pharmacists® mutual
INSURANCE GROUP

**Pharmacists Mutual Insurance Group**
Pharmacists Insurance Company NAIC #13714
Chiron Insurance Company NAIC #16356

**NOTIFICATION OF WORKERS' COMPENSATION CLAIM**
Email completed form: **workcomp@pmuw.com** or fax: **562-506-0306**

## EMPLOYER

INSURED NAME
ADDRESS
CITY STATE ZIP
COUNTY PHONE
FEDERAL TAX ID
UNEMPLOYMENT ID
SIC/NAICS CODE
LOCATION # POLICY #
D/B/A NAME
ADDRESS
CITY STATE ZIP

## EMPLOYEE

FIRST NAME MIDDLE NAME LAST NAME
ADDRESS
CITY STATE ZIP
COUNTY
EMPLOYEE NUMBER
SSN
PHONE NO.
DATE OF BIRTH
☐ MALE ☐ FEMALE
MARITAL STATUS
# DEPENDENTS
OFFICER / PARTNER ☐ YES ☐ NO
DATE OF HIRE
STATE OF HIRE
MINOR'S WORK CERTIFICATE NUMBER (IF UNDER 18)
REGULAR DEPARTMENT OR DIVISION No. NAME
OCCUPATION
NCCI CLASS CODE
WAGE RATE PER
AVERAGE HOURS/DAY
AVERAGE DAYS/WEEK

## OCCURRENCE

PLACE OF ACCIDENT OR OCCURRENCE
CITY STATE ZIP
COUNTY OF INJURY FILING STATE
EMPLOYER'S PREMISES? ☐ YES ☐ NO ☐ UNKNOWN
DATE OF INJURY / ILLNESS
TIME OF OCCURRENCE
TIME WORKDAY BEGAN
DID EMPLOYEE LOSE ONE OR MORE DAYS OF WORK?
☐ YES
LAST DATE WORKED
FIRST DATE OF DISABILITY
FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO ☐ N/A
DID SALARY CONTINUE? ☐ YES ☐ NO ☐ N/A
☐ NO
☐ UNKNOWN
RETURNED TO WORK? ☐ YES: DATE ☐ NO ☐ UNKNOWN
DATE EMPLOYER NOTIFIED PERSON NOTIFIED
DESCRIBE NATURE OF INJURY OR ILLNESS IN DETAIL (Include part of body affected, e.g., strain to lower back, fractured arm, lead poisoning.)
EMPLOYEE'S WORK ACTIVITY AT TIME OF INJURY (e.g., loading truck, typing, assembling product)
DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURRED WITH DETAILS OF HOW EVENT OCCURRED (Who was involved, tools, machinery, employee's actions, etc.)
FATALITY? ☐ YES ☐ NO
DATE OF DEATH
WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO ☐ N/A
WERE THEY USED? ☐ YES ☐ NO ☐ N/A

## MEDICAL INFORMATION

SELECT TYPE OF TREATMENT
☐ NO MEDICAL TREATMENT
☐ HOSPITALIZED
☐ OUTPATIENT
☐ EMERGENCY ROOM
☐ IN-HOUSE / FIRST AID
☐ UNKNOWN
FACILITY NAME
ADDRESS
CITY STATE ZIP
TELEPHONE
PHYSICIAN'S NAME
WITNESSES (NAME & PHONE NO.)

| DATE COMPLETED | REPORTED BY/CALLER | TITLE | PHONE NUMBER & EXT. | EMAIL |
|---|---|---|---|---|
| | | | | |