



A member of the Tokio Marine Group

FIRST REPORT

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

Policy Number: _____ Policy Period: _____ SIR: _____

Date of Loss: _____ Accident State: _____

Claim #: _____ Safety National Claim #: _____

Claimant First Name: _____ DOB: _____ Marital Status: _____

Claimant Last Name: _____ Add. Claimant(s): _____

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? _____

<u>Attach Computer Printout</u>	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