

**For SAIF Customer Use**

Area \_\_\_\_\_  
Dept. \_\_\_\_\_  
Shift \_\_\_\_\_ **CC** \_\_\_\_\_

CLAIM NO. \_\_\_\_\_  
SUBJECT DATE \_\_\_\_\_  
CLASS \_\_\_\_\_  
DEFAULT DATE \_\_\_\_\_  
EMPLOYER'S ACCOUNT NO. \_\_\_\_\_

Toll Free Phone: 1-800-285-8525  
Toll Free FAX: 1-800-475-7785

# Report of Job Injury or Illness

Workers' compensation claim

## Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. **If you do not intend to file a workers' compensation claim with SAIF Corporation, do not sign the signature line.** Your employer will give you a copy.

1. Date of injury or illness:		2. Date you left work:		3. Shift on day of injury: (from) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. (to) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		4. Regularly scheduled days off: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> M T W T F S S	
5. Time of injury or illness: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		6. Time you left work: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		7. Check here if you are employed by more than one employer: <input type="checkbox"/>			
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot)				<input type="checkbox"/> Left <input type="checkbox"/> Right		9. Worker's language preference other than English: <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please specify):	
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carrying a 40-lb. box of roofing materials)							
11. Name of witnesses:				12. Have you previously injured this body part? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Your legal name:				14. Birthdate:		15. Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
16. Mailing address, city, state and zip:						17. Home phone:	
18. SSN (See #25 below):			19. Occupation:			20. Work phone:	
21. Name of physician or health-care professional:				22. If medical treatment was given away from the worksite, print name and address of facility:			
23. Were you hospitalized overnight as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No							
24. Were you treated in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No							
<p><b>25. By my signature, I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.</b></p> <p>I authorize the use of my SSN in the processing of this claim. (Authorizing the use of your SSN will ensure prompt processing of your claim and that your medical records are not released to unauthorized parties. If you do not authorize the use of your SSN, check here <input type="checkbox"/>.)</p>							
26. Worker signature:			27. Completed by (please print):			28. Date:	

## Employer

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

29. Employer legal business name:		30. Phone:		31. FEIN:	
32. If worker leasing company, list client business name:				33. Client FEIN:	
34. Address of principal place of business (not P.O. box):				35. Insurance policy no.:	
36. Street address from which worker is/was supervised: ZIP:				37. Nature of business in which worker is/was supervised:	
38. Street address, city, and state where event occurred:					
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? <input type="checkbox"/> Yes <input type="checkbox"/> No				40. Class code:	
41. Were other workers injured? <input type="checkbox"/> Yes <input type="checkbox"/> No		42. Did injury occur during course and scope of job? <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No		43. OSHA 300 log case #:	
44. Date employer knew of claim:		45. Worker's weekly wage: \$		46. Date worker hired:	
47. If fatal, date of death:					
48. Return-to-work status: <input type="checkbox"/> Not returned <input type="checkbox"/> Regular Date: <input type="checkbox"/> Modified Date:				49. If returned to modified work, is it at regular hours and wages? <input type="checkbox"/> Yes <input type="checkbox"/> No	
50. Employer signature:		51. Name, title, and phone (please print):			52. Date:

**How do I file a claim?**

- Notify your employer about your job-related injury or illness as soon as possible.
- Ask your employer to give you **Form 801, "Report of Job Injury or Illness,"** and complete Form 801.
- Ask your employer the name of its workers' compensation insurer.
- Get medical treatment from a health care provider **of your choice** and tell your provider that you were injured on the job. Your employer cannot choose your health care provider for you.
- Your health care provider should ask you to complete **Form 827, "Worker's and Physician's Report for Workers' Compensation Claims."**

**How do I get medical treatment?**

- You may receive medical treatment from the health care provider **of your choice**, including:
  - Authorized nurse practitioners
  - Chiropractors
  - Medical doctors
  - Naturopaths
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatrists
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

**If I can't work, will I receive payments for lost wages?**

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified or light duty job.

**What if I have questions about my claim?**

- The insurance company or your employer should be able to answer your questions.
- You may also call any of the numbers below:

**Ombudsman for Injured Workers:  
An advocate for injured workers**

Toll-free: 800.927.1271

Email: [oiw.questions@state.or.us](mailto:oiw.questions@state.or.us)

**Workers' Compensation Infoline:  
Benefit Consultants**

Toll-free: 800.452.0288

Email: [workcomp.questions@state.or.us](mailto:workcomp.questions@state.or.us)

- **Health care providers may be *limited* in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**