

PINNACOL

ASSURANCE

FIRST REPORT OF INJURY

To report a claim:
Call 303-361-4000 or 1-800-873-7242
Or Fax to 303-361-5000 or 1-888-329-2251
Or, go to www.pinnacol.com
PLEASE PRINT CLEARLY

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.

POLICY INFORMATION

Policy Number: 4156349 Company Name: MANITOU SPRINGS SCHOOL DISTRICT 14
Address or Location (if different than mailing address): N/A
Prepared by: _____ Title: _____
Please Print
E-mail: _____ Fax: (____) _____
Phone: (____) _____ - _____ Date Completed: ____/____/____

INJURED WORKER INFORMATION

Injured Worker's Social Security Number: _____ - _____ - _____ Date of Injury: ____/____/____
First Name: _____ M.I. _____ Last Name: _____
Home/Mailing Address: _____
City State Zip Code Phone: (____) _____ - _____
Date of Birth: ____/____/____ Male Female Martial Status: _____
Language: English Spanish Other: _____ E-mail: _____
Occupation: _____ Date Hired: ____/____/____
Employee Status: Full-time Part-time Seasonal Volunteer Independent Contractor
Days Worked per Week: _____ Hours Worked per Day: _____
Pay Rate: _____ Hourly Weekly Monthly Annually Other: _____

ACCIDENT / INJURY INFORMATION

Fatal Injury: Yes No If Fatal Injury: Date of Death ____/____/____
Time of Injury: _____ am pm Time Work Began: _____ Last Day Worked: ____/____/____
Full Pay on Date of Injury: Yes No
Accident Occurred on Employers Premises: Yes No If Applicable: Location Code: _____ Dept Code: _____
Accident Location: _____
City State Zip Code
Name of Employer Representative Notified: _____ Date Notified: ____/____/____
Witnesses: _____
Name(s) and Phone Number(s)

How Did the Injury Occur: _____
Attach Additional Information if Necessary
Specific Activity the Employee Was Engaged In: _____ What Equipment Was Being Used: _____
Body Part(s) Injured: _____ Right Left Not Applicable
Type of Injury Sustained: _____
 Safety Equipment Provided Safety Equipment Used Possible Drug/Alcohol Involved Employer Questioning Liability

RETURN TO WORK INFORMATION

Has the Injured Worker Returned to Work? Yes No
Date Returned to Work: ____/____/____ Estimated Return to Work Date: ____/____/____
Is this a lost time Claim? Yes No (Claim is lost time if there is a loss of more than three scheduled work days due to the injury).

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 Code _____ Phone _____