EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

(Connecticut)

INSTRUCTIONS:

This form is to be completed by the employer to be sent to the Insurer within one week of notice of injury for injuries that result in incapacity for one day or more. The form should be typed or printed in ink, in duplicate, as follows:

1. Employer section (Employer's name, address, ZIP, SIC code, FEIN, Location Address, phone number);
2. Carrier name, address and phone number;
3. Claims Administrator name, address and phone number;
4. Policy information (Policy number or Self-Insured number, Policy period);
5. Employee information (Name, address, phone, date of birth, Social Security number, date hired, occupation, State of hire, rate of pay)
6. Occurrence (Date, time, place of injury, etc.);
7. Treatment
8. Preparer information.

Do not enter data in shaded fields.

Insurer: Send original to:

Workers' Compensation Commission
Office of the Chairman
Capitol Place
21 Oak Street
Hartford, CT 06106

Phone: (860) 493-1500

Include the *Notice of Claim* in the filing and keep a copy for your files.