ Employer Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Business Phone: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Accident Location Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Did the injury occur on the insured's premises? ☐Yes ☐ No If no, where did injury occur? _____

PERSON REPORTING CLAIM TO THE HARTFORD – INFORMATION

Name: _____ Title: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Mobile Phone: _____ Fax Number: _____
Email Address: _____

INSURED CONTACT INFORMATION

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Mobile Phone: _____ Fax Number: _____
Email Address: _____ Contact Preference: ☐ Email ☐ Mail ☐ Phone

EMPLOYEE/CLAIMANT INFORMATION

Employee Name: _____
Employee Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Night Phone: _____ Mobile Phone: _____

Email Address: _____

Social Security Number: _____ Date of Birth: _____ # of Dependents: _____

Gender: _____ Marital Status: _____ Preferred Language: _____

EMPLOYMENT INFORMATION

Date of Hire: _____ State of Hire: _____ Date Shift Begin: _____

Time Shift Begin: _____ ☐ AM ☐PM Time Shift Ends: _____ ☐ AM ☐PM

Hours Worked Per Day: _____ Days Worked Per Week: _____

Pay Type: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Salary

Pay Check Frequency: ☐ Bi Weekly ☐ Weekly ☐ Monthly ☐ Twice Monthly

Is the claimant's typical work schedule Monday through Friday? ☐ Yes ☐ No ☐ Unknown

Is it a fixed or varied schedule? ☐ Fixed ☐ Varied ☐ Unknown

Scheduled Work Days: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

Employment Status: ☐ Full Time ☐ Part Time ☐ Seasonal/Temporary ☐ Other/Unknown

Recent Disciplinary Action: ☐ Yes ☐ No ☐ Unknown

Occupation: _____ Regular Department: _____

Injured in Regular Occupation? ☐ Yes ☐ No ☐ Unknown

Department Where Injury Occurred: _____

Describe Physical Demands of the Employee's Job:

☐ Sedentary (sitting most of the time)
☐ Light (usually walking or standing)
☐ Medium (exerting up to 10lbs of force constantly)
☐ Heavy (exerting up to 20lbs of force constantly)
☐ Very Heavy (exerting excess 20lbs of force constantly)
☐ Unknown

NCCI (Job Class Code): _____ Officer/Owner/Partner? ☐ Yes ☐ No ☐ Unknown

Supervisor Name: _____

Supervisor Address: _____

City: _____ State: _____ Zip Code: _____

Supervisor Day Phone: _____ Supervisor Mobile Phone: _____

Supervisor Email Address: _____

LOSS INFORMATION

*Please provide a description of the accident (what was employee doing at time of injury and what type of injury was sustained):

Injury Result in Death? ☐ Yes ☐ No

Was the employee injured while performing normal job duties? ☐ Yes ☐ No ☐ Unknown

Did the injury occur during normal work hours? ☐ Yes ☐ No ☐ Unknown

Do you question the injury? (If yes, provide Reason in Additional Information below) ☐ Yes ☐ No ☐ Unknown

Date of Notice (Reported to Employer): _____ Time Reported: _____

Who was the injury reported to? _____

Address: _____

City: _____ State: _____ Zip Code: _____

Day Phone: _____ Mobile Phone: _____

Email Address: _____

Does the employee have Group Health Insurance? ☐ Yes ☐ No ☐ Unknown

Name of Group Health Carrier: _____

Address: _____

City: _____ State: _____ Zip Code: _____
Phone: _____ Has the employee received treatment? ☐ Yes ☐ No ☐ Unknown

INITIAL TREATMENT INFORMATION

Incident only: ☐ Yes ☐ No ☐ Unknown

Where did employee receive treatment?
☐ Clinic ☐ Emergency Room ☐ First Aid ☐ Other ☐ Admitted to Hospital ☐ Unknown

Emergency transportation required? ☐ Ambulance ☐ Helicopter ☐ Other _____
Medical Provider Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Business Phone: _____ Name of Physician: _____
Treatment Type: ☐ Stitches ☐ X-ray ☐ Physical Therapy ☐ Other: _____
Additional Treatment Received: _____
Do you expect further medical treatment? ☐ Yes ☐ No ☐ Unknown
If Yes: Will the injury require surgery? ☐ Yes ☐ No ☐ Unknown

LOST TIME

Has the employee lost time from work? ☐ Yes ☐ No ☐ Unknown

IF YES
Last Date Worked: _____ First Day Missed: _____
Salary/Wages Continued: ☐ Yes ☐ No ☐ Unknown

Paid for Date of Injury? ☐ Yes ☐ No ☐ Unknown
*Has the employee returned to work? ☐Yes ☐No ☐ Unknown
Date returned or expected to return to work: _____
Will or has the employee returned to: ☐ Regular Duty ☐ Light Duty ☐ Unknown
Will or has the employee returned to reduced hours or wage? ☐ Yes ☐ No ☐ Unknown
Is there any intermittent lost time? ☐ Yes ☐ No ☐ Unknown

ADDITIONAL INCIDENT INFORMATION

Was the employee performing an unsafe act? ☐ Yes ☐ No ☐ Unknown
Did the injury involve equipment or machinery? ☐ Yes ☐ No ☐ Unknown
If Yes: Was the equipment or machinery defective? ☐ Yes ☐ No ☐ Unknown
Safety equipment provided? ☐ Yes ☐ No ☐ Unknown
Safety equipment used? ☐ Yes ☐ No ☐ Unknown

Is a 3rd party potentially responsible for the injury? ☐ Yes ☐ No ☐ Unknown

IF YES
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Night Phone: _____
Mobile Phone: _____ Email Address: _____

Are there any witnesses? ☐ Yes ☐ No ☐ Unknown

IF YES

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Day Phone: _____ Night Phone: _____

Mobile Phone: _____ Email Address: _____

Has the employee had previous injuries? ☐ Yes ☐ No ☐ Unknown

IF YES:

Please describe**:**

ADDITIONAL INFORMATION