Worker's Compensation Reporting

If an employee is injured on the job, it is the responsibility of the employee or Supervisor to notify the Payroll Clerk immediately and fill out an **Employer's First Report of Injury or Illness.** This must be completed **WITHIN 24 HOURS OF THE INJURY**.

If you do not have a supply of the above forms, notify payroll and they will be supplied.

REMINDER: PLEASE REPORT ALL INJURIES TO THE PAYROLL CLERK IMMEDIATELY.

Confirmation Email

PROGRAM FOR SOVEREIGN INDIAN NATIONS
TRIBAL WORKERS' BENEFITS CLAIM FORM

SUBMIT FORM

IMPORTANT: To submit your claim form, after answering all questions, click on logo:

Program for Sovereign Indian Nations
Claims Administration 1.800.875.6466
8390 E. Cresent Pkwy, Suite 200
Greenwood Village, CO 80111

Insured:
Policy No.: Effective:
Client Code: Expiration:

Claim Number: Carrier:

1. Name (Last, First, M.I.)	2. Sex	12. Date of Injury	13. Time of Injury	14. Date Lost Time Began

3. Social Security Number	*4. Home Phone*	5. Birthdate	*15. Nature of Injury*	*16. Part of Body Injured or Exposed*

6. Does the Employee Speak English? If No, Specify Language
Yes ☑ No ☐

17. How and Why Accident/Injury Occurred

7. Mailing Address (Street or P.O. Box)

18. Was Employee Doing his Regular Job?
Yes ☐ No ☐

19. Worksite Location of Injury (stairs, etc.)

City	State	Zip Code

20. Address Where Injury or Exposure Occurred (Name of Business if incident occurred on a business site)

8. Marital Status
Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

9. Number of Dependent Children	10. Spouse's Name

21. Cause of Injury (fall, tool, etc.)

11. Physician's Name and Address

22. List Witnesses

23. Return to Work Datd Or Expected	24. Did Employee Die?	25. Supervisor's Name	26. Date Report

27. Date of Hire	28. Is the Employee entitled to IHS benefits?	29. Length of Service In Current Position	30. Length of Service in Occupation

31. Occupation of Injured Worker

32. Rate of Pay at This Job	*33. Full Work Week Is*	34 Last Paycheck Was
$ Hourly $ Weekly	Hours Days	$ for Hours or Days

35. Name and Title of Person Completing This Form	36. Name of Business

36. Business Mailing Address and Telephone Number	37. Business Location (If different from Mailing Address)

38. Standard Industrial Classification Code (SIC)

SIGNATURE AND TITLE OF PERSON COMPLETING THIS FORM

***** SEE IMPORTANT NOTICE TO RIGHT *****

IMPORTANT NOTICE - ELECTRONIC SIGNATURE

Transmission of signatory's name as presented in the Claim Form constitutes a binding electronic signature pursuant to C.R.S. § 24-71 et seq. and the Uniform Electronic Transactions Act. Once the completed Claim Form is transmitted, the document may be construed as a claim pursuant to the Insured's policy.

The Named Insured is a Federally recognized Tribal Government and/or Tribal Entity; and is exempt from State law. The Tribe is NOT a "State Employer" and DOES NOT insure employees subject to any State Workers' Compensation laws.

12/11/2009 3:59pm

*Special instructions on back

SUBMIT FORM

S\WP\WINWORD\CMS\PIN\WCFORM.DOC

SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS

Item **4:** If no home phone, please provide a phone number where the employee can be reached.

Item 15: List nature of accident or exposure, e.g. fall from scaffold, contact with radiation, etc..

Item 16: List specific body part, e.g. chin, right leg, forehead, left upper arm, etc.. If more than one body part is affected, list each part.

Item 17: Describe in detail (1) the events leading up the accidentlinjury, (2) the actual injury, e.g. cut left forearm, broken right foot, etc., and (3) the reason(s) why accidentlinjury occurred. Use an additional sheet of paper if necessary.

Item 19: State the exact work site location of the injury, e.g. construction site, office area, storage area, etc..

Item 21: List object, substance, or exposure that directly inflicted the injury or illness, e.g. floor, hammer, chemicals, etc..

Item 33: Enter the number of days or hours that make up a full work week for your employees.