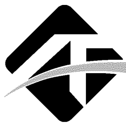

Accident Fund
INSURANCE COMPANY OF AMERICA

P.O. Box 40790
Lansing, MI 48901-7990

Employee's Report of Injury

(Answer all questions fully)

This form must be completed and signed before further benefits are paid.

Name:____ Social Security #:____________________
First Middle Last

Address:____
Street # Street Apt # / RR # City State Zip Code

Telephone #: (_________)____________________ Age:________ Date of Birth: ______________________

Height:________ Weight:__________ Tax Filing Status:____________________ Education Completed: ______________

Does your spouse receive any type of Employment Wages, Social Security, Pension, Unemployment, wage continuance, or reimbursement by a Self-Insured plan? ❑ Yes ❑ No If yes, who pays it and how much per month?____________________

If you pay child support: Through what county(ies)? ______________________________ How much weekly?______________

Employer's Name:____

Employer's Address:____

Date of hire:__________________ Occupation:______________________________ Foreman:____________________

Weekly wage:______________________ Hourly rate:__________________________ Hours per week:________________

Date of injury:_____________________ **Time of injury:** ________________ **Last day worked:** __________________

Explain in detail what caused the injury:____

____

What part of your body was injured?____ Type of injury:________________

Was injury reported to employer?_________ When?__________________________ Who?___________________________

Name of witness to injury:_________________________________ Have you had any previous injuries?_________________

If so, when and where, and what type of injury?____

Did you receive any compensation for these injuries?__________ If so, from whom and how much?__________________________

List names and addresses of doctors that you have been treated by:__________________________________

____

____

Have you been hospitalized?_________ Where?_______________________________________ How long?________________

Diagnosis from your doctor:____ Were you given time off?______________

How long? From______________ to _______________ Do you have a possible return to work date?________ When?______________

Next Dr. appt.? ____________________ Were you working a second job when you were injured for this employer?____________________

If you are losing time from that employer, who is it and what are your earnings?__________________________________

____

Do you receive any type of Social Security, Pension, Unemployment, wage continuance, or reimbursement by a Self-Insured plan? ❑ yes ❑ no

If so, who pays you and how much per month?____

All wages you earn while receiving benefits from us must be reported to Accident Fund Insurance Company of America.

I certify I have read the information on this sheet and have answered the questions correctly to the best of my knowledge.

Signed:____ Date:__________________