

Early reporting can save you money. Report all injuries immediately!

The information below allows Pinnacol Assurance's customer service representatives to quickly and accurately process your claim. Use the completed form as a guide when reporting by phone or online to save you time. Don't wait to report if you don't have all the answers.

A. Critical Data - REQUIRED INFORMATION TO BEGIN PROCESSING YOUR CLAIM BY PHONE OR ONLINE.

Policy Number: _____ Company Name: _____
Address or Location (if different than mailing address): _____
Injured Worker's Social Security Number: _____ - _____ - _____ Date of Injury: _____
First Name: _____ M.I. _____ Last Name: _____

B. Injured Worker Information

Home Address: _____ City _____ State _____ Zip _____ Phone: _____
Date of Birth: _____ ☐ Male ☐ Female Marital Status: _____
Language: ☐ English ☐ Spanish ☐ Other: _____ Occupation: _____
Date Hired: _____
Employee Status: ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Volunteer ☐ Independent Contractor
Days worked per week: _____ and average weekly wage \$ _____
OR
Hours worked per day: _____ and hourly pay rate \$ _____ and hours worked per week: _____

C. Accident / Injury Information

Fatal Injury? ☐ Yes ☐ No If fatal injury: Date of Death: _____
Is this a lost-time claim? ☐ Yes ☐ No (Claim is lost time if there is a loss of more than three scheduled workdays due to the injury.)

Time of Injury: _____ ☐ a.m. ☐ p.m. Time Work Began: _____ ☐ a.m. ☐ p.m. Last Work Date: _____

Full Pay on Date of Injury: ☐ Yes ☐ No

Accident Occurred on Employers Premises: ☐ Yes ☐ No Severe Injury: ☐ Yes ☐ No

Accident Location: _____ If Applicable: Location Code: _____ Dept. Code: _____

Name of Employer Representative Notified: _____ Date Notified: _____

How did Injury Occur: _____

Specific Activity the Employee Was Engaged In: _____ What Equipment Was Being Used? _____ Attach additional pages if necessary

Body Part(s) Injured: _____

Witnesses: _____

Name(s) & Phone Number(s)

☐ Safety Equipment Provided ☐ Safety Equipment Used ☐ Possible Drug/Alcohol Involved ☐ Employer Questions Liability

D. Medical Provider Information; Where was your employee treated?

☐ No Medical Treatment ☐ Treated by Employer ☐ 911 Called ☐ Walk-In Clinic

☐ Emergency Room ☐ Hospitalized > 24 hrs / Overnight ☐ Possible Surgery

Medical Provider Name _____ Street Address _____ City _____ State _____ Zip _____ Phone _____

E. Return to Work Information

Has injured worker returned to work? ☐ Yes ☐ No

Date Returned to Work: _____ Estimated Date of Return to Work: _____

Prepared By: _____ Title: _____

Please Print

Email: _____ Fax: _____

Phone: _____ Date: _____

PINNACOL ASSURANCE FIRST REPORT OF INJURY FORM INSTRUCTIONS

1. **Report all work-related injuries within 24 hours!** Quick reporting can save up to six percent of the total cost of the claim. Our **goal** is to get your employee back to work as quickly as possible and reporting within 24 hours streamlines that process. Report the injury to Pinnacol Assurance even if you question whether the injury is truly job related. Provide information as to why you question the validity of the claim.
2. This form is a guide for reporting injuries by phone, or fax using the numbers on the front of this form. Online reporting is fastest. To report online, go to www.pinnacol.com, select "Pinnacol ServiceLink", then "Report an Injury." The employer or authorized representative should report the injury to Pinnacol Assurance; please do not have the injured worker complete this form.
3. The employer has the right to **designate the injured worker's initial medical provider**. Designating a provider from Pinnacol's **SelectNet** list helps ensure your employee is seen by an occupational medical provider knowledgeable about the workers' compensation system and return to work issues. If you do not have a designated provider, call Pinnacol for assistance. Designating a medical provider may entitle you to a premium discount.
4. When reporting a claim by phone or the Internet, a copy of the completed form will be mailed to you for your records. Please review the copy to ensure all information is correct. If changes are needed, please contact Pinnacol's claim representative assigned to the claim.
5. If the injured worker owes court ordered child support, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee. (C.R.S. 8-42-124 & 26-16-122(4))

A. CRITICAL DATA - You must answer all questions in this section for Pinnacol to begin processing the claim, especially the date of injury. Don't wait to report if you don't have all the answers for sections B - E, however all questions on this form will need to be completed in order to meet the requirements of the Colorado Workers' Compensation Act. **Especially critical is the information regarding Date of Injury, if the injured worker will miss more than three scheduled days from work, and when you expect the injured worker to return to work.**

Definitions:

Date of Injury (Section A): The date the accident occurred, or in the case of an occupational disease, the date of the first and last exposure.

Lost Time Claim (Section C): The loss of more than three scheduled workdays due to the injury.

Wages and Time Worked (Section B): Provide either the weekly pay rate and hours OR the hourly pay rate and hours worked. Wages may also include: overtime wages, tips, commissions, room & board, housing, lodging and cost of health insurance. If you are unsure how to answer, call the customer service phone number on the front of this form. **Accident Location:** Provide the address if the accident occurred on the employer's premises or if it occurred outside the employer's premises at an identifiable location. If it occurred at a place that cannot be identified by a number or street, such as a public highway, provide references locating the place accurately as possible.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or injured worker for the purpose of defrauding or attempting to defraud the policyholder or injured worker with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

OSHA FORM 301 QUESTIONS "If you had 10 or fewer employees during all of the last calendar year or your business is classified in a specific low-hazard retail, service, financial, insurance, or real estate industry, you do not have to keep injury and illness records unless the Bureau of Labor Statistics or OSHA informs you in writing that you must do so."

For this Pinnacol Assurance First Report of Injury to be considered an equivalent OSHA Form 301 (Injury and Illness Incident Report) the following questions must be completed along with the information on the front of this form. If you have questions regarding the OSHA recordkeeping standard contact your Pinnacol Assurance Safety Consultant.

Case number from OSHA 300 Log Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

What was the Injury or Illness? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." Examples: "strained back"; "chemical burns, hand"; "carpal tunnel syndrome."

What object or substance directly harmed the employee? Examples: "concrete floor", "chlorine", "radial arm saw." *If this question does not apply to the incident, leave blank.*