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

First Report

Fax: 406-444-5963
Voice: 800-332-6102

Claims Examiner Date Stamp

Worker

Dept Code: (if applicable)

Last Name	First Name	M.I.	Date of Birth	Social Security Number - -
Home address		City	State	Postal Code -
Phone Number ( ) -	Education ☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	Gender ☐ Male ☐ Unknown ☐ Female	Marital Status ☐ Married ☐ Separated ☐ Not Married ☐ Unknown	Number of Dependents

Wages

Date Hired	Gross earnings for four pay periods preceding the injury.	1 Date / Amount /	2 Date / Amount /	3 Date / Amount /	4 Date / Amount /
Employment Status ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer	Number of days worked per week:	Wage: ☐ Hour ☐ Week ☐ Month ☐ Other: ☐ Day ☐ BI-weekly ☐ Year			
In addition to gross earnings cited above worker received: ☐ Board & Room ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other:		Estimated value if any:	Is sick leave available? ☐ Yes ☐ No	Used? ☐ Yes ☐ No	
Worked next scheduled shift ☐ Yes ☐ No	Off work more than 4 work days ☐ Yes ☐ No ☐ Not Sure	Date Last Worked	Date of Return to work	Full wages paid for date of Injury? ☐ yes ☐ No	Salary continued? ☐ Yes ☐ No

Accident Description

Description of Accident (continue on separate sheet if necessary)

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? ☐ Yes ☐ No	Accident address or location: City: State: Postal code: -		
Date employer notified:	Accident reported to:	Safety equipment provided? ☐ Yes ☐ No	Safety equipment used? ☐ Yes ☐ No

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: ☐ No treatment ☐ Emergency room ☐ Treatment on-site by employer or medical Staff ☐ Clinic/Dr. Office ☐ Hospital

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 of rehabilitation records, Social Security records and health care information (medical records) relevant to this claim to the workers' compensation insurer and the insurer's agents. **I also understand** that if I obtain or exert unauthorized control over workers' compensation benefits, I may be subject to civil and criminal penalties.

Signature of Injured Worker or Beneficiary: Date:

Employer

Employer Name	Doing Business as:			Federal Employer Identification Number (tax I.D.)
Mailing Address	City	State	Postal Code -	Phone Number ( ) -
Location of operation, if different from mailing address:		Nature of Business or SIC Code:	Self-Insured? ☐ Yes ☐ No	
Employer is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	Injured worker is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ A member of the employer's (sole proprietor or) family living in the employer's household.		
Do you have any reason to question this accident? ☐ Yes ☐ No	If yes, please explain fully. Use separate sheet if you need additional space.			Was worker injured while in your employ? ☐ yes ☐ no
Insurance Agent's Name	Insurance Agency	Agent's Telephone Number ( ) -		
Prepared by:	Official title:	Date:		
Payroll Classification Code under which you report employee's wages:	Authorized Employer's Signature:_____ Date:_____			

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)
Third Party Administrator's Name:	Claim Administrator's Address:	Insurer FEIN:
Insurer's Name:	Third Party Administrator's FEIN:	
Policy Number:	Policy Effective Date:	Policy Expiration Date: