FIRST REPORT OF INJURY (FROI)

Suite 100 -- 701 Rodi Road
Pittsburgh, PA 15235
(412) 825-5415
(800) 590-4404
(412) 825-5425 (fax)
www.loml915.com
FEIN: 25-0611340 Bureau Code: 0019

Please complete each section.

Print and fax it to Claims at (412) 825-5425, or print and mail to the above address.
Those areas highlighted in RED are required fields and must be completed in order to submit claim.

ONLY the EMPLOYER is authorized to COMPLETE this form.

A. EMPLOYER INFORMATION

Employer Name | Employer FEIN | Policy Number

Primary/Physical Address | Policy Period From: (mm-dd-yyyy) | Policy Period To: (mm-dd-yyyy)

City | State | Zip Code

Phone Number | Fax Number | County

B. INJURED EMPLOYEE INFORMATION

Employee Social Security Number | Date of Birth (mm-dd-yyyy) | Gender | Phone Number

Employee Birth Name | M.I. | Employee Last Name

Address | County

City | State | Zip Code

Marital Status | Number of Dependents

Occupation/Job Title | Employment Status

◯ Full-Time ◯ Part-Time ◯ Other ◯ Seasonal

Primary Work Location *(This is the location that the employee reports to and work from on a daily basis.)*

Address Line 1

Address Line 2

City | State | Zip Code

C. INJURY INFORMATION

Date of Injury *(mm-dd-yyyy)*

Time Employee Began Work : ○ am ○ pm

Time of Injury : ○ am ○ pm

Full Pay for Day of Injury? ○ Yes ○ No

Date of Hire *(mm-dd-yyyy)* | Date of Disability | Last Date Worked | Date Employer Notified of Injury | Date Returned to Work (If Applicable)

Did disability occur on employer's premises? ○ Yes ○ No

Is employee off of work due to injury? ○ Yes ○ No

Were Safeguards/Safety Equipment Provided? ○ Yes ○ No

Were Safeguards/Safety Equipment Used? ○ Yes ○ No

Accident Location Address *(Complete ONLY if different than the employee's Primary Work Location above.)*

Address Line 1 | If Out of State, Specify State of Injury

Address Line 2

City | State | Zip Code

Type of Injury or Illness | Parts of Body Affected | Date of Death (If Fatal)

Cause of Injury

All equipment, materials, or chemicals employee was using when accident or illness occurred

How injury or illness/abnormal health condition occurred. Describe the sequence of events

Witness to Injury

Name | Position/Title | Phone | Email

D. TREATMENT INFORMATION *(If treatment has occurred)*

Physician/Health Care Provider

First Name | Last Name

Address

City | State | Zip Code

Phone Number | Fax Number | Initial Treatment Date

Initial Treatment

Hospital Information

Hospital Name | Address

City | State | Zip Code

E. CERTIFICATION OF FACT

◯ Certification - to the best of our knowledge the employer certifies that the facts in this application are correct and valid

◯ Rejection - the employer rejects the validity of this claim for the following reasons:

Rejection Reason

Person Completing Form First Name | Person Completing Form Last Name | Phone Number | Email

Signature | Date | Position/Title

Employer Claims

Contact First Name | Contact Last Name | Contact Phone | Contact Email

FRAUD WARNING....
ANY INDIVIDUAL FILING MISLEADING OR INCOMPLETE INFORMATION KNOWINGLY AND WITH THE INTENT TO DEFRAUD, OR HELPS IN ANY MANNER TO COMMIT A FRAUD AGAINST AN INSURER, IS IN VIOLATION OF SECTION 102 OF THE PENNYSLVANIA WORKERS' COMPENSATION ACT AND MAY BE SUBJECT TO CRIMINAL AND CIVIL PENALTIES AND CRIMINAL PROSECUTION FOR INSURANCE FRAUD THROUGH PENNSYLVANIA ACT 165.

Date Prepared