POLICY UNDERWRITTEN BY

PINNACOL ASSURANCE

Questions about your policy?

CAKE

cakeinsure.com | 833-230-2253

support@cakeinsure.com

First Report of Injury

The following information allows our partners at Pinnacol Assurance's to quickly and accurately process your claim. Use this form as a guide when reporting an injury. Don't wait to report if you don't have all the answers.

Policy Information

Policy Number: _____ Company Name: _____

Address or Location (if different than mailing address): _____

Prepared by (please print): _____ Title: _____

Email: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____ Date Completed:_____/_____/_____

Injured Worker Information

Injured Worker's Social Security Number:_____-_____-_____ Date of Injury:_____/_____/_____

First Name:_____ M.I.: _____Last Name: _____

Home/Mailing Address: _____

City/State/Zip:_____Phone: (_____) _____- _____

Date of Birth:_____/_____/_____ ☐ Male ☐ Female Martial Status:_____

Language: ☐ English ☐ Spanish ☐ Other: _____ Email:_____

Occupation: _____ Date Hired:_____/_____/_____

Employee Status: ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Volunteer ☐ Independent Contractor

Days Worked per Week:_____ Hours Worked per Day: _____

Pay Rate: _____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ Other: _____

Accident/Injury Information

Fatal Injury: ☐ Yes ☐ No If Fatal Injury, Date of Death:_____/_____/_____

Time of Injury:_____ ☐ am ☐ pm Time Work Began: _____ ☐ am ☐ pm

Full Pay on Date of Injury: ☐ Yes ☐ No Last Day Worked:_____/_____/_____

Accident Occurred on Employer's Premises: ☐ Yes ☐ No If Applicable, Location Code:_____Dept. Code: _____

Accident Location: _____

Name of Employer Representative Notified:_____ Date Notified:_____/_____/_____

Witnesses (Names and Phone Numbers): _____

_____

How Did the Injury Occur (Attach Additional Information if Necessary): _____

_____

Specific Activity the Employee Was Engaged In: _____

What Equipment Was Being Used:_____

Body Part(s) Injured:_____ ☐ Right ☐ Left ☐ Not Applicable

Type of Injury Sustained: _____

☐ Safety Equipment Provided ☐ Safety Equipment Used ☐ Possible Drug/Alcohol Involved ☐ Employer Questions Liability

Return to Work Information

Has the Injured Worker Returned to Work: ☐ Yes ☐ No

Date Returned to Work:_____/_____/_____ Estimated Return to Work Date:_____/_____/_____

Is this a Lost Time Claim: ☐ Yes ☐ No (Claim is lost time if there is a loss of more than three scheduled work days due to the injury.)

Medical Provider Information

☐ No Medical Treatment ☐ Treated by Employer ☐ 911 Called ☐ Walk-In Clinic

☐ Emergency Room ☐ Hospitalized >24 Hours/Overnight ☐ Possible Surgery

Medical Provider Name: _____Phone: (_____) _____- _____

Address:_____

City/State/Zip:_____

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First Report of Injury Form Instructions

1. Report all work-related injuries within 24 hours to Cake's Client Care team. Quick reporting can significantly reduce the total cost of a claim. Our partners at Pinnacol will help get your employee back to work as quickly as possible and reporting within 24 hours streamlines that process. Report the injury even if you question whether the injury is truly job-related.
2. This form is a guide for reporting injuries. To file a claim, please contact a member of the Cake Client Care team. Alternatively, you can fill out some preliminary information on the Client Portal, and we will contact you directly. We'll help you get your claim filed and put you in touch with our dedicated claims partners at Pinnacol. The employer or authorized representative should report the injury; please do not have your injured employee complete this form or call to file their claim.
3. As an employer, you are required to provide your injured employee with a list of your four designated medical providers within seven days after the claim is filed. Designating providers from Pinnacol's SelectNet list helps ensure your employee is seen by an occupational medical provider who is knowledgeable about the workers' compensation system and return to work issues. If you do not have four designated providers or you have any questions about your providers, call Cake for assistance.

Please answer as many questions as possible. Don't wait to report the injury if you don't have all of the answers, however, all questions on this form will need to be completed to meet the requirements of the Colorado Workers' Compensation Act. **Especially critical is the information regarding the date of injury if your employee will miss more than three scheduled days from work and when you expect your employee to return to work.**

Helpful Definitions:

Date of Injury: The date the accident occurred, or in the case of an occupational disease, the date of the first and last exposure.

Lost Time Claim: The loss of more than three scheduled workdays due to the injury.

Wages and Time Worked: Provide either the weekly pay rate and hours OR the hourly pay rate and hours worked. Wages may also include overtime wages, tips, commissions, room & board, housing, lodging and cost of health insurance. If you are unsure how to answer, call on of our Cake team members, and they will be happy to help.

Accident Location: Provide the address if the accident occurred on the employer's premises or if it occurred outside the employer's premises at an identifiable location. If it occurred at a place that cannot be identified by a number or street, such as a public highway, provide references locating the place as accurately as possible.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or injured worker for the purpose of defrauding or attempting to defraud the policyholder or injured worker with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

OSHA Form 301 Questions

"If you had 10 or fewer employees during all of the last calendar year or your business is classified in a low-hazard industry specified by OSHA, you do not have to keep injury and illness records unless the Bureau of Labor Statistics or OSHA informs you in writing that you must do so."

For this First Report of Injury to be considered equivalent to OSHA Form 301 (Injury and Illness Incident Report) the following questions must be completed along with the information on the front of this form. If you have questions regarding the OSHA recordkeeping standard, contact Cake, and we can put you in touch with our safety consultant partners at Pinnacol Assurance.

Case Number from OSHA 300 Log _____ **Was the Employee Hospitalized Overnight as an In-Patient?** ☐ Yes ☐ No

What was the Employee doing just Before the Incident Occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials," "spraying chlorine from hand sprayer," "daily computer key-entry."

_____

What was the Injury or Illness? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." Examples: "strained back," "chemical burns to hand," "carpal tunnel syndrome."

_____

What Object or Substance Directly Harmed the Employee? Examples: "concrete floor," "chlorine," "radial arm saw." *If this question does not apply to the incident, leave blank.*

_____