Montana Association of Counties
Workers' Compensation Trust

MACo JPA

FIRST REPORT
of Injury and Occupational Disease

MACO CLAIMS DEPARTMENT
P.O. Box 7059 Helena, MT 59604

Adjusters Date Stamp

Worker

Last Name	First Name	M.I.	Date of Birth	Social Security Number

Home Address	City	State	Postal Code

Phone Number	Education	Gender	Marital Status	Number of Dependants
	☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	☐ Male ☐ Unknown ☐ Female	☐ Married ☐ Separated ☐ Not ☐ Unknown	

Wages

Date Hired	Gross earnings for Four pay periods preceding the injury	Date/Amount /	Date/Amount /	Date/Amount /	Date/Amount /

Employment Status	Number of days worked per week	Wage				
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer		☐ Hour ☐ Day	☐ Week ☐ Bi-weekly	☐ month	☐ Other: ☐ year	

In addition to Gross earnings cited above worker received: ☐ Board & Room ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other: Estimated value if any

Worked next scheduled shift	Off work more than 5 work days	Date Last Worked	Date of Return to Work	Full wages paid for date of Injury?	Salary Continued?
☐ Yes ☐ No	☐ Yes ☐ No ☐ Not Sure			☐ Yes ☐ No	☐ Yes ☐ No

Accident Description

Job Title	Description of Accident
Dept.	

Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	Date and Time of Injury /

Date disability began	Date of Death	Names of witnesses:	1)	2)	3)

Accident on employer's: premises?	Accident address or location		
☐ Yes ☐ No	City	State	Postal code

Date employer notified	Accident Reported to	Safety equipment provided?	Safety Equipment used?
		☐ Yes ☐ No	☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code	Phone Number

Hospital Name	Address	State	Postal Code	Phone Number

Type of initial medical treatment received ☐ No Treatment ☐ Emergency room ☐ Treatment on-site by employer or medical staff ☐ Clinic/Dr. Office ☐ Hospital

Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. **I understand** that signing this claim for compensation authorizes the release of rehabilitation records, Social Security records and health care information relevant to this claim to the workers' compensation insurer and the insurer's agents (medical records pursuant to HIPAA, Public Law 104-191, 42 U.S.C. 1301 et seq. and Section 50-16-527(4)&(5). **I also understand** that if I obtain or exert unauthorized control over workers' compensation benefits, I may be fined and/or imprisoned."

Signature of Injured Worker or Beneficiary: Date

Employer

Employer Name	Doing Business As	Federal Employer Identification Number (tax I.D.)

Mailing Address:	City	State	Postal Code	Phone Number

Location of operation, if different from mailing address	Nature of Business or SIC/NAICS Code	Self-Insured? ☐ Yes ☐ No

Employer is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	Injured worker is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ A member of the employer's (sole proprietor or partner) family living in the employer's household.

Do you have any reason to question this accident? ☐ Yes ☐ No	If yes, please explain fully. Use separate sheet if you need additional space.	Was worker injured while in your employ? ☐ yes ☐ no

Prepared by	Official Title	Date:

Payroll Classification Code Under which you report Employee's wages	Authorized Employer's Signature_____ Date_____

Insurer

Claim Administrator's Claim Number	Date reported to Claim Administrator	The above information is correct with the following exceptions ☐ (Attach extra sheets if box at right is checked)

Third Party Claim Administrator's Name	Claim Administrator's Address	Insurer FEIN
MACO CLAIMS DEPARTMENT	**PO BOX 7059 HELENA, MT 59604 1-888-442-8552**	

Insurer Name	Third Party Administrator FEIN

Policy Number	Policy Effective Date	Policy Expiration Date