First Report
of Injury or Occupational Disease Instructions

Workers' compensation insurance is a state-required insurance, which provides medical benefits, wage compensation and rehabilitation to workers injured on the job. Severe penalties can be assessed against an uninsured employer. Neither general liability nor health and accident insurance policies are substitutes for workers' compensation insurance.

The worker and employer may complete this form together, or they may each submit a separate form.

Injured Worker's Instructions

Workers have two reporting requirements: 1) notify your employer of an on-the-job injury within 30 days of its occurrence; and 2) complete this form as a claim for compensation. The form must be signed and submitted to the employer's insurer or the Department of Labor and Industry within 12 months of the accident. The form must be submitted for all injuries in order to protect your right to benefits in the event a seemingly minor injury develops into a more serious condition.

Complete a report of the injury

Be thorough in completing all areas except the gray shaded areas. It is important to you that we have complete information. Provision of the Social Security Number (SSN) is voluntary, per the Privacy Act of 1974, 5 U.S.C. 552a. The SSN is used as a key identifier of the claimant. Failure to provide the SSN may delay certain actions on a claim. Use extra sheets of paper if needed. Type or print with a ballpoint pen.

To ensure that workers' compensation systems will not be disrupted, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104191,42 USC 1301, et. seq., **permits the disclosure of protected health care informationpursuant to the provisions of state laws regarding workers' compensation.** 45 CFR 165.512(1) states:

"Standard: Disclosures for workers' compensation: A covered entity may disclose protected health information **as authorized by and to the extent necessary to comply with laws relating to workers' compensation** or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault."

Employer's Instructions

Montana law requires employers to complete this form within six days after notice of every on-the-job injury and/or Occupational Disease (OD) by a worker.

Ensure **all** areas are completed except the gray shaded areas which your insurer will complete. It is important for you that we have complete information. Type, or print with a ball point pen. If you are completing with WORD software, you may tab through the fields.

If the injured worker is available to do so, they may file a claim for workers' compensation by completing and signing their portions of this form. You may then complete the employer section.

Send the original immediately to your workers' compensation insurer. If you don't know who your insurer is, contact the Montana Department of Labor and Industry (see below). SEND THIS FORM WITHIN THE 6-DAY LIMIT EVEN IF THE WORKER IS NOT AVAILABLE TO SIGN. This form must be submitted even if the employer questions whether or not the reported accident/OD is job-related. Additional sheets of paper may be attached, if needed, to fully explain all conditions concerning the accident/OD.

The United States Department of Labor, OSHA, requires employers to maintain a record of occupational injuries in the employer's office. For the employer's convenience, this form has been designed to meet such requirements and to provide employers with a copy for their records. The yellow copy is for your records.

Insurer/Adjuster (not submitting electronically)

Please complete all gray shaded areas, and mail immediately to the Montana Department of Labor and Industry at the address shown below. Boxes that have been **BOLDED** are mandatory in order to file this report. If you wish to file First Report information electronically, please contact the Employment Relations Division.

Further Information

Montana State Fund
Insurance Operations
PO Box 4759
Helena MT 59604-4759
406-444-6500 -800-332-6102

Workers' Compensation Claims Assistance Bureau
Employment Relations Division - Department of Labor & Industry
PO Box 8011
Helena MT 59604-8011
(406) 444-6543

MONTANA STATEFUND

P.O. Box 4759
Helena, MT 59604-4759

First Report

Fax: 406-444-5963
Voice: 800-332-6102

Claims Examiner Date Stamp

Worker

Dept Code: (if applicable)

Last Name	First Name	M.I.	Date of Birth	Social Security Number - -

Home address	City	State	Postal Code -

Phone Number ( ) -	Education ☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	Gender ☐ Male ☐ Unknown ☐ Female	Marital Status ☐ Married ☐ Separated ☐ Not Married ☐ Unknown	Number of Dependents

Wages

Date Hired	Gross earnings for four pay periods preceding the injury.	1 Date / Amount /	2 Date / Amount /	3 Date / Amount /	4 Date / Amount /

Employment Status ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer	Number of days worked per week:	Wage: ☐ Hour ☐ Week ☐ Month ☐ Other: ☐ Day ☐ BI-weekly ☐ Year

In addition to gross earnings cited above worker received: ☐ Board & Room ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other:	Estimated value if any:	Is sick leave available? ☐ Yes ☐ No	Used? ☐ Yes ☐ No

Worked next scheduled shift ☐ Yes ☐ No	Off work more than 4 work days ☐ Yes ☐ No ☐ Not Sure	Date Last Worked	Date of Return to work	Full wages paid for date of Injury? ☐ yes ☐ No	Salary continued? ☐ Yes ☐ No

Accident Description

Description of Accident (continue on separate sheet if necessary)

Cause of Injury	Part of Body	Nature of Injury	Date and Time of Injury /

Date disability began:	Date of Death:	Occupation:	Names of witnesses: 1) 2)

Accident on employer's premises? ☐ Yes ☐ No	Accident address or location: City: State: Postal code: -

Date employer notified:	Accident reported to:	Safety equipment provided? ☐ Yes ☐ No	Safety equipment used? ☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code -	Phone Number ( ) -

Hospital Name	Address	State	Postal Code -	Phone Number ( ) -

Type of initial medical treatment received: ☐ No treatment ☐ Emergency room ☐ Treatment on-site by employer or medical Staff ☐ Clinic/Dr. Office ☐ Hospital

Signature

This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. **I understand** that signing this claim for compensation authorizes the release of rehabilitation records, Social Security records and health care information (medical records) relevant to this claim to the workers' compensation insurer and the insurer's agents. **I also understand** that if I obtain or exert unauthorized control over workers' compensation benefits, I may be subject to civil and criminal penalties.

Signature of Injured Worker or Beneficiary: Date:

Employer

Employer Name	Doing Business as:	Federal Employer Identification Number (tax I.D.)

Mailing Address	City	State	Postal Code -	Phone Number ( ) -

Location of operation, if different from mailing address:	Nature of Business or SIC Code:	Self-Insured? ☐ Yes ☐ No

Employer is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	Injured worker is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ A member of the employer's (sole proprietor or) family living in the employer's household.

Do you have any reason to question this accident? ☐ Yes ☐ No	If yes, please explain fully. Use separate sheet if you need additional space.	Was worker injured while in your employ? ☐ yes ☐ no

Insurance Agent's Name	Insurance Agency	Agent's Telephone Number ( ) -

Prepared by:	Official title:	Date:

Payroll Classification Code under which you report employee's wages:

Authorized Employer's Signature:_____ Date:_____

Insurer Only

Claim Administrator's Claim Number:	Date reported to Claim Administrator:	The above information is correct with the following exceptions: ☐ (Attach extra sheets if box at right is checked)

Third Party Administrator's Name:	Claim Administrator's Address:	Insurer FEIN:

Insurer's Name:	Third Party Administrator's FEIN:

Policy Number:	Policy Effective Date:	Policy Expiration Date: