MJ Insurance/Sorority Division

First Report of Injury Form for Workers' Compensation Claims

Sorority and House Corporation/Chapter			
Street Address			
City, State ZIP			
Contact Name		**Contact Phone**	( )

Employee Information:

Injured Employee's Name			
Injured Employee's Street Address			
City, State ZIP			
Male or Female		**Marital Status**	
Injured Employee's Social Security Number		**Employee Phone**	( )
Number of Dependents			
Date of Birth		**Date of Hire**	
Occupation		**Average Weekly Wage**	
Number of days worked per week		**Number of hours worked per week**	

Accident Information:

Accident Date		**Time of Accident**	
Description of Accident			
Any days lost		**First day of lost time**	
Last day worked		**Date of return**	
Was employee paid for date of injury?		**Time employee begins work**	
Eyewitness Name		**Eyewitness Phone Number**	( )

Doctor/Hospital Information:

Doctor's Name	
Doctor's Street Address	
Doctor's City, State ZIP	
Hospital Name	
Hospital Address	
Hospital City, State ZIP	

First Report of Injury Form Preparer Information:

Name		**Title**	
Street Address			
City, State ZIP			

Fax or e-mail the completed form to Bev Stiles at (317)805-7580 or bev_stiles@mjinsurance.com. *Time is of the essence in the reporting of workers' compensation claims. Please submit the above form to Bev Stiles within 10 days of the date of the accident. Should you have any questions, please contact Bev Stiles at (888)442-7470.*