

First Report of Injury or Occupational Disease Montana Department of Labor and Industry PO Box 8011 Helena, MT 59604-8011

BUSINESS & LABOR Adjuster Date Stamp

EXHIBIT NO. 2-17-15 BILL NO. HB299

Worker

Form with fields: LAST NAME, FIRST NAME, M.I., DATE OF BIRTH, SOCIAL SECURITY NUMBER, MAILING ADDRESS, CITY, STATE, POSTAL CODE, PHONE NUMBER, EDUCATION, GENDER, MARITAL STATUS, NUMBER OF DEPENDANTS

Wages

Form with fields: DATE HIRED, GROSS EARNINGS FOR FOUR PAY PERIODS PRECEDING THE INJURY, EMPLOYMENT STATUS, IN ADDITION TO GROSS EARNINGS CITED ABOVE WORKER RECEIVED, WORKED NEXT SCHEDULED SHIFT, OFF WORK MORE THAN 4 WORK DAYS, DATE LAST WORKED, DATE OF RETURN TO WORK, FULL WAGES PAID FOR DATE OF INJURY, SALARY CONTINUED

Accident Description

Form with fields: JOB TITLE, DESCRIPTION OF ACCIDENT, CAUSE OF INJURY, CAUSE CODE, PART OF BODY, PART CODE, NATURE OF INJURY, NATURE CODE, DATE OF INJURY, TIME OF INJURY, DATE