**REPORT ALL WORKER'S COMPENSATION INJURIES TO LIBERTY MUTUAL**
The 1-800-CLAIMS SERVICE CENTER is open 24 hours a day including Weekends and Holidays. For efficient service, have the following information available for the Customer Service Representative

*Call:* 1-800-362-0000

# ExPRSCall W C Report Form / National Market

## CLAIM INFORMATION

| | | |
|---|---|---|
| Date/Time of Injury | ☐ AM ☐ PM | After the call, write claim number here: **WC** |
| Is this claim work related? | Will the employee miss time from work? ☐ | |

**Employer Name:**

**Employer Address:**

## EMPLOYEE INFORMATION

Employee's Social Security Number: _____

Employee's Name:

Employee's Date of Birth _____

Home Address: (Street) (City) (State) (Zip)

| | |
|---|---|
| Home Phone Number: | Male ☐ Female ☐ |
| Hire Date: | Number of Dependents: Dependents under 18: |
| Occupation: | Department Name: |
| State Hired: | Supervisor Name & Phone: |

| | | |
|---|---|---|
| Current Weekly Wage: | Hourly Wage: | Hours Worked per Day: |
| Days Worked per Week: | Hours Worked per Day: | Employment Status: |
| Employer Report No: | Employee ID No: | Was Salary Continued: |
| Was Employee Paid in Full for Date of Injury: | How often is Employee Paid: | |
| Education Level: | Any Prior WC Injuries: | OSHA Reference No: |

## EMPLOYER INFORMATION

Contact Name, Telephone Number, and Title:

Work Location: (Street) (City) (State) (Zip)

Mailing Addr: (Street) (City) (State) (Zip)

| | |
|---|---|
| Employer Location Code: | Employer SIC.: |
| Employer FED ID: | Employer Code: |

Nature of Business:

Contract Number:

## ACCIDENT INFORMATION

Did the Accident Occur at the Work Location? Yes ☐ ☐

Accident Address: (Street) (City) (State) (Zip)

Nature of Accident:

Give a Full Description of the Accident: (Be as Complete as Possible)

| | |
|---|---|
| Are Other WC Claims Involved? Yes ☐ No ☐ | Date and Time Reported to Employer: |
| Person Reported To: | |

**CONTINUED ON REVERSE SIDE**

ASC-3085 R2

## INJURY INFORMATION

Injury Description:

| | |
|---|---|
| Date of Death (*if applicable)*: | Is Employee Hospitalized? Yes ☐ No ☐ |
| Lost Time? Yes ☐ No ☐ | If Yes, What was First Full Day Out: |
| Date Last Day Worked: | Date Disability Began: |
| Date Returned to Work: | **OR** Estimated Return to Work Date: |

Time Workday Began:

| | |
|---|---|
| Which Part of the Body was Injured? (e.g. Head, Neck, Arm, Leg)? | Nature of Injury: (e.g. Laceration, Bruise, Fracture) |
| Part of Body Location: (e.g. Left, Right, Upper, Lower?) | Source of Injury: |

## MEDICAL INFORMATION

Safeguards Provided? Yes ☐ No ☐ Safeguards Utilized? Yes ☐ No ☐

Initial Medical Treatment: (Select One) ☐ ER Treated and Released ☐ Hospitalized ☐ Physician/Clinic ☐ Minor/Onsite ☐ No Medical Treatment

**Hospital** - Name, Address, Phone:

**Clinic/Doctor** - Name, Address, Phone:

## WITNESS INFORMATION

Were there any Witnesses? Yes No

If Yes, List Names and How to Contact Them:

## ADDITIONAL COMMENTS & INFORMATION

## REPORT PREPARED BY

| | |
|---|---|
| Name: | Title: |
| Signature: | Phone: |