PINNACOL ASSURANCE

FIRST REPORT OF INJURY
To report a claim:
Call 303.361.4000 or 800.873.7242
Or Fax to 303.361.5000 or 888.329.2251
Or, go to www.pinnacol.com
PLEASE PRINT CLEARLY

Early reporting can save you money. Report all injuries immediately!
The information below allows Pinnacol Assurance's customer service representatives to quickly and accurately process your claim. Use the completed form as a guide when reporting by phone or online to save you time. Don't wait to report if you don't have all the answers.

POLICY INFORMATION

Policy Number: 3345034 Company Name: _____

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

Prepared by: _____ Title: _____
Please Print

E-mail: _____ Fax: (_____) _____-_____

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

INJURED WORKER INFORMATION

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

First Name: _____ M.I. ____ Last Name: _____

Home/Mailing Address: _____ Phone: (_____) _____-_____
City State Zip Code

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

Language: ☐ English ☐ Spanish ☐ Other: _____ E-mail: _____

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: _____ Last Day Worked: _____ /_____ /_____

Full Pay on Date of Injury: ☐ Yes ☐ No

Accident Occurred on Employers Premises: ☐ Yes ☐ No If Applicable: Location Code: _____ Dept Code: _____

Accident Location: _____
City State Zip Code

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

Witnesses: _____
Name(s) and Phone Number(s)

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 Questioning 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: Where Was Your Employee Treated?

☐ No Medical Treatment ☐ Treated by Employer ☐ 911 Called ☐ Walk-In Clinic
☐ Emergency Room ☐ Hospitalized > 24 hrs/Overnight ☐ Possible Surgery

Medical Provider Name | Street Address | City | State | Zip Code | Phone

PINNACOL ASSURANCE FIRST REPORT OF INJURY FORM INSTRUCTIONS

1. Report all work-related injuries within 24 hours! Quick reporting can significantly reduce the total cost of the claim. Our **goal** is to get your employee back to work as quickly as possible and reporting within 24 hours streamlines that process. Report the injury to Pinnacol Assurance even if you question whether the injury is truly job related. Provide information as to why you question the validity of the claim.
2. This form is a guide for reporting injuries by phone, or fax using the numbers on the front of this form. Online reporting is fastest. To report online, go to www.pinnacol.com, select "Quicklinks," then "Report an Injury." The employer or authorized representative should report the injury to Pinnacol Assurance; please do not have the injured worker complete this form.
3. Within 7 days after notification of an injury, the employer is required to provide the injured worker with a list of four medical providers who have been designated by the employer to provide medical treatment for the injured employee. The injured worker must choose one of the designated providers from this list. Designating providers from Pinnacol's SelectNet list helps ensure your employee is seen by an occupational medical provider knowledgeable about the workers' compensation system and return to work issues. If you do not have four designated providers, call Pinnacol for assistance.
4. When reporting a claim by phone or the Internet, a copy of the completed form will be mailed to you for your records. Please review the copy to ensure all information is correct. If changes are needed, please contact Pinnacol's claim representative assigned to the claim.
5. If the injured worker owes court ordered child support, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee. (C.R.S. 8-42-124 & 26-16-122(4))

Please answer as many questions as possible for Pinnacol to begin processing the claim. Don't wait to report if you don't have all the answers, however all questions on this form will need to be completed in order to meet the requirements of the Colorado Workers' Compensation Act. **Especially critical is the information regarding Date of Injury, if the injured worker will miss more than three scheduled days from work, and when you expect the injured worker to return to work**.

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 the customer service phone number on the front of this form. **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 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 Pinnacol Assurance 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 your Pinnacol Assurance Safety Consultant.

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.*

_____

What was the Name of the Physician/Health Care Professional Who Provided Medical Treatment to the Employee?

_____

MANAGEMENT ACCIDENT INVESTIGATION REPORT

MISSION YOGURT, INC.

GENERAL CONTACT

1333 W. 120th Ave., Suite 207
Westminster, CO 80234

303.252.7500

info@MissionYogurt.com

HR CONTACTS

Maria Wilson

303.252.7500

maria@MissionYogurt.com

Julia Lambert

303.252.7500

julia.lambert@MissionYogurt.com

INSTRUCTIONS

Please complete all items on this report as accurate as possible.

