FIRST REPORT

Insured: ______ Assoc. Member No: (If applicable): ______
Policy number & Policy period: ______ SIR: ______
Date of Loss: ______ Accident State: ______
Claim #: ______ Safety Nat'l Claim #: ______
Claimant(s): ______ DOB: ______ Marital Status: ______
NCCI Job Class Code: ______ Job Description: ______
Dependents, if applicable (Names, DOB's):

AWW: $ ______ TT: $ ______ PPD: $ ______ PT: $ ______
Supplemental/Cola: $ ______
Actual/estimated RTW Date: ______ Full? ______ Modified? ______ Same Employer? ______
Detailed Description of Accident: ______
Full Descrip. all injuries/med. treatment? ______

Attach computer printout	**Paid to Date**	**Future Estimate**	**Total**
Indemnity:	$	$	$
Medical	$	$	$
Rehab:	$	$	$
Legal/Expenses:	$	$	$
Total:	$	$	$

Interest/Penalties paid? ☐ Y ☐ N If yes, please explain: ______

Are these issues relevant in this case?

2nd Inj. Fund: ☐ Y ☐ N ☐ Maybe Offsets: ☐ Y ☐ N ☐ Maybe
Subrogation: ☐ Y ☐ N ☐ Maybe Disputed/Legal Issues: ☐ Y ☐ N ☐ Maybe
Settlement? ☐ Y ☐ N ☐ Maybe Amount $ ______ Demand $ ______ Offer $ ______

Please comment on relevant issues, status, settlement and disposition plans. (Attach add'l page if needed)

Do you expect this claim to exceed the SIR? ______ **Expected closure date:** ______

Please attach the Employer's First Report of Injury and all pertinent file material.

Form completed by: ______ Date completed: ______
Company: ______ Address: ______
Phone: ______ Fax: ______ Email: ______

Safety National Casualty Corporation
1832 Schuetz Road, St. Louis, Missouri 63146
Telephone: (314) 995-5300 Facsimile: (314) 995-3897