Sedgwick Workers' Compensation Standard Intake Form Email: 1578RetailersInsuranceCompany@SedgwickCMS.com Fax: 1-866-261-5795



Retailers Insurance Company	Client Name:	Con	tract N	lumber:					
Reporter Information	Retailers Insurance Company	1578							
First Name:									
Description				Last Name:					
Unit Name:		Phone:		East Hamo.	Fxt	•			
Unit Number:		110110.				•			
Street Address:			T i	Init Number:					
State				illi Nullibel.					
Phone Number		State:			7ii	v Code.			
Is this the Loss Location? Yes						o Code.			
Unit Name:		1	Locati	on Code.					
Unit Number:									
Street Address:			hor:						
State Stat		Offic Nuff	ibei.						
Phone Number:		State			7:	n Codo:			
Claimant Information		State.			ZI	p Code.			
Employee ID #:									
Home Phone:						. .			
Home Address: City:						Name:			
State:			vvork Pn	one:	EXT:				
Email Address:		21.1			T =:	0 1			
Date of Birth:					∠ıp	Code:			
Department Sate Select One					0 1 10				
Employee Title:		status: Sele	ct One	Gender:	Select O	ne			
Status Select One									
Full/Part Time: Full Time		artment:							
Wage Amount:						1			
Hours Per Day: Mon			Date	of Hire:		Date of Termin	nation:		
Claimant Supervisor Information						ı			
MI:		Wed	Th	ur	Fri	Sat	Sun		
Title:	Claimant Supervisor Information								
Phone:	First Name:	MI:	Las	st Name:					
Do you question the validity of this claim? Yes No	Title:		Email	Address:					
Incident Information Date of Incident:									
Date of Incident:	Do you question the validity of this claim? Yes No								
Department Where Injury Occurred: Incident Description: Safeguards/Safety Equipment Provided? Yes No Safeguards/Safety Equipment Used? Yes No Cause: Body Part: Nature: Incident Description: Medical Information Facility Name: Street Address: City: State: Ext: Initial Treatment: Select One Physician Name: Street Address: City: State: Zip Code: State: Jip Code: Facility Name: Street Address: City: Jip Code: Street Address: City: State: Zip Code: City: State: Zip Code:									
Department Where Injury Occurred: Incident Description: Safeguards/Safety Equipment Provided? Yes No Safeguards/Safety Equipment Used? Yes No Safeguards/Safety Equipment Used? Yes	Date of Incident: Time of Incide	ent:	AM \square	PM	Date Empl	oyer Notified:			
Incident Description: Safeguards/Safety Equipment Provided? Yes No Safeguards/Safety Equipment Used? Yes No Safeguards									
Safeguards/Safety Equipment Provided? Yes No Safeguards/Safety Equipment Used? Yes No Cause: Body Part: Nature: Incident Description: Medical Information Facility Name: Street Address: City: State: Ext: Initial Treatment: Select One Physician Name: Street Address: City: State: Ext: Initial Treatment: Select One Physician Name: Street Address: City: State: Ext: Initial Treatment: Select One Physician Name: Street Address: City: State: Zip Code: City: State: Ext: City: State: Ext: City: Select One City: State: Zip Code: City: State: Zip Code:									
Cause: Body Part: Nature: Incident Description: Medical Information Facility Name: Street Address: City: State: Zip Code: Phone: Ext: Initial Treatment: Select One Transportation Type: Select One Physician Name: Street Address: City: State: Zip Code:									
Body Part: Nature: Incident Description: Medical Information Facility Name: Street Address: City: State: Zip Code: Phone: Ext: Initial Treatment: Select One Transportation Type: Select One Physician Name: Street Address: City: State: Zip Code:									
Nature: Incident Description: Medical Information Facility Name: Street Address: City: State: Zip Code: Phone: Ext: Initial Treatment: Select One Transportation Type: Select One Physician Name: Street Address: City: State: Zip Code:									
Incident Description: Medical Information Facility Name: Street Address: City: State: Zip Code: Phone: Ext: Initial Treatment: Select One Physician Name: Street Address: City: State: Zip Code: City: Transportation Type: Select One Physician Name: Street Address: City: State: Zip Code:									
Medical Information Facility Name: Street Address: City: State: Zip Code: Phone: Ext: Initial Treatment: Select One Physician Name: Street Address: City: State: Zip Code:									
Street Address:									
Street Address: City: State: Zip Code: Phone: Ext: Initial Treatment: Select One Physician Name: Transportation Type: Street Address: State: Zip Code:									
City: State: Zip Code: Phone: Ext: Initial Treatment: Select One Physician Name: Transportation Type: Street Address: Zip Code:									
Phone: Ext: Initial Treatment: Select One Transportation Type: Select One Physician Name: Street Address: City: State: Zip Code:		State:			Zin	Code:			
Initial Treatment: Select One Transportation Type: Select One Physician Name: Street Address: City: State: Zip Code:		otato.		Fxt·	<u>~</u> ip				
Physician Name: Street Address: City: State: Zip Code:			Transi		Select O	ne			
Street Address: City: State: Zip Code:									
City: State: Zip Code:	•								
		State:			7in	Code:			
	Phone:	2.3.0.		Ext:	1 <u>~</u> ip	- 540.			

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Witness Information								
Name:								
Street Address:								
City:	State:			Zip Code:				
Phone:	Ext:							
Lost Time Information								
Will Claimant Miss Work Beyond Date of Injury? Select One								
Last Date Worked:			Returned to Work Date:					
Salary Continued: Select One								
Contact Information								
First Name:	MI:			Last Name:				
Phone: Ex	xt:	Email Address:						
Comments/Remarks:								