Actec® Reporting Guide

Workers' Compensation

Date ____/____/____

INSURANCE INFORMATION

Carrier (insurance company) | Policy number

EMPLOYER INFORMATION

Employer name

Federal Tax ID Number | Location number

Address | City | State | Zip

Phone number | Fax number

Preparer's name | First | Last

Preparer's title | Phone number

Physical location (if different)

Address | City | State | Zip

EMPLOYEE INFORMATION

Employee's name | First | Middle | Last

Address | City | State | Zip

Employee ID number | SSN __ __ __ - __ __ - __ __ __ __ | Phone number

Date of birth / / | Marital status | Sex | Female ☐ | Male ☐ | Number of Dependents | Under 18 | Other

Department | Date of hire / / | State of hire

Wage rate $ | Per | Average hours per day | Average days per week

Paid in full for date of injury? | Yes ☐ | No ☐ | Did salary continue? | Yes ☐ | No ☐

INCIDENT INFORMATION

Address where incident occurred | City | State | Zip

Filing state | On employer's premises? | Yes ☐ | No ☐

Did employee lose one or more days of work? | Yes ☐ | No ☐ | Injury Date / / | Time of injury | ☐AM ☐PM

Time work began on day of injury | ☐AM ☐PM | If lost time, last day worked / / | Date returned to work / /

Date employer was notified / / | Name of person notified

Fatality? | Yes ☐ | No ☐ | If yes, date of death / /

Were safeguards or safety equipment provided? | Yes ☐ | No ☐ | If so, was employee using them? | Yes ☐ | No ☐

Type of injury | Part of body

Describe what happened, in detail (employee's activity, objects involved, how injury occurred, etc.)

WITNESSES

Witness name	Phone number
Witness name	Phone number

MEDICAL TREATMENT

Did Employee go to …Clinic/Physician?	Name			Phone number			
Address		City		State	Zip		
…Hospital?	Name			Phone number			
Address		City		State	Zip		
Type of treatment	ER ☐	First Aid ☐	Hospital ☐	In-house ☐	None ☐	Unknown ☐	Outpatient ☐
Any reason to believe this was not work related?			Yes ☐	No ☐	Unknown ☐		

STATE SPECIFIC QUESTIONS

INSURED CUSTOM QUESTIONS (WHEN APPLICABLE)