

**GHS PROPERTY & CASUALTY INSURANCE COMPANY
OCCUPATIONAL ACCIDENT REPORT OF INJURY**

C/o Caprock Claims Management
PO Box 743427 Dallas, TX 75374-3427

Phone (972) 934-3086

PLEASE FAX to (972) 934-3091

All Reports of Injury must be submitted within 30 days from the Date of Injury

please print

Employer Information

Group Name _____ Group Policy Number _____
Supervisor/Manager Name _____ Supervisor/Manager Phone Number _____

Employee Information

Injured Employee Name _____ Soc. Sec. Num. _____ Date of Birth _____
Home Address (incl. city, state, zip) _____ Home Phone Number _____ E-mail _____
Employment Status _____ Job Title/Description _____
 Active Disabled Terminated Retired
Date Hired _____ Date Last Worked _____ Date Disability Began _____

If unable to work, please submit 13 weeks pre-injury payroll information

Accident Information

Date of Accident _____ What time did the accident happen? (specify am or pm) _____ Date of Report _____
When was the accident reported to Supervisor? _____ Name of Supervisor in charge at the time _____ Name of person filing report _____

What was the CAUSE of the accident?

WHERE did the accident occur?

What BODY PART(s) were injured?

What Type of Injury (ex.: Cut, Sprain, Fracture...)

Describe the DETAILS of the accident and how it happened. *Attach additional paper if necessary.*

Did the injury require immediate emergency treatment?

Employee refused medical attention and/or treatment.

Employee Signature _____

Supervisor Signature _____

Witnesses to Accident: Attach witness statements if taken.

Name	Address	Phone
(1) _____	_____	_____
(2) _____	_____	_____
(3) _____	_____	_____

Date of first medical treatment _____

Treating physician and treating facility (name, address and phone number) _____

Has the employee ever been treated for this before? If yes, please explain. _____

Give full name, address and phone number of ALL other physicians consulted in the past three years. _____

The employer agrees to make modified duty available for partially disabled employees who are able to return to some form of work as agreed to by their treating physician.

I certify that the injured individual is an Employee according to the provisions of the policy.

Employer Signature

Print Name

Date

Reimbursement Agreement

The undersigned may receive benefits under the policy as a result of Injuries sustained as a result of the accident identified in the Accident Report Form. The undersigned agrees to reimburse the carrier within 30 days for benefits paid under the policy from recoveries he or she may receive from a third party other than the undersigned's employer, in connection with the accident.

* _____
Employee Signature

Date

Right of Subrogation and Refund

The injured employee may incur expenses due to injuries for which benefits are paid by the policy. If the injuries are caused by the wrongful act, omission or negligence of another person, the employee may have a claim against that other person for payment of the expenses. We will be subrogated to all rights the employee may have against that other person and the employee must repay us out of the recovery made from: (a) the other person; or (b) the other person's insurer; or (c) any carrier providing uninsured or underinsured motorist coverage. The employee agrees to assist us in any recoveries and to not take any action that would prejudice our subrogation rights. Our subrogation rights only apply to the amount of the policy benefit paid because of that injury or death.

Name and address of third party or other party involved:

* _____
Employee Signature

Date

Authorization

I certify that the information is true and correct to the best of my knowledge. I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, or other organization, institution or person that has any records or knowledge of me or my health to give to GHS P&C Insurance Company, Caprock Claims Management, their legal representative, or designees any such information. Such release may include information that may be considered a communicable and/or venereal disease, hepatitis, HIV related, AIDS, AIDS related disorders, mental/nervous disorders, drug abuse and/or alcoholism.

I understand the information obtained by the use of this Authorization will be used by GHS P&C Insurance Company or Caprock Claims Management to determine eligibility for benefits under the Group Policy. Any Information will not be released to any person or organization except insurance companies, or any other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

A photocopy of this Authorization shall be as valid as the original.

I understand that I am entitled to a copy of this Authorization.

* _____
Employee Signature

Date

I authorize payment of all medical benefits and weekly disability benefits to my employer.

* _____
Employee Signature

Date

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

EMPLOYER—Please submit documentation of injured individual's employment (such as a copy of their last paycheck stub) along with this Report of Injury.