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DATE OF PRINCE CAME #   DISCRIPTION   DISCRI		JURISDICTION	STATE FILE	#)		_			THE USE	OF THIS FO	RM IS RE	EQUIRE	D UNDER	THE PROVISIONS OF THE			
SHATOSCASE#	-	CLAIMS ADM (		_													
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CLAMS ADJUSTER NAME  CLAMS ADJUSTER NAME  CLAMS ADJUSTER NAME  EMPLOYER FEIN  EMPLOYER FEIN  SEC CODE  PHONE NAME  EMPLOYER FEIN  SEC CODE  PHONE NAME  EMPLOYER FEIN  NATURE OF HISINESS  CITY  STATE  ZIP  INSURED REFORT IF  EMPLOYER ADDRESS LINE I AND LINE 2  EMPLOYER ADDRESS LINE I AND LINE 2  ROLLTY NUMBER  FAMF OFFER)  SEL PENJURED?  PART OFFER  EMPLOYER LAST NAME  PHONE N	ADM,	NAME OF INSURANCE CARRIER					CARRIER FEIN			FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF							
CLAMS ADJUSTER NAME  CLAMS ADJUSTER NAME  CLAMS ADJUSTER NAME  EMPLOYER FEIN  EMPLOYER FEIN  SEC CODE  PHONE NAME  EMPLOYER FEIN  SEC CODE  PHONE NAME  EMPLOYER FEIN  NATURE OF HISINESS  CITY  STATE  ZIP  INSURED REFORT IF  EMPLOYER ADDRESS LINE I AND LINE 2  EMPLOYER ADDRESS LINE I AND LINE 2  ROLLTY NUMBER  FAMF OFFER)  SEL PENJURED?  PART OFFER  EMPLOYER LAST NAME  PHONE N	AIMS		ME (IF DIFFE	ERENT FROM		FEIN O	F CLM	IS ADM		IF YOU HAVE QUESTIONS, THE STATE NOW HAS A BENEFIT REVIES SYSTEM WHERE A WORKERS' COMPENSATION SPECIALIST CA							
DATE OF BUILTY    CLAIM HANDLING OFFICE ADDRESS LINE I AND LINE 2	C		E			CLMS /	ADJ PF	HONE #	SYSTEM								
DEFINITION OF BUSINESS    STATE   ZP													332-2667	32-2667 (TDD).			
POWER ADDRESS LINE I AND LINE 2  INTURE OF BUSINESS  TOTAL  INDICATE ADDRESS LINE I AND LINE 2  INTURE OF BUSINESS  TOTAL  INDICATION  INDICED NAME (PARENT CO. IF DIFFERENT THAN  INDICATION  INDICED NAME (PARENT CO. IF DIFFERENT THAN INDICATION  INDICED NAME (PARENT CO. IF DIFFERENT THAN INDICATION  INDICED NAME (PARENT CO. IF DIFFERENT THAN INDICATION  INDICED NAME (PARENT CO. IF DIFFERENT THAN INDICATION CO. IF DIFFERENT CO. IF DIFFE		CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2								CITY			STATE	ZIP			
POLICY NUMBER   EFF DATE     EMPLOYMENT STATUS CODE   EMPLOYER	R	EMPLOYER NAME						EMPLOYER FEIN		SIC CODE			PHONE NUMBER				
POLICY NUMBER	LOYE	EMPLOYER ADDRESS LINE 1 AND LINE 2									NATURE OF BUSINESS				3		
NUMBER   PERIOD   STATE	E MP	CITY					,	ZIP		INSURED RE		RT# EMPLOYER LOCATION			PLOYER LOCATION		
BPFLOYER																	
EMPLOYEE LAST NAME	POLICY	· ·										F					
PRINCE  ADRESS LINE 1 & 2  DEPARTMENT REGULARLY   GEMALE   GAPPRENTICE FULL TIME   GAPPRENTICE FULL TI										EXP DATE			1 =				
FIRST	ЕМРГОУЕЕ	EMPLOYEE LAST NAME							AREA CODE	MALE			SEASONAL VOLUNTEER				
ADRRESS LINE 1 & 2    WORKED		FIRST							T REGULARLY			_ =					
SEPARATED   SEPA									THEODE ME	UNKNO							
SEPARATED   SEPA		ADRRESS LINE 1 & 2								OCCUPATI	ON DESCRI	PTION	ΓΙΟΝ				
WAGE PERIOD WEEKLY NUMBER OF DAYS WORKED PER SALARY CONTINUED IN LIEU OF COMPENSATION YES NO FULL WAGES PAID FOR DATE OF INJURY YES NO FULL WAGES PAID FOR DATE OF INJURY YES NO FULL WAGES PAID FOR DATE OF INJURY YES NO DATE OF INJURY YES NO THE EMPLOYEE BEGAN WORK ON INJURY DATE COULD NOT BE DETERMINED AT TIME OF INJURY YES NO DATE CLAIM ADM NOTIFIED OF INJURY BODY PART AFFECTED COBE NATURE OF INJURY CODE CAUSE OF INJURY CODE DATE CLAIM ADM NOTIFIED OF INJURY HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE. THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.  DATE OF DEATH (IF APPLICABLE)  ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES) COUNTY OF INJ		CITY						ZIP					=	NCCI CLASS CODE			
