

EMPLOYEE'S PHONE NUMBER

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 LossRptCSS@constitutionstateservices.com OR CALL 800.243.2490.

ACCOUNT INFORMATION			
PREPARER'S PHONE NUMBER AND EMAIL ADDRESS	PREPARER'S TITLE AND NAME		IN WHICH STATE DOES THE INJURED EMPLOYEE PRIMARILY WORK
SUBSIDIARY (COMPANY) NAME	SUBSIDIARY (COMPANY) ADDRESS (STREET, CITY, STATE & ZIP)		SUBSIDIARY (COMPANY) MAILING ADDRESS (STREET, CITY, STATE & ZIP) SAME
DID THE LOSS OCCUR AT THE LOCATION ADDRESS? (IF "NO	O", ADDRESS WHERE LOSS OCCURRED)		
□ YES □ NO			
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	PRIMARY LANGUAGE
		□ MALE □ FEMALE	
DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS		

EMPLOYEE'S EMAIL ADDRESS

EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)

EMPLOYEE JOB INFORMATION EMPLOYMENT STATUS CODE REGULAR ASSIGNED DEPARTMENT REGULAR OCCUPATION ☐ FULL-TIME ☐ PART-TIME ☐ OTHER OCCUPATION WHEN INJURED **EMPLOYEE'S WORK SCHEDULE** REGULAR WORK HOURS HOURS/DAY DAYS/WEEK **EMPLOYEE'S WAGE INFORMATION** OR WEEKLY OVERTIME ADD'L BENEFITS HOUR OR ANNUAL 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 IS THE EMPLOYEE BACK AT WORK? THEY WORKING MODIFIED DUTY BEYOND THE DATE OF THE ☐ YES INJURY? ☐ YES IF YES, DATE RETURNED TO WORK □ NO IS THERE AN ANTICIPATED RETURN TO WORK DATE? ☐ YES □ NO IF YES, ANTICIPATED RETURN DATE RETURN TO WORK STATUS DATE EMPLOYEE LAST WORKED WAS INJURY FATAL? IF YES, DATE OF DEATH ☐ YES ☐ LIGHT ☐ MODIFIED \square NO ☐ REGULAR DO YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING IF YES, WHAT ARE YOU QUESTIONING? THE INJURY? ☐ WORK-RELATED INJURY ☐ YES □ EXTENT OF INJURY \square NO ☐ OTHER WITNESS INFORMATION NAME (FIRST, MI, LAST) PHONE NUMBER ADDRESS NAME (FIRST, MI, LAST) PHONE NUMBER ADDRESS NAME (FIRST, MI, LAST) PHONE NUMBER

ADDRESS

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INJURY INFORMATION			
CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)			
PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)			
PART OF BOOT INJURED (E.G., NEAD, NECK, ARIM, LEG)			
PRIOR INJURY OR PREEXISTING CONDITION(S) (IF YES, PLEASE DESCRIBE)			
□ YES			
TREATMENT ("X" BY ALL THAT APPLY)			
UNKNOWN			
□ NO MEDICAL TREATMENT			
☐ FIRST AID/MINOR ON-SITE TREATMENT			
□ DOCTOR'S OFFICE/WALK-IN CLINIC			
□ EMERGENCY ROOM			
☐ HOSPITAL/CLINIC – ADMITTED >24 HOURS			
DESCRIPTION OF TREATMENT AND DATE OF FIRST TREATMENT			
NAME, ADDRESS, PHONE NUMBER OF TREATING FACILITY			
PHYSICIAN'S NAME			
INICLIDED CONTACT INFORMATION			
INSURED CONTACT INFORMATION			
CONTACT NAME, PHONE NUMBER, EMAIL ADDRESS, AND BEST TIME TO CONTACT AND WHERE TO CONTACT			
ADDITIONAL NOTES/COMMENTS OR CUSTOMER-SPECIFIC INFORMATION			
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