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| **TO BE COMPLETED BY EMPLOYEE** | | |
| First Name: | Last Name: | |
| Date of Birth: | Phone Number: | |
| Date of Accident: | Time of Accident: | |
| Where did the incident occur? | | |
| Nature of Injury: (e.g., cut, sprain, bruise, etc.) | | |
| Body Part Affected: (e.g., arm, leg, back, etc.) | | |
| Immediate Treatment Provided: (Describe any first aid or treatment administered on-site.) | | |
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| Employee’s Statement (Describe what you were doing and how the accident occurs, what injury resulted?): | | |
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| Employee’s Signature: | | Date: |

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| **TO BE COMPLETED BY SUPERVISOR** | | |
| First Name: | Last Name: | |
| Date/Time Supervisor Notified: | | |
| Where did the incident occur? | | |
| Nature of Injury: (e.g., cut, sprain, bruise, etc.) | | |
| Body Part Affected: (e.g., arm, leg, back, etc.) | | |
| Immediate Treatment Provided: (Describe any first aid or treatment administered on-site.) | | |
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| Has employee returned to work? ☐ Yes ☐ No | | |
| Supervisor’s Statement (Describe what you witnessed and how the accident occurs, what injury resulted?): | | |
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| Supervisor’s Signature: | | Date: |

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| **TO BE COMPLETED BY HUMAN RESOURCES** | |
| Claim Number: | Date Reported Processed: |

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| **BILLING INSTRUCTIONS** |
| Please send all bills to:  Please include claim number, Claimant Name and Date of Loss/Injury in all correspondence.  AmTrust North America Inc.   P.O. Box 5876  Cleveland, OH  44101  AmTrustClaims@AmTrustGroup.com |