Lackawanna Insurance Group
Workers' Compensation
First Report of Injury Form

(* denotes required field)

***Date of Injury:**			
***Employee Social Security No:**			
***Employee First Name:**	***Employee Last Name:**		
***Street Address:**			
***City:**	***State:**	***Zip Code:**	
County:	***Phone No:**		
***Date of Birth:**	***Gender:**	**Marital Status:**	**No. of Dependents:**
***Occupation or Job Title:**	***Employment Status:**	***Date of Hire:**	
***Employer:**			
***Employer Contact First Name:**	***Employer Contact Last Name:**		
***Employer Contact Phone No:**	**Employer Contact Fax No:**	**Employer Contact E-Mail Address:**	
***Street Address:**			
***City:**	***State:**	***Zip Code:**	
County:	***Phone No:**		
Employer FEIN.:	**Policy Number:**	**Policy Period Dates:**	
***Date & Time Employer Notified:**	***Time employee began work:**	***Time of occurrence:**	
***Full pay for day of injury?:**	**Last day worked:**	**Date of disability:**	**Date returned to work:**

*Type of Injury:	*Part of Body Affected:	*Cause of Injury:

*How injury/illness/abnormal health condition occurred. Describe sequence of events including objects/substances directly responsible:

*Did injury or illness occur on employer's premises?:	*If accident did not occur at Employer Address provided on page one (1), please provide complete address:	*If Injury Out of State, Specify State:

*Were safeguards or safety equipment provided?:	*Were safeguards or safety equipment used?:

All equipment, material, or chemicals employee was using when accident or illness exposure started:

If fatal, give date of death:

Type of Initial Treatment:

- ☐ No (formal) Medical Treatment; only first aid
- ☐ Hospital – Emergency Care
- ☐ Panel Physician
- ☐ Employee Physician

Healthcare Provider Name:

Street Address:

City:	State:	Zip Code:

Phone No:

Witness First Name:	Witness Last Name:

Witness Phone No.:

*Person Completing This Form – Name:	*Phone Number:

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: _____ **Date Posted:** _____

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company:

Address:

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator):

Address:

Telephone Number: _____

IF SELF-INSURED
(Complete all applicable spaces)

Name of person handling claims at the self-insured:

Address:

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator):

Address:

Telephone Number: _____

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

Lackawanna Insurance Group

Lackawanna Casualty Company • Lackawanna American Insurance Company
• Lackawanna National Insurance Company

Authorization to Release Information

To Whom It May Concern:

I hereby request and authorize you to furnish to Lackawanna Insurance Group any and all information you have concerning

_____,

with respect to any illness or injury, medical history, consultation, treatment, including x-rays, as well as copies of all hospital or medical records, military records and / or other Workers' Compensation records.

I further request and authorize employers to furnish complete information including but not limited to wages, commissions, and any other form of compensation.

A photocopy of this authorization shall be considered as effective and valid as the original authorization.

Date: _____

Signature: _____

Print Name: _____

Street Address:

_____

City: _____ State: _____ Zip: _____

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

The Pennsylvania Workers' Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising in the course of his/her employment and causally related thereto. Pursuant to the Act, your employer will provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

If you require emergency medical treatment, you may seek it from any provider; however, any subsequent non-emergency treatment shall be obtained from one of the designated health care providers whose names appear on the list posted on your employer's premises. If you are faced with a medical emergency, you may secure assistance from a hospital or physician/health care provider of your choice. However, once the emergency no longer exists, the injured employee must treat with a listed provider for the remainder of the ninety (90) day period.

During the initial ninety (90) days from the date of your first visit, you have the right to switch from one health care provider on the list to another, and your employer will pay for that treatment.

If a designated health care provider refers you for treatment to another health care provider whose name is not on the list, your employer will pay for the treatment rendered by the provider to whom you were referred.

Naturally, you have the right to seek treatment or medical consultation from a non-designated health care provider during the initial ninety (90) day period following the first visit, but you are personally responsible for payment for those services.

You have the right to seek treatment from any health care provider at the expiration of the ninety (90) day period from the date of first visit. Your employer will pay for this treatment unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the Workers' Compensation Act.

Your employer will be responsible for the cost of that treatment after the initial ninety (90) day period has ended but only if you notify the employer that you are receiving treatment from non-designated health care provider and only if that notice is provided to your employer within five (5) days of the first visit to that provider. If you provide notice to your employer of treatment by a non-designated provider more than five (5) days after the first visit to that provider, the employer will not be responsible to pay for treatment rendered by that non-designated provider until it receives notification from you that you are receiving such treatment.

Should a designated health care provider prescribe invasive surgery, your employer will pay for an additional opinion from a health care provider of your choice. If the additional opinion differs from the opinion of the designated health care provider and if the additional opinion provides a specific and detailed course of treatment, you will then determine which course of treatment to follow. If you choose to follow the procedures recommended in the additional opinion, your employer will pay to have such procedures performed by one of its designated health care providers and will not be responsible for payment for treatment provided by a non-designated provider for a period of ninety (90) days from the date of your visit to the health care provider from whom you obtained the additional opinion.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND MY RIGHTS AND DUTIES UNDER THE PENNSYLVANIA WORKERS' COMPENSATION ACT AS SET FORTH HEREIN.

Employee Name	**Employee Signature**	**Date**

EMPLOYEE RE-NOTIFICATION AT OR NEAR THE TIME OF THE CLAIMED WORK INJURY

I hereby acknowledge that I have been informed again and that I understand my rights and duties under the Pennsylvania Workers' Compensation Act. I have received a copy of this workers' compensation employee notification form.

Employee Name	**Employee Signature**	**Date**

WORKERS' COMPENSATION INFORMATION

(1) The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

(2) Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

(3) You should report immediately any injury or work-related illness to your employer.

(4) Your benefits could be delayed or denied if you do not notify your employer immediately.

(5) If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

(6) The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at: Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); www.state.pa.us, PA Keyword: workers comp.

EMPLOYEE INITIAL ACKNOWLEDGEMENT OF RECEIPT OF WORKERS' COMPENSATION INFORMATION

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND READ THE WORKERS' COMPENSATION INFORMATION PROVIDED HEREIN.

_____ _____

Employee Name **Employee Signature** **Date**

EMPLOYEE ACKNOWLEDGEMENT OF RECEIPT OF WORKERS' COMPENSATION INFORMATION AT OR SOON AFTER THE TIME OF CLAIMED WORK INJURY
I HEREBY ACKNOWLEDGE THAT I HAVE AGAIN RECEIVED AND RE-READ THE WORKERS' COMPENSATION INFORMATION PROVIDED HEREIN.

_____ _____

Employee Name **Employee Signature** **Date**