CopperPoint Insurance Companies

P.O. Box 33069 Phoenix, AZ 85067-3069
602-631-2300
1-800-231-1363

COMPLETE AND MAIL

Claim No.:
CARRIER: CopperPoint Insurance Company

WORKER'S REPORT OF INJURY AND RELEASE OF MEDICAL INFORMATION

CLAIM NUMBER | DATE INJURED

SOCIAL SECURITY NUMBER | TELEPHONE NUMBER

BIRTH DATE | SEX M F | MARITAL STATUS Single Married

IF MARRIED, IS SPOUSE EMPLOYED? YES NO

ARE YOU RIGHT OR LEFT HANDED?

LAST DAY WORKED MO/DAY/YR

IF NO PHONE OR STREET ADDRESS, HOW CAN YOU BE LOCATED?

HAVE YOU RETURNED TO WORK? YES NO | DATE RETURNED TO WORK MO/DAY/YR

TREATMENT RECEIVED

NAME OF DOCTOR WHO EXAMINED YOU | ADDRESS OF DOCTOR WHO EXAMINED YOU | CITY | STATE | ZIP CODE

DATE OF FIRST TREATMENT MO/DAY/YR | DATE OF LAST TREATMENT MO/DAY/YR | STILL UNDER TREATMENT? YES NO

IF TREATED IN EMERGENCY ROOM | NAME OF HOSPITAL | NAME OF PHYSICIAN | DATE TREATED MO/DAY/YR

IF TREATED IN A GOV'T OR V.A. HOSPITAL | NAME OF HOSPITAL | DATE TREATED MO/DAY/YR

INJURY INFORMATION

DESCRIBE FULLY HOW YOUR INJURY HAPPENED

PARTS OF BODY YOU INJURED

HOUR OF INJURY AM PM | ADDRESS OR LOCATION WHERE INJURED

DATE YOU REPORTED INJURY MO/DAY/YR | NAME OF SUPERVISOR INJURY REPORTED TO

IF INJURY REPORTED LATE, GIVE REASON FOR DELAY

WITNESS TO YOUR INJURY: GIVE FULL NAME AND ADDRESS. IF NO WITNESSES, WRITE NONE.

IF INJURY CAUSED BY ANOTHER PERSON GIVE FULL NAME AND ADDRESS

OCCUPATIONAL DATA

EMPLOYER'S NAME AND ADDRESS | CITY | STATE | ZIP CODE

OCCUPATION AT TIME OF INJURY | WERE YOU EMPLOYED ELSEWHERE AT TIME OF INJURY? YES NO

LIST EMPLOYMENT DATA ON PAGE 2

AT TIME OF INJURY WERE YOU A CONTRACTOR, SUBCONTRACTOR, OR WORK FOR OTHER THAN WAGES? YES NO

DATE HIRED | NUMBER OF DAYS WORKED PER WEEK | NUMBER OF HOURS WORKED PER DAY | HOURLY WAGE $ | MONTHLY SALARY $

GENERAL INFORMATION

EDUCATION (ENTER LAST GRADE COMPLETED) | GRADE SCHOOL (1 2 3 4 5 6 7 8) | HIGH SCHOOL (9 10 11 12) | COLLEGE (13 14 15 16)

YEAR YOU BECAME ARIZONA RESIDENT | STATE YOU MOVED FROM | VALID DRIVER'S LICENSE? YES NO

LIST FULL NAMES AND ADDRESSES OF PERSONS DEPENDENT ON YOU FOR SUPPORT

SPOUSE'S NAME | SPOUSE'S SOCIAL SECURITY NUMBER

MPORTANT ALL THREE PAGES OF THIS FORM MUST BE COMPLETED AND SIGNED PREVENTING DELAY OF ANY BENEFITS TO WHICH YOU MAY BE ENTITLED.

