



**Early reporting can save you money. Report all injuries immediately!**

The information below allows Pinnacol Assurance's customer service representatives to quickly and accurately process your claim. Use the completed form as a guide when reporting by phone or online to save you time. Don't wait to report if you don't have all the answers.

### POLICY INFORMATION

Policy Number: \_\_\_\_\_ Company Name: \_\_\_\_\_

Address or Location (if different than mailing address): \_\_\_\_\_

Prepared by: \_\_\_\_\_ Title: \_\_\_\_\_  
Please Print

E-mail: \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_ Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

### INJURED WORKER INFORMATION

Injured Worker's Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

First Name: \_\_\_\_\_ M.I. \_\_\_\_ Last Name: \_\_\_\_\_

Home/Mailing Address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
City State Zip Code

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female Marital Status: \_\_\_\_\_

Language:  English  Spanish  Other: \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date Hired: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Status:  Full-time  Part-time  Seasonal  Volunteer  Independent Contractor

Days Worked per Week: \_\_\_\_\_ Hours Worked per Day: \_\_\_\_\_

Pay Rate: \_\_\_\_\_  Hourly  Weekly  Monthly  Annually  Other: \_\_\_\_\_

### ACCIDENT / INJURY INFORMATION

Fatal Injury:  Yes  No If Fatal Injury: Date of Death \_\_\_\_/\_\_\_\_/\_\_\_\_

Time of Injury: \_\_\_\_\_  am  pm Time Work Began: \_\_\_\_\_  am  pm Last Day Worked: \_\_\_\_/\_\_\_\_/\_\_\_\_

Full Pay on Date of Injury:  Yes  No

Accident Occurred on Employers Premises:  Yes  No If Applicable: Location Code: \_\_\_\_\_ Dept Code: \_\_\_\_\_

Accident Location: \_\_\_\_\_  
City State Zip Code

Name of Employer Representative Notified: \_\_\_\_\_ Date Notified: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witnesses: \_\_\_\_\_  
Name(s) and Phone Number(s)

How Did the Injury Occur: \_\_\_\_\_

Specific Activity the Employee Was Engaged In: \_\_\_\_\_ What Equipment Was Being Used: \_\_\_\_\_  
Attach Additional Information if Necessary

Body Part(s) Injured: \_\_\_\_\_  Right  Left  Not Applicable

Type of Injury Sustained: \_\_\_\_\_

Safety Equipment Provided  Safety Equipment Used  Possible Drug/Alcohol Involved  Employer Questioning Liability

### RETURN TO WORK INFORMATION

Has the Injured Worker Returned to Work?  Yes  No

Date Returned to Work: \_\_\_\_/\_\_\_\_/\_\_\_\_ Estimated Return to Work Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this a lost time Claim?  Yes  No (Claim is lost time if there is a loss of more than three scheduled work days due to the injury).

### MEDICAL PROVIDER INFORMATION: Where Was Your Employee Treated?

No Medical Treatment  Treated by Employer  911 Called  Walk-In Clinic

Emergency Room  Hospitalized > 24 hrs/Overnight  Possible Surgery

Medical Provider Name \_\_\_\_\_ Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Did You Provide the Injured Worker with the Designated Provider Information Letter?  Yes  No

## PINNACOL ASSURANCE FIRST REPORT OF INJURY FORM INSTRUCTIONS

1. Report all work-related injuries within 24 hours! Quick reporting can significantly reduce the total cost of the claim. Our **goal** is to get your employee back to work as quickly as possible and reporting within 24 hours streamlines that process. Report the injury to Pinnacol Assurance even if you question whether the injury is truly job related. Provide information as to why you question the validity of the claim.
2. This form is a guide for reporting injuries by phone, or fax using the numbers on the front of this form. Online reporting is fastest. To report online, go to [www.pinnacol.com](http://www.pinnacol.com), select "Quicklinks," then "Report an Injury." The employer or authorized representative should report the injury to Pinnacol Assurance; please do not have the injured worker complete this form.
3. Within 7 days after notification of an injury, the employer is required to provide the injured worker with a list of two medical providers who have been designated by the employer to provide medical treatment for the injured employee. The injured worker must choose one of the designated providers from this list. Designating providers from Pinnacol's SelectNet list helps ensure your employee is seen by an occupational medical provider knowledgeable about the workers' compensation system and return to work issues. If you do not have two designated providers, call Pinnacol for assistance.
4. When reporting a claim by phone or the Internet, a copy of the completed form will be mailed to you for your records. Please review the copy to ensure all information is correct. If changes are needed, please contact Pinnacol's claim representative assigned to the claim.
5. If the injured worker owes court ordered child support, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee. (C.R.S. 8-42-124 & 26-16-122(4))

Please answer as many questions as possible for Pinnacol to begin processing the claim. Don't wait to report if you don't have all the answers, however all questions on this form will need to be completed in order to meet the requirements of the Colorado Workers' Compensation Act. **Especially critical is the information regarding Date of Injury, if the injured worker will miss more than three scheduled days from work, and when you expect the injured worker to return to work.**

### Definitions:

**Date of Injury:** The date the accident occurred, or in the case of an occupational disease, the date of the first and last exposure.

**Lost-Time Claim:** The loss of more than three scheduled work days due to the injury.

**Wages and Time Worked:** Provide either the weekly pay rate and hours OR the hourly pay rate and hours worked. Wages may also include: overtime wages, tips, commissions, room & board, housing, lodging and cost of health insurance. If you are unsure how to answer, call the customer service phone number on the front of this form. **Accident Location:** Provide the address if the accident occurred on the employer's premises or if it occurred outside the employer's premises at an identifiable location. If it occurred at a place that cannot be identified by a number or street, such as a public highway, provide references locating the place accurately as possible.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or injured worker for the purpose of defrauding or attempting to defraud the policyholder or injured worker with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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**OSHA FORM 301 QUESTIONS** "If you had 10 or fewer employees during all of the last calendar year or your business is classified in a specific low-hazard retail, service, financial, insurance, or real estate industry, you do not have to keep injury and illness records unless the Bureau of Labor Statistics or OSHA informs you in writing that you must do so."

For this Pinnacol Assurance First Report of Injury to be considered equivalent to OSHA Form 301 (Injury and Illness Incident Report) the following questions must be completed along with the information on the front of this form. If you have questions regarding the OSHA recordkeeping standard contact your Pinnacol Assurance Safety Consultant.

**Case Number from OSHA 300 Log** \_\_\_\_\_ **Was the Employee Hospitalized Overnight as an In-Patient?**  Yes  No

**What was the Employee doing just Before the Incident Occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials," "spraying chlorine from hand sprayer," "daily computer key-entry."

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**What was the Injury or Illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." Examples: "strained back," "chemical burns to hand," "carpal tunnel syndrome."

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**What Object or Substance Directly Harmed the Employee?** Examples: "concrete floor," "chlorine," "radial arm saw." *If this question does not apply to the incident, leave blank.*

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**What was the Name of the Physician/Health Care Professional Who Provided Medical Treatment to the Employee?**