Please send completed report to HR@MissionYogurt.com within one week of accident occuring.

TO BE COMPLETED BY THE MANAGER

Type Of Accident

- ☐ Injury - First Aid Only
- ☐ Injury - Medical Treatment
- ☐ Property Damage
- ☐ Near Miss - Record Only

Employee Name: _____ Phone: _____

Employer: _____ Title: _____

Date of Accident: _____ Time of Accident: _____

Addresss and Location of Accident:

_____

_____

SUMMARY

Describe the accident. Use photos or sketches if necessary.

ANALYSIS

Identify possible causes for the accident and if/how it could have been avoided.

MANAGEMENT ACCIDENT INVESTIGATION REPORT

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HR CONTACTS

Maria Wilson

303.252.7500

maria@MissionYogurt.com

Julia Lambert

303.252.7500

julia.lambert@MissionYogurt.com

INSTRUCTIONS

Please complete all items on this report as accurate as possible.

Please send completed report to HR@MissionYogurt.com within one week of accident occuring.

RECOMMENDATIONS

Outline any possible corrective actions that may prevent the recurrence of similar accidents.

ACTION TAKEN

Describe measures taken by management to improve the system (employee training, new equipment, changes in safety policies, changes in operating procedures, etc.) and to prevent occurrence of similar accidents.

CORRECTIVE ACTION	ASSIGNED TO	DATE IMPLEMENTED	NOTES

Report Completed By: _____ **Date:** _____

Report Reviewed By: _____ **Date:** _____

EMPLOYEE ACCIDENT REPORT

MISSION YOGURT, INC.

GENERAL CONTACT

1333 W. 120th Ave., Suite 207
Westminster, CO 80234

303.252.7500

info@MissionYogurt.com

HR CONTACTS

Maria Wilson

303.252.7500

maria@MissionYogurt.com

Julia Lambert

303.252.7500

julia.lambert@MissionYogurt.com

INSTRUCTIONS

Please complete all items on this report as accurate as possible.

Please send completed report to HR@MissionYogurt.com within one week of accident occuring.

TO BE COMPLETED BY THE INJURED EMPLOYEE.

Employee Name: _____ Phone: _____

Employer: _____ Title: _____

Date of Accident: _____ Time of Accident: _____

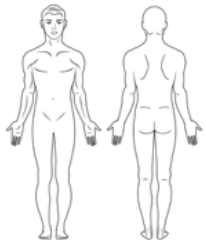
Addresss and Location of Accident:

_____

_____

Please explain step-by-step how the accident occurred:

Describe the affected body parts:



Identify possible causes for the accident and if/how it could have been avoided:

Employee Signature: _____ Date: _____

WITNESS STATEMENT

MISSION YOGURT, INC.

GENERAL CONTACT

1333 W. 120th Ave., Suite 207
Westminster, CO 80234

303.252.7500

info@MissionYogurt.com

HR CONTACTS

Maria Wilson

303.252.7500

maria@MissionYogurt.com

Julia Lambert

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julia.lambert@MissionYogurt.com

INSTRUCTIONS

Please complete all items on this report as accurate as possible.

Please send completed report to HR@MissionYogurt.com within one week of accident occuring.

TO BE COMPLETED BY THE WITNESS

Witness Name: _____ Phone: _____

Employer: _____ Title: _____

Date of Accident: _____ Time of Accident: _____

Addresss and Location of Accident:

_____

_____

SUMMARY

☐ I saw the accident. Please explain step-by-step how the accident occurred:

☐ I did not see the accident occur but can provide additional information about the scene and factors and/or unusual conditions that may have led up to the accident:

WITNESS STATEMENT

MISSION YOGURT, INC.

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INSTRUCTIONS

Please complete all items on this report as accurate as possible.

Please send completed report to HR@MissionYogurt.com within one week of accident occuring.

RECOMMENDATIONS

Identify possible causes for the accident and if/how it could have been avoided:

OTHER WITNESSES

Identify witnesses or others in the surrounding area:

DRAWING

If applicable please draw a diagram of the accident below:

Witness Signature: _____ **Date:** _____

Statement Taken By: _____ **Date:** _____