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 104-191, 42 USC 1301, et. seq., permits the disclosure of protected health care information pursuant 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 ballpoint 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

ERD-instructions (Rev 12/06)
Worker

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

Home address

Phone Number

<table>
<thead>
<tr>
<th>Education</th>
<th>Gender</th>
<th>Marital Status</th>
<th>Number of Dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than High School</td>
<td>Female</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>GED or High School Diploma</td>
<td>Male</td>
<td>Married</td>
<td>Separated</td>
</tr>
<tr>
<td>Beyond High School</td>
<td>Unknown</td>
<td>Not Married</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Insurer's Name:

Third Party Administrator's Name:

Claim Administrator's Claim Number:

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: ____________________________

Safety equipment provided:

Yes ☐ No ☐

Safety equipment used:

Yes ☐ No ☐

Accident Description

Description of Accident (continue on separate sheet if necessary)

Wages

<table>
<thead>
<tr>
<th>Date</th>
<th>Gross earnings for four pay periods preceding the injury</th>
<th>Date / Amount</th>
<th>Date / Amount</th>
<th>Date / Amount</th>
<th>Date / Amount</th>
</tr>
</thead>
</table>

Employment Status:

- Full Time
- Part Time
- Seasonal
- Volunteer

Number of days worked per week:

Wage:

- Hourly
- Weekly
- Monthly
- Other:

In addition to gross earnings cited above worker received:

- Board & Room
- Rent
- Commissions
- Other:

Estimated value of any:

- Yes ☐ No ☐

Worker is a:

- Sole Proprietorship
- Partnership
- Limited Liability Company
- Corporation

Nature of Business or SIC Code:

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Names of witnesses:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date employer notified:

Accident reported to:

Date:

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

Employee Name

Doing Business as:

Federal Employer Identification Number (tax I.D.):

Mailing Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Postal Code</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

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

Injured worker is a:

- Sole Proprietorship
- Partnership
- Corporation

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 ☐

Was worker injured while at 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 employer's wages:

Authorized Employer's Signature: ____________________________

Date: ____________________________

Insurer Only

Claim Administrator's Claim Number:

Date reported to:

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:

ERD - 991 (Rev. 12/2006LW)