THE RESEARCH FOUNDATION
The State University of New York

WORKERS' COMPENSATION-DIRECT LOSS REPORTING GUIDE
1-800-699-9916 (CHUBB*First*)
Fax: 1-800-884-3946

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 worksheet. However, whether you are calling or faxing, do not delay in reporting the claim if you do not have answers to every question.

Location Code			**State**				
Date of Accident			**Employer's FEIN #**				
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 Inj 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$**	
Wages/Day$		**Avg. Wage/Wk$**		**Salary/MO$**			
Reg Days Off				**Per (W/M/Y)**			

Accident LOC (Street Address)				**City**							**Zip**							
County			**St**				**Zip**				**On Premises (Y/N)**							
Injury/Disease (I/D)			**Time of Inj**		**A/P**		**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 Inj**							
Fatal (Y/N)		**Date of Death**			**What was the employee doing?**													
Nature of Injury/Body Part					**Objects/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**		**A/P**		**Reg ( )**	**Light ( )**	**Duty (X)**	**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 and address

Preparer's Phone Number		**Mail 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 #_____