MONTANA STATEFUND

P.O. Box 4759
Helena, MT 59604-4759

First Report SAMPLE

Fax: 406-495-5020
Voice: 800-332-6102

Adjuster Date Stamp

Worker

Dept Code: (if applicable)

Last Name	First Name	M.I.	Date of Birth	Social Security Number
		J		

Home address	City	State	Postal Code
	Helena	MT	

Phone Number	Education	Gender	Marital Status	Number of Dependents
	HS Grad or GED			0

Wages payroll will fill this part

Date Hired	Gross earnings for four pay periods preceding the injury.	1 Date / Amount	2 Date / Amount	3 Date / Amount	4 Date / Amount
		/ 0	/ 0	/ 0	/ 0

Employment Status	Number of days worked per week:	Wage:
Full-time employee		

In addition to gross earnings cited above worker received:	Estimated value if any:	Is sick leave available? Used?
0		

Worked next scheduled shift	Off work more than 4 work days	Date Last Worked	Date of Return to work	Full wages paid for date of Injury?	Salary continued?
Yes					

Accident Description

Description of Accident (Limited to 1269 characters; continue on separate sheet if necessary) **At the beginning of March I noticed continual pain when using computer mouse. Last week as pain continued I noticed a bump on the bone at base of index finger. Pain and bump are constant while using mouse. On March 13 I reported to HR and immediate supervisor that I was making an appointment to have hand examined.** (please send an email another with more details)

Cause of Injury	Part of Body	Nature of Injury	Date and Time of Injury

Date disability began:	Date of Death:	Occupation:	Names of witnesses: 1) 2)

Accident on employer's premises?	Accident address or location: 301 North Roberts City: Helena State: Montana Postal code: 59601

Date employer notified:	Accident reported to:	Safety equipment provided?	Safety equipment used?
		n/a	

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: **Medical Provider will be Seen**

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 to the workers' compensation insurer or its agent, rehabilitation records, Social Security records and health care information (medical records, pursuant to HIPPA, Public Law 104-191, 42 USC section 1301, et.seq., and section 39-71-604, MCA) that are directly relevant to the claimed injury, disease or death. **I also understand** that if I obtain or exert unauthorized control over workers' compensation benefits, I may be prosecuted for theft."

Signature of Injured Worker or Beneficiary: Date:

Employer

Employer Name	Doing Business as:	Federal Employer Identification Number (tax I.D.)
DEPARTMENT OF LIVESTOCK		81-0302402

Mailing Address	City	State	Postal Code	Phone Number
SHEILA MARTIN PO BOX 202001	Helena	MT	59620-2001	406-444-2045

Location of operation, if different from mailing address:	Nature of Business or SIC Code:	Self-Insured?
MONTANA DEPARTMENT OF LIVESTOCK (SHEILA MARTIN PO BOX 202001 Helena MT 59620-2001)		

Employer is a	Injured worker is a
State Government	Employee

Do you have any reason to question this accident? No, Bonnie has a pea size knot on her hand.	If yes, please explain fully. Use separate sheet if you need additional space.	Was worker injured while in your employ? Yes -

Prepared by:	Official title:	Date:
Sheila Martin	Human Resource Officer	3/14/2012

Payroll Classification Code under which you report employee's wages: **881100**

Authorized Employer's Signature: Sheila Martin
Date: 3/14/2012

Insurer Only

Claim Administrator's Claim Number:	Date reported to Claim Administrator:	The above information is correct with the following exceptions: ☐ (Attach extra sheets if box at right is checked)
041000775938		

Third Party Administrator's Name:	Claim Administrator's Address:	Insurer FEIN:
	P O BOX 4759, HELENA, MT 59604-4759	81-0302402

Insurer's Name:	Third Party Administrator's FEIN:
MONTANA STATE FUND	

Policy Number:	Policy Effective Date:	Policy Expiration Date:
030099766		