

PINNACOL ASSURANCE

Early reporting can save your money. Report all injuries immediately!

The information below allows Pinnacle Assurance's customer service representatives to quickly and accurately process your claim. Please completed form as a guide when reporting by phone or when to send your form. Don't wait to report if you don't have all the answers.

FIRST REPORT OF INJURY

To report a claim:

Call 1-800-561-4000 or 800-873-1243

Or Fax to 800-561-5000 or 800-873-1243

Or go to pinnaclecol.com

PLEASE PRINT CLEARLY

POLICY INFORMATION

Policy Number _____ Company Name _____

Address or Location (if different than mailing address): _____

Prepared by: _____ Title: _____

E-mail: _____ Fax: (_____) _____

Phone: (_____) _____ Date Completed: _____

INJURED WORKER INFORMATION

Injured Worker's Social Security Number _____ Date of Injury: ____/____/____

First Name _____ M.I. _____ Last Name _____

Home/Celling Address: _____ City _____ State _____ Zip Code _____ Phone: (_____) _____

Date of Birth: ____/____/____ ☐ Male ☐ Female Marital Status _____

Language: ☐ English ☐ Spanish ☐ Other _____ E-mail: _____

Occupation: _____ Date Hired: ____/____/____

Employee Status: ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Volunteer ☐ Independent Contractor

Days Worked per Week: _____ Hours Worked per Day: _____

Pay Rate: _____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ Other _____

ACCIDENT / INJURY INFORMATION

Fatal Injury: ☐ Yes ☐ No If Fatal Injury: Date of Death ____/____/____

Time of Injury: _____ ☐ am ☐ pm Time Work Began: _____ Last Day Worked: ____/____/____

Full Pay on Date of Injury: ☐ Yes ☐ No

Accident Occurred on Employer's Premise: ☐ Yes ☐ No If Applicable, Location Code: _____ Dept Code: _____

Accident Location: _____ City _____ State _____ Zip Code _____

Name of Employer Representative Notified: _____ Date Notified: ____/____/____

Witnesses: _____ (Name(s) and How Notified)

How Did the Injury Occur: _____

Specific Activity the Employee Was Engaged In: _____ What Equipment Was Being Used: _____

Body Part(s) Injured: _____ ☐ Right ☐ Left ☐ Not Applicable

Type of Injury Sustained: _____

☐ Safety Equipment Provided ☐ Safety Equipment Used ☐ Possible Drug/Alcohol Involved ☐ Employer Questioning Liability

RETURN TO WORK INFORMATION

Has the Injured Worker Returned to Work? ☐ Yes ☐ No

Date Returned to Work: ____/____/____ Estimated Return to Work Date: ____/____/____

Is this a Lost Time Claim? ☐ Yes ☐ No (Claims in lost time if there is a loss of more than three scheduled work days due to the injury)

MEDICAL PROVIDER INFORMATION: Where Was Your Employee Treated? _____

☐ No Medical Treatment ☐ Treated by Employer ☐ 911-Called ☐ Walk-In Clinic

☐ Emergency Room ☐ Hospitalized > 24 hours/Overnight ☐ Possible Surgery

Medical Provider Name: _____ Street Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____

Updated 02/2010

Pinnacol First Report Injury Form

**Colorado. State Compensation
Insurance Authority**



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