ACCORD Workers Compensation - First Report of Injury or Illness

lossconnect@thehartford.com

Employer (Name & Address inc. zip) Hart Mechanical Inc. 293 Oakwood Drive Glastonbury, CT. 06033	**Insured Report #**
	Claim Office
SIC / **Employer Fein**	**Employers Location Address (if different)** / **Location** / **Phone #**

Do Not Fill In This Section.

CARRIER - ADMINISTRATOR

Carrier (Name, Address & Phone)

Policy Period

Claims Administrator (Name, Address & Phone)

Check if Appropriate

Self Insurance

Carrier fein

Policy/Self Insured Number

Administration fein

Agent Name and Code Number

EMPLOYEE WAGE

Name (Last, First, Middle) | **Date of Birth** | **Social Security Number** | **Date Hired** | **State of Hire**

Address (Inc zip)

Sex: Male ☐ Female ☐ Unknown ☐

Marital Status: ☐ Unmarried/Single/Divorced ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

Phone

Dependents

Miscellaneous Code

Rate ☐ **Day** ☐ **Week** | **Month** | **Other** | **# Days Worked**

Full Pay for Day of Injury ☐ **Yes** ☐

Did salary continue ☐ **Yes** ☐

OCCURRENCE/TREATMENT

Time Ee began work ☐ **AM** ☐ **PM**

Date of Injury/Ill

Time of Occurrence ☐ **AM** ☐ **PM**

Last Day Worked | **Dte Er Notified** | **Date Disability Began**

Contact Name and Phone

Type of Injury/Illness

Part of Body Affected

Did injury/illness exposure occur on Er premises? ☐ **Yes** ☐ **No**

Type of Injury/Illness Code

Part of Body Affected Code

Department or location where accident or illness exposure occurred

All equipment, materials, or chemicals Ee was using when accident or illness exposure occurred.

Specific activity the Ee was engaged in when the accident or illness exposure occurred

Work process the Ee was engaged in when the accident or illness exposure occurred

How injury or illness/abnormal health condition occurred. Describe in detail the sequence of events and include any objects or substances that directly injured the employee or made employee ill.

Cause of Injury Code

Date Returned to Work

If fatal, give date of death

Were safe guards or safety equipment provided? ☐ **Yes** ☐ **No**

Were they used? ☐ **Yes** ☐ **No**

Physician/Health Care Provider (Name & Address)

Hospital (Name & Address)

Initial Treatment
- ☐ No Medical Treatment
- ☐ Minor by Employer
- ☐ Minor clinic/hosp
- ☐ Emergency Care
- ☐ Hospitalized > 24 hrs
- ☐ Future major medical/lost time anticipated

Witness (Name & Phone #)

Date Administrator Notified | **Date Prepared** | **Preparers Name and Title** | **Phone Number**