CLAIM NO.:
DOC TYPE: IR407

LIST MAJOR INJURIES, MEDICAL CONDITIONS, OR ILLNESSES BELOW

DATE OF INJURY OR DIAGNOSIS MO/DAY/YR	DESCRIBE INJURY, CONDITION, OR ILLNESS (BROKEN LEG, HERNIATED DISC, DIABETES, HEART DISEASE, ETC.)	TYPE OF INJURY/CONDITION	CLAIM DISPOSITION	IF CLAIM ACCEPTED GIVE TYPE & DATE OF FINAL SETTLEMENT. IF CONDITION RATED, GIVE PERCENTAGE OF PERMANENT DISABILITY
		☐ INDUSTRIAL ☐ NON INDUSTRIAL	☐ NO CLAIM ☐ CLAIM DENIED ☐ CLAIM ACCEPTED	NAME OF INSURANCE COMPANY
DATE OF INJURY OR DIAGNOSIS MO/DAY/YR	DESCRIBE INJURY, CONDITION, OR ILLNESS (BROKEN LEG, HERNIATED DISC, DIABETES, HEART DISEASE, ETC.)	TYPE OF INJURY/CONDITION	CLAIM DISPOSITION	IF CLAIM ACCEPTED GIVE TYPE & DATE OF FINAL SETTLEMENT. IF CONDITION RATED, GIVE PERCENTAGE OF PERMANENT DISABILITY
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		☐ INDUSTRIAL ☐ NON INDUSTRIAL	☐ NO CLAIM ☐ CLAIM DENIED ☐ CLAIM ACCEPTED	NAME OF INSURANCE COMPANY

MILITARY SERVICE (BRANCH, DATES SERVED AND DUTIES)

ARE YOU NOW RECEIVING DISABILITY COMPENSATION OR PENSION FROM ANY SOURCE (INCL. SOC. SEC.)? YES NO IF "YES" AMOUNT RECEIVED $ PER WK MO YR

DATE OF INJURY TYPE OF INJURY/CONDITION CLAIM NUMBER

NAME AND ADDRESS OF INSURANCE COMPANY

EMPLOYMENT INFORMATION FOR TWELVE (12) MONTHS BEFORE INJURY (LIST CURRENT EMPLOYER FIRST, THEN THE EMPLOYER BEFORE THAT, ETC., AND PERIODS OF UNEMPLOYMENT)

EMPLOYER NAME AND ADDRESS (SHOW UNEMPLOYMENT COMPENSATION PERIODS AND GROSS AMOUNT RECEIVED)	TYPE OF WORK & EMPLOYMENT DATES	GROSS EARNINGS BEFORE DEDUCTIONS
1 CURRENT EMPLOYER	TYPE OF WORK	
ADDRESS	FROM TO	$
2	TYPE OF WORK	
	FROM TO	$
3	TYPE OF WORK	
	FROM TO	$
4	TYPE OF WORK	
	FROM TO	$
IMPORTANT - FILL IN TOTAL INCOME FOR TWELVE (12) MONTHS BEFORE INJURY		$

REMARKS

BY THIS INSTRUMENT I MAKE APPLICATION FOR ALL BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE LAW AND I DO HEREBY CERTIFY, WITH FULL KNOWLEDGE THAT IT IS A CRIME TO MAKE WILLFUL, FALSE STATEMENTS TO OBTAIN COMPENSATION, THAT ALL OF MY STATEMENTS ON THIS FORM ARE TRUE, ACCURATE AND COMPLETE.

DATE AND SIGNATURE MUST BE FILLED IN BEFORE MAILING DATE SIGNED SIGNATURE

CLAIM NO.:
DOC TYPE: Initiating Docs
CARRIER: CopperPoint

P.O. Box 33069 Phoenix, AZ 85067-3069
602-631-2300
1-800-231-1363

Claimant: _____ Claim No.: _____

Social Security No.: _____ Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION

By this authorization or reproduction thereof, I hereby authorize and request any person or organization to allow the above referenced carrier or its authorized representative to examine, discuss and copy any information, records, reports and x-rays regarding my medical condition, treatment and employment history.

Disclosure of medical records for the purpose of administration of workers' compensation claims is authorized by the Health Insurance Portability and Accountability Act (HIPAA), § 45 C.F.R. § § 164.512.

Date: _____Claimant's Signature:_____

Address:_____
Street City State Zip

_____

Witness: _____