S   HOURLY   BI-WEEKLY   WEEK   FULL WAGES PAID FOR DATE OF INJURY   YES   NO  DATE OF INJURY   TIME OF INJURY   AM   PM   TIME EMPLOYEE BEGAN WORK ON INJURY DATE   COULD NOT BE DETERMINED   NATURE OF INJURY CODE   CAUSE OF INJURY CODE    DATE CLAIM ADM NOTIFIED OF INJURY   HOW INJURY OR ILLINESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY   HARMED THE EMPLOYEE.  DATE LAST DAY WORKED   HARMED THE EMPLOYEE.  DATE OF DEATH (IF APPLICABLE)   IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP   WIDOW   PATHER   SISTER   TOTAL # DEPENDENTS    DID INJURY/ILLINESS OCCUR ON EMPLOYER'S   WIDOW   DAUGHTER   BROTHER    PREMISES?   YES   NO		SSN DATE OF				BIRTH DATE O			FHIRE	_				· =			
S   HOURLY   BI-WEEKLY   WEEK   FULL WAGES PAID FOR DATE OF INJURY   YES   NO  DATE OF INJURY   TIME OF INJURY   AM   PM   TIME EMPLOYEE BEGAN WORK ON INJURY DATE   COULD NOT BE DETERMINED   NATURE OF INJURY CODE   CAUSE OF INJURY CODE    DATE CLAIM ADM NOTIFIED OF INJURY   HOW INJURY OR ILLINESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY   HARMED THE EMPLOYEE.  DATE LAST DAY WORKED   HARMED THE EMPLOYEE.  DATE OF DEATH (IF APPLICABLE)   IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP   WIDOW   PATHER   SISTER   TOTAL # DEPENDENTS    DID INJURY/ILLINESS OCCUR ON EMPLOYER'S   WIDOW   DAUGHTER   BROTHER    PREMISES?   YES   NO		WAGE PERIOD ☐ WEEKI.Y					NUMBER OF DAYS		WORKED PER	SALARY CONTINUED IN LIFTLOF COMPENSATION TYPES THO							
DATE OF INJURY    DATE EMPLOYER NOTIFIED OF INJURY   DATE   DATE EMPLOYEE BEGAN WORK ON INJURY DATE   DATE EMPLOYER NOTIFIED OF INJURY   BODY PART AFFECTED CODE   NATURE OF INJURY CODE   CAUSE OF INJURY CODE	GE	\$   HOURLY   BI-WEEKLY															
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DATE CLAIM ADM NOTIFIED OF INJURY    DATE LAST DAY WORKED		DATE OF INJURY								АМ 🏻 РМ	IPLOYEE I						
JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.    DATE LAST DAY WORKED	RY	DATE EMPLOYER NOTIFIED OF INJURY				BODY PART AFFECTE			D CODE	NATURE O	ODE		CAUSI	E OF INJURY CODE			
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DATE OF DEATH (IF APPLICABLE)    IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP   WIDOW	IDEN	RETURN TO WORK DATE (IF APPLICABLE)															
WIDOW	ACC	DATE OF DEATH (IF APPLICABLE)					IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP										
PREMISES? YES NO MOTHER SON HANDICAPPED CHILD  ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)  CITY STATE ZIP  PHYSICIAN NAME  ADDRESS LINE 1 AND 2  CITY STATE ZIP  CITY STATE ZIP  CITY STATE ZIP  INITIAL TREATMENT MINOR BY EMPLOYER HOSPITALIZED > 24 HRS FUTURE MAJOR MEDICAL/LOST TIME  NO MEDICAL TREATMENT MINOR BY CLINIC/HOSPITAL  EMERGENCY CARE  ANTICIPATED  DEPENDED IN NAME FUTURE MAJOR MEDICAL/LOST TIME  ADDRESS LINE 1 AND 2  REPREMENTATION OF THE PROPERTY OF THE PRO								·1, G1 ·	_					TOTAL # DEPENDENTS			
ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)  CITY STATE ZIP  PHYSICIAN NAME  ADDRESS LINE 1 AND 2  CITY STATE ZIP  CITY STATE ZIP  CITY STATE ZIP  CITY STATE ZIP  INITIAL TREATMENT   MINOR BY EMPLOYER   HOSPITALIZED > 24 HRS   FUTURE MAJOR MEDICAL/LOST TIME							l <b>=</b>										
PHYSICIAN NAME  ADDRESS LINE 1 AND 2  CITY  STATE ZIP  INITIAL TREATMENT  NO MEDICAL TREATMENT  MINOR BY EMPLOYER  NO MEDICAL TREATMENT  MINOR BY CLINIC/HOSPITAL  EMERGENCY CARE  ANTICIPATED  DEPARTMENT  DATE DEPARTMENT  D	=									· · · · · · · · · · · · · · · · · · ·	ZID	COUNTY OF INJURY		COUNTY OF INJURY			
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DATE DEFINADED DEPO C NAME & THE E DEFINADED'S COMPANY NAME DIONE NUMBER									=	<del>-</del>			ICAL/LOST TIME				
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