Quick Action Claim Directions for

Ute Indian Tribe

Things You Should Know – Helpful Hints

At the time you report any loss, be prepared to furnish the following information:

- Date and time of loss
- Location/Condition
- Complete description of loss
- Names, addresses and phone number of drivers, persons injured or owners/managers of damaged property
- Any witnesses (including names, addresses, phone number)
- The nature of the injuries or damages

Please do not delay reporting the claim if you do not have all of the above information.

- Do not accept liability or agree to pay for any medical treatment or property damage.
- Do not give a copy of your claim report to anyone other than your insurance claims representative or counsel.
- Discuss your claim only with those persons who properly identify themselves as your claim representative.

EMPLOYER'S FIRST REPORT OF INJURY

Employee's Name (first, middle, Last):	Gender ☐ Male ☐ Female	**Employee's Home Phone #:**

Employee's Street Address:	**City:**	**State:**	**Zip code:**

Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Unknown	**Date of Hire:**	**Occupation:**	**Employment Status:** ☐ Full Time ☐ Part Time ☐ Other ☐ Unknown

Employer's Name:	**Employer's Federal ID #:**	**Employer's Phone #:**

Employer's Mailing Address:	**City:**	**State:**	**Zip code:**

Average weekly wage at time of injury:	$	**Check box if employee receives:** ☐ Tips ☐ Meals ☐ Room ☐ Health Insurance	**Check if these are included in AWW:** ☐ Tips ☐ Meals ☐ Room ☐ Health Insurance

Is the employer self-insured? ☐ Yes ☐ No	**Were full wages paid for the DOI?** ☐ Yes ☐ No	**Are wages continued?** ☐ Yes ☐ No

Injury/Illness date:	**Time employee began work:** a.m. ☐ p.m. ☐	**Injury time:** a.m. ☐ p.m. ☐ ☐ unknown	**Last day worked:**	**Date employer notified:**	**Date disability began:**	**Date returned to work:**

Did injury cause death? ☐ Yes ☐ No	**If so, date of death:**	**Name, relationship, and address of closest dependent if injury caused death**	**Injury occurred because of:** ☐ Intoxication ☐ Safety Violation ☐ Not Applicable

What part of the body was affected?	**What is the nature of the injury/illness?**

What was the employee doing just before the accident occurred?

How did the injury occur?	**What object or substance directly harmed the employee?**

Injury site address:	**City:**	**State:**	**Zip code:**

Did injury on premises? ☐ Yes ☐ No	**Initial treatment:** ☐ None ☐ Emergency Room ☐ Minor on-site ☐ Hospital >24 Hours ☐ Clinic/Hospital	**Was the employee hospitalized overnight as an in-patient?** ☐ Yes ☐ No

Name(s) of witnesses:	**Name of employer representative notified:**
Name and address of treating doctor or healthcare professional:	**Name and address of facility where treated:**

Completed by (name):	**Title:**	**Phone #:**	**Date Completed:**

ACCIDENT REPORT

(Employee's Injury Report to Employer)

INSTRUCTIONS: ***(1) Requirement to Notify Employer*** – The employee is under a duty to notify the employer of any injuries immediately. ***(2) Requirement to Investigate*** – The supervisor is under obligation to investigates the circumstances of the injury occurrence, and note his/her findings on this form. ***(3) Seeking Medical Care*** – If the injury is not an emergency, the employee must be sent to the Designated Medical Provider (DMP). ***(4) Declination of Medical Care*** – employee chooses not to seek medical treatment at this time, he/she should check the box "Declines Medical Care at this time". This declination means no medical treatment is needed at this time. However, if the condition worsens, generally within a few days, the employee may request to seek medical treatment. The employer is then under legal obligation to complete a First Report of Injury (FROI) promptly, AND then send the employee to DMP. The first aid only type of injury then becomes a workers' compensation claim.

EMPLOYEE INFORMATION

Last Name: ______ **First Name:** ______ **MI:** ______

Address: ______

City: ______ **State:** ______ **Zip:** ______ **Phone:** ______

INJURY DETAILS

Date of Injury: ______ **Day of Week:** ______ **Time of Injury:** ______ a.m. p.m.

Date/Time Left Work: ______ **Date/Time Returned:** ______ **Lost Time:** ☐ Yes ☐ No

Date/Time Supervisor Notified: ______ **Date/Time Accident Report Completed:** ______

Supervisor's Name: ______ **Supervisor's Phone:** ______

Employee's Explanation of Injury:

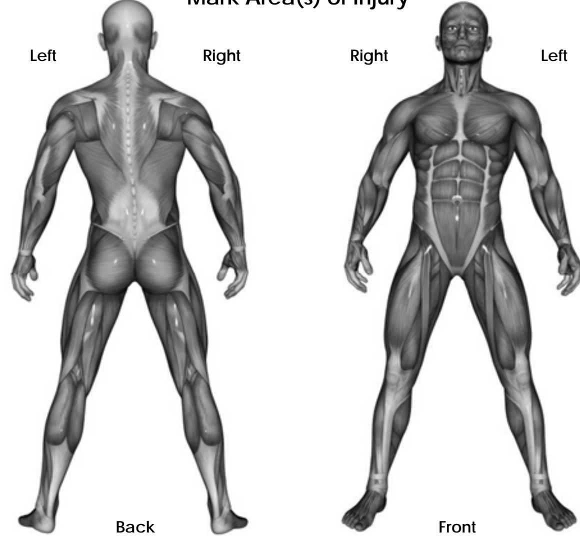
Cause of Injury:

- ☐ Burn, Scald, Exposure, Contact Injury
- ☐ Caught In, Under, or Between
- ☐ Cut, Puncture, Scrape, Injured By
- ☐ Fall, Slip or Trip
- ☐ Motor Vehicle
- ☐ Repetitive Motion Injury
- ☐ Rubbed or Abraded By
- ☐ Strain or Injured By
- ☐ Striking Against or Stepping On
- ☐ Struck or Injured By (Kick, Stabbed, Bit)

Type of Injury:

- ☐ No Apparent Injury
- ☐ Amputation
- ☐ Burn
- ☐ Contusion
- ☐ Crushing
- ☐ Electrical Shock
- ☐ Cumulative Trauma (repetitive motion)
- ☐ Foreign Body (e.g., in eye)
- ☐ Laceration/Cut
- ☐ Puncture (e.g., needle stick)
- ☐ Sprain/Strain
- ☐ Other: ______

Mark Area(s) of Injury



Name of Witness(s): ______

Accident Investigation Conducted: ☐ Yes ☐ No **Was there any of the following:** ☐ Safety Rule Violation ☐ Machine Malfunction ☐ Motor Vehicle Accident ☐ Other Violation

Supervisor's Findings/Comments:

What actions have been taken to prevent a recurrence: ______

MEDICAL

Employee Referred To: ☐ Designated Medical Provider (specify): ______
☐ Hospital Emergency Room (specify): ______
☐ Declines Medical Care at this time

______ ______ ______ ______

Employee's Signature **Date** **Supervisor's Signature** **Date**