Benchmark
INSURANCE COMPANY

7710 INSURANCE
Built by first responders, for first responders.
a Trean Company

WORKERS COMPENSATION INJURY NOTICE

(To be handwritten by employee)

Injured Worker's Name: _____

Best Contact Number: _____ Social Security Number: _____

Date of Birth: _____ Marital Status: _____

Number of Children Under 18: _____ Salary: _____

Date of Hire: _____ Job Title: _____

Date of Injury: _____ Time of Injury:_____

Location Where the Injury Occurred: _____

To Whom Was the Injury Reported:_____

When Was Injury Reported: _____

Names of Witnesses (if any): _____

Which Body Part(s) Injured: _____

Description of Incident (Explain in Detail How Incident Occurred): _____

_____

_____

_____

_____

_____

_____

Did you seek medical attention and, if so, where? _____

_____

I, the undersigned injured worker, or legal representative of the injured worker named above, do hereby certify that the information provided is complete, true and correct to the best of my knowledge and that I have provided that information in order to obtain the benefits provided for by all applicable codes and rules. I hereby authorize any physician, chiropractor, practitioner, or other person, any hospital, including Veteran's Administration or other governmental hospital, any medical service organization, any insurance company, or other entity or organization, governmental or private, to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or any other disabilities or injuries. A photocopy of this authorization shall be as valid as the original.

Signature: _____ Date: _____

PRIOR HISTORY
(Initial correct box)

☐ I have NO prior conditions, injuries, or disabilities, of which I am aware, that might affect the disposition of the claim referenced above. If you checked this box, no further information is needed at this point.

☐ I have a prior condition, injury, or disability that could affect the disposition of the claim referenced above (this can include birth defects, prior surgeries, injuries, etc. whether work related or not). If you checked this box, indicating a pre-existing condition, please explain in detail in the space below. Please attach additional sheets of paper to this form if necessary.

_____

_____

_____

_____

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