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? ☐Yes ☐No

Employer Name:

Address:

EMPLOYEE INFORMATION

Employee's Social Security Number: ______________________

Employee's Date of Birth:

Employee's Name:

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 ☐ No ☐ If No, Where Did the Accident Occur?

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

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: