Eastern insurance
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A smart way to protect your business and your employees.

Workers' Compensation Report

ENTITY INFORMATION

Legal entity name (LLC, Inc., etc.):	Location address:	
Date of incident:	Time of incident: ________ AM ☐ PM ☐	Report as notice only: Yes ☐ No ☐
Contact person for this claim:	Phone:	Email:

INJURED EMPLOYEE INFORMATION

Name:	Date of birth:	
SS# (Last 4):	Phone:	Email:
Home address: (Street/City/State/Zip)		
Male ☐ Female ☐	Single ☐ Married ☐ Divorced ☐	# of dependents:
Primary language:	Has employee ever received disciplinary action? Yes ☐ No ☐	Has employee reported other WC claims? Yes ☐ No ☐
Job title / Position:	Hourly ☐ $ Salary ☐ $	
Date of hire:	Full time ☐ Part time ☐	
Days worked per week:	Hours worked per week:	Do days off vary: Yes ☐ No ☐
What was employees shift day of incident:	Were they able to complete shift: Yes ☐ No ☐	
Has employee missed a scheduled shift: Yes ☐ No ☐ Number of missed shifts:	Date of last shift worked: Did injury occur on premises: Yes ☐ No ☐	
Has employee returned to work: Yes ☐ No ☐ If yes - Regular duty ☐ Modified/light duty ☐		
Date returned to work:	Was employee paid for shift day of incident: Yes ☐ No ☐	
Date employee notified employer of injury:		
Name of employee's manager:	Phone:	Email:

ACCIDENT INFORMATION

How did accident occur (provide as much detail as possible – if handwriting, please attach 2nd page)		
Do you have surveillance video of incident: Yes ☐ No ☐**(Please copy & save video)**		
Do you have pictures of the incident area: Yes ☐ No ☐**(Please take cell phone pictures)**		
Body part(s) injured (Be specific):		
Any equipment being used at time:		
Did employee request to continue working: Yes ☐ No ☐		
Initial treatment: None needed ☐ Refused treatment ☐ In-house first aid ☐ ER visit ☐		
Was an ambulance called: Yes ☐ No ☐		
Hospital name:	Address:	
Witness name:	Phone:	Email:

SEND COMPLETED REPORT FORMS TO:
franchiseclaims@easterninsurance.com Fax: 508-651-4700
Any questions or concerns please contact Paul-Michael Quintin
pquintin@easterninsurance.com 508-620-3493

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