

How to respond to a workplace injury:

For life-threatening medical emergencies, call **911**.

For non-life-threatening injuries, call the **24/7 Nurse Line at (844) 581-0828** to report the incident and get your employee the right care

Workers' comp claims

You can file your first report of injury for a workers' comp claim in three simple ways:

Call the 24/7 claim intake line within 24 hours of the incident: **(844) 581-0828**

Submit the claim information online here

Email the claims team within 24 hours of the incident: **claims@pieinsurance.com**

- **In your email, please include the following:**

- The name of your business
- The policy number
- Reporting party's contact information (name, phone, email)
- The name, phone, and email address of the injured employee
- Date of the injury or accident
- A description of the injury or accident

Thank you.



NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes New Jersey, by insuring with the

() Insurance Company

for the period

Beginning Ending

Employer

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

AVISO

El patron avisa que ha asegurado el pago de compensación a los empleados y sus dependientes, de acuerdo con lo provisto por la ley de responsabilidad de los patrones de seguro para sus empleados. Titulo 34, Capitulo 15, Articulo 5, revision de estatutos del Estado de New Jersey, asegurandolos con.

() Compañía de Seguro

por el periodo

Comenzando Terminando

Patron

De acuerdo con la ley mencionada arriba, esta noticia debe ser colocada y mantenida en un lugar visible en todos los lugares de trabajo..

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)				CARRIER/ADMINISTRATOR CLAIM NUMBER		OSHA LOG NUMBER		REPORT PURPOSE CODE	
				JURISDICTION		JURISDICTION CLAIM NUMBER			
				INSURED REPORT NUMBER					
				EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #	
PHONE #									
INDUSTRY CODE		EMPLOYER FEIN							

CARRIER/CLAIMS ADMINISTRATOR									
CARRIER (NAME, ADDRESS, & PHONE #)				POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)			
				TO					
				CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE					
CARRIER FEIN		POLICY/SELF-INSURED NUMBER				ADMINISTRATOR FEIN			

EMPLOYEE/WAGE											
NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE	
ADDRESS (INCL ZIP)				SEX <input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN		MARITAL STATUS <input type="checkbox"/> U UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN		OCCUPATION/JOB TITLE			
								EMPLOYMENT STATUS			
								NCCI CLASS CODE			
PHONE				# OF DEPENDENTS							
RATE PER:		<input type="checkbox"/> DAY <input type="checkbox"/> WEEK	<input type="checkbox"/> MONTH <input type="checkbox"/> OTHER:	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		

OCCURRENCE/TREATMENT													
TIME EMPLOYEE BEGAN WORK		<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE () CANNOT BE DETERMINED		<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE		DATE EMPLOYER NOTIFIED		DATE DISABILITY BEGAN	
CONTACT NAME/PHONE NUMBER					TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED				
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO					TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE				
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED					ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED								
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED					WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED								
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL										CAUSE OF INJURY CODE			
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO				
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)					HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)					INITIAL TREATMENT			
										0 NO MEDICAL TREATMENT			
										1 MINOR: BY EMPLOYER			
										2 MINOR CLINIC/HOSP			
										3 EMERGENCY CARE			
										4 HOSPITALIZED > 24 HOURS			
5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED													

OTHER									
WITNESSES (NAME & PHONE #)									
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER	

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.