

REPORT OF INJURY FAX COVER SHEET

Complete this form and fax it to 1-800-442-0597
or call 1-800-442-0593

All claims should be reported to MEM within 24 hours.

To: Missouri Employers Mutual Insurance
Attention: Customer Service Center

From: Name of company: _____

Name of injured employee: _____

Date injury was reported to employer: _____

Please indicate what type of injury you are reporting.

- This is a "report only" claim.** We will be paying the related bills, and our employee is not expected to lose more than three days of work. The Workers' Compensation Law allows employers to pay for claims which total less than \$1,000 (effective Aug. 28, 2005) and are clearly work-related. If you have questions about when a claim is report only, please call 1-800-442-0593.
- This is a "medical only" claim.** We don't expect this employee to lose more than three days of work. Please pay any necessary bills associated with this claim.
- This is a "lost time" claim.** Our employee will lose more than three days of work. Please pay any necessary bills associated with this claim.

Do you have any concerns about the validity of this claim?

yes no

If yes, a Claims Representative will contact you as soon as possible.

MEM REPORT OF INJURY FORM

INJURY REPORTING AND CLAIMS INQUIRY HOTLINE 1-800-442-0593
 FAX 1-800-442-0597 WEBSITE: www.mem-ins.com

GENERAL	EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE	
	SIC CODE		EMPLOYER FEIN		PHONE	
	JURISDICTION		JURISDICTION CLAIM NUMBER			
	INSURED REPORT NUMBER		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION	
CARRIER CLAIMS ADMIN	CARRIER (NAME, ADDRESS & PHONE No) MISSOURI EMPLOYERS MUTUAL 101N. KEENE ST. COLUMBIA, MO 65201 1.800.442.0593		POLICY PERIOD To		CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE No)	
	CARRIER FEIN		POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN	
	AGENT NAME AND CODE NUMBER		CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE			
	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH		SOCIAL SECURITY NUMBER	
EMPLOYEE	ADDRESS (INCL ZIP)		SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		MARITAL STATUS <input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	
	PHONE		NO OF DEPENDENTS		OCCUPATION/JOB TITLE	
	RATE PER <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER		No. OF DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	DATE EMPLOYER NOTIFIED		DATE DISABILITY		NCCI CLASS CODE	
WAGE	TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM		DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE <input type="checkbox"/> AM <input type="checkbox"/> PM	
	CONTACT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED	
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE	
	DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
	SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
	HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.					
	CAUSE OF INJURY					
OCURRENCE	DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYEE <input type="checkbox"/> MINOR: CLINIC/HOSPITAL <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED GREATER THAN 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
TREATMENT	WITNESS (NAME & PHONE #)		DATE ADMINISTRATOR NOTIFIED		DATE PREPARED	
	DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE	
OTHERS	DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PHONE NUMBER	
	DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PHONE NUMBER	

The shaded portions will be completed by Missouri Employers Mutual. White areas to be completed by policyholder.