MeM Report of Injury Form

Injury Reporting and Claims Inquiry Hotline 1.800.442.0593
Fax 1.800.442.0597 **Website:** www.mem-ins.com

General

Employer (Name & Address Incl Zip)	Carrier/Administrator Claim Number	Report Purpose Code
	Jurisdiction / Jurisdiction Claim Number	
	Insured Report Number	
	Employer's Location Address (If Different)	Location
SIC Code / Employer FEIN		Phone

Carrier Claims Admin

Carrier (Name, Address & Phone No)	Policy Period To / Check if Appropriate ☐ Self Insurance	Claims Administrator (Name, Address, & Phone No)
Missouri Employers Mutual **101 N. Keene Street** **Columbia, MO 65201** **1.800.442.0593**		
Carrier FEIN	Policy/Self-Insured Number	Administrator FEIN
Agent Name and Code Number		

Employee

Name (Last, First, Middle)	Date of Birth	Social Security Number	Date Hired	State of Hire
Address (Incl Zip)	Sex [M] Male [F] Female [U] Unknown	Marital Status [U] Unmarried/Single/Divorced [M] Married [S] Separated [K] Unknown	Occupation/Job Title	
			Employment Status (i.e. Full time, Part-Time, etc)	
Phone	No of Dependents		NCCI Class Code	

Wage

Rate Per ☐ Day ☐ Week ☐ Month ☐ Other	No. of Days Worked/Week	Full Pay for Day of Injury? ☐ Yes ☐ No Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM	Date of Injury/Illness	Time of Occurrence ☐ AM ☐ PM	Last Work Date	Date Employer Notified	Date Disability
Contact Name/Phone Number		Type of Injury/Illness		Part of Body Affected	
Did Injury/Illness Exposure Occur On Employer's Premises? ☐ Yes ☐ No		Type Of Injury/Illness Code		Part of Body Affected Code	

Department or Location Where Accident or Illness Exposure Occurred	All Equipment, Materials, or Chemicals Employee was Using when Accident or Illness Exposure Occurred
Specific Activity the Employee was Engaged in when the Accident or Illness Exposure Occurred	Work Process the Employee was Engaged in when Accident or Illness Exposure Occurred

How Injury or Illness/Abnormal Health Condition Occurred. Describe the Sequence of Events and Include any objects or Substances that Directly Injured the Employee or Made the Employee Ill.

Cause of Injury

Date Return(ed) to Work	If Fatal, Give Date Of Death	Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No Were They Used? ☐ Yes ☐ No

Treatment

Physician/Health Care Provider (Name & Address)	Hospital (Name & Address)	Initial Treatment [0] No Medical Treatment [1] Minor: By Employee [2] Minor: Clinic/Hospital [3] Emergency Care [4] Hospitalized Greater Than 24 Hrs [5] Future Major Medical/ Lost Time Anticipated

Others

Witness (Name & Phone #)			
Date Administrator Notified	Date Prepared	Preparer's Name & Title	Phone Number

The shaded portions will be completed by Missouri Employers Mutual. White areas to be completed by policyholder.