First Report

Voice: 800-332-6102 • Email: stfclaim@mt.gov • Fax: 406-495-5020
PO Box 4759 Helena, MT 59604-4759

You can also file your claim online by visiting montanastatefund.com

Injured Employee

Last Name*	First Name*	M.I.	Gender*	Date of Birth*	Social Security Number*
			○ Male ○ Female ○ Unknown		

Mailing Address (including Apt/Ste/Trlr #)*				Injured Employee's Email Address	Phone Number*
Address	City	State	Postal Code		

Physical Address (including Apt/Ste/Trlr #)				Education Level
Address	City	State	Postal Code	○ Less Than High School ○ GED or High School Diploma ○ Beyond High School

Wages

Date Hired*	Date Last Worked*	Employment Status*	Worked Next Scheduled Shift	Off Work More Than 4 Work Days	Full Wages Paid for Date of Injury	Salary Continued
		○ Full Time ○ Part Time ○ Seasonal ○ Volunteer ○ Other ○ Piece Worker	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Pay Frequency	Wage Rate	Is Sick Leave Available	Was Sick Leave Used	Returned to Work Date
○ Hour ○ Day ○ Week ○ Month ○ Bi-Weekly		○ Yes ○ No	○ Yes ○ No	

Accident Description

Date of Injury*	Time of Injury	Description of Accident*

Cause of Injury	Part of Body*	Job Title*	Date Disability Began*	Date of Death

Name of Witnesses	Accident Reported To*	Accident on Employer's Premises
1. 2.		○ Yes ○ No

Loss Location*				Date Employer Notified*	Safety Equipment Provided	Safety Equipment Used
Address	City	State	Postal Code		○ Yes ○ No	○ Yes ○ No

Injured Employee Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease, or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer (and its agents) and to the Montana Uninsured Employers' Fund of: Social Security records; rehabilitation records; and all health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA), that are directly relevant to the claimed injury, disease, or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signature of injured Employee, Beneficiary or Guardian _____ **Date** _____

Medical

Attending Physician and/or Hospital		Medical Provider Address			
Physician:	Hospital:	Address	City	State	Postal Code

Medical Provider Phone Number	Type of Medical Treatment Received*				
	○ No Treatment	○ Treatment Will Be Sought	○ Emergency Room/Hospital	○ Treatment On-Site by Employer or Medical Staff	○ Clinic/Urgent Care

Employer

Employer Name*	Doing Business As*	Federal Employer Identification Number (Tax ID)

Mailing Address*				Phone Number*	Location of Operation, If Different From Mailing Address
Address	City	State	Postal Code		

Do you have any reason to question this accident?* If yes, we will contact you for more information. ○ Yes ○ No	Prepared By*	Official Title*	Phone Number*	Date

Policy Number*	Contact Person*	Contact Person's Phone Number*	Contact Person's Email

Payroll classification code under which you report employee's wages	**Authorized Employer's Signature**	**Date**

* Indicates required field

Montana State Fund