ProSight Specialty Insurance

FIRST REPORT OF INJURY

EMPLOYER				
EMPLOYER NAME				
MAILING ADDRESS				
LOCATION ADDRESS if different from Mailing Address				
LOCATION NUMBER	POLICY NUMBER	FEIN	PHONE NUMBER	EXT.
CONTACT NAME	TITLE		PHONE NUMBER	EXT.

INJURY OR ILLNESS			
DATE OF INJURY	TIME OF INJURY _____ AM _____ PM	TIME EMPLOYEE BEGAN WORK _____ AM _____ PM	DATE EMPLOYER NOTIFIED
LOCATION WHERE ILLNESS/EXPOSURE OCCURRED			
FATALITY ☐	IF DECEASED, DATE OF DEATH	LAST WORK DATE	UNABLE TO WORK ONE FULL DAY YES ☐ NO ☐
TYPE OF INJURY/ILLNESS	BODY PART(S) AFFECTED		DATE RETURNED TO WORK
MATERIALS, EQUIPMENT OR CHEMICALS USED BY EMPLOYEE AT TIME OF OCCURRENCE/ILLNESS			
WORK PROCESS/ACTIVITY EMPLOYEE ENGAGED AT EVENT			OCCURRENCE/ILLNESS ON EMPLOYER'S PREMISES YES ☐ NO ☐
DESCRIPTION OF OCCURRENCE			

TREATMENT			
HOSPITAL/OFF-SITE FACILITY NAME	ADDRESS	PHONE NUMBER	EXT.
PHYSICIAN NAME	ADDRESS	PHONE NUMBER	EXT.

EMPLOYEE				
EMPLOYEE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	PHONE NUMBER	EXT.
ADDRESS	OCCUPATION/JOB TITLE		DATE OF HIRE	

MARITAL STATUS	Single ☐	Separated ☐	EMPLOYMENT STATUS	Full-time ☐	Seasonal ☐
	Married ☐	Unknown ☐		Part-time ☐	Temporary ☐
SEX	Female ☐	Employee works on average	hours per day	RATE PER:	Hour	Day
	Male ☐	days per week	total weekly hours		Week	Other:

ADDITIONAL EMPLOYER INFORMATION			
REPORTED BY	TITLE	PHONE NUMBER	EXT.

ADDITIONAL NOTES	FOR CARRIER USE ONLY	
	REPORTED TO	DATE REPORTED