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

TACO BELL

# 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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