MJ Insurance/Sorority Division

First Report of Injury Form for Workers' Compensation Claims

Sorority and House Corporation/Chapter			
Street Address			
City, State ZIP			
Contact Name		Contact Phone	( )

Employee Information:

Injured Employee's Name			
Injured Employee's Street Address			
City, State ZIP			
Male or Female		Marital Status	
Injured Employee's Social Security Number		Employee Phone	( )
Number of Dependents			
Date of Birth		Date of Hire	
Occupation		Average Weekly Wage	
Number of days worked per week		Number of hours worked per week	

Accident Information:

Accident Date		Time of Accident	
Description of Accident			
Any days lost		First day of lost time	
Last day worked		Date of return	
Was employee paid for date of injury?		Time employee begins work	
Eyewitness Name		Eyewitness Phone Number	( )

Doctor/Hospital Information:

Doctor's Name	
Doctor's Street Address	
Doctor's City, State ZIP	
Hospital Name	
Hospital Address	
Hospital City, State ZIP	

First Report of Injury Form Preparer Information:

Name		Title	
Street Address			
City, State ZIP			

Fax or e-mail the completed form to Heather Cox at (317)805-7580 or heather.cox@mjinsurance.com. *Time is of the essence in the reporting of workers' compensation claims. Please submit the above form to Heather Cox within 10 days of the date of the accident. Should you have any questions, please contact Heather Cox at (888)442-7470.*