FIRST REPORT

Insured: _____ Assoc. Member No. (If Applicable): _____

Policy Number & Policy Period: _____ SIR: _____

Date of Loss: _____ Accident State: _____

Claim #: _____ Safety National Claim #: _____

Claimant(s): _____ DOB: _____ Marital Status: _____

NCCI Job Class Code: _____ Job Description: _____

Dependents, if applicable (Name, DOB's): _____

AWW: $ _____ TT: $ _____ PPD: $ _____ PT $ _____

Supplemental/Cola: $ _____

Actual/Estimated RTW Date: _____ Full? _____ Modified? _____ Same Employer? _____

Detailed Description of Accident: _____

Full Description of all injuries/med. Treatment? _____

Attach Computer Printout	**Paid To Date**	**Future Estimate**	**Total**
Indemnity:	$ _____	$ _____	$ _____
Medical:	$ _____	$ _____	$ _____
Rehab:	$ _____	$ _____	$ _____
Legal/Expenses:	$ _____	$ _____	$ _____
Total:	$ _____	$ _____	$ _____

Interest/Penalties paid? ☐ Yes ☐ No If "yes", please explain: _____

Are these issues relevant in this case?

2nd Injury Fund: ☐ Yes ☐ No ☐ Maybe Offsets: ☐ Yes ☐ No ☐ Maybe

Subrogation: ☐ Yes ☐ No ☐ Maybe Disputed/Legal Issues: ☐ Yes ☐ No ☐ Maybe

Settlement? ☐ Yes ☐ No ☐ 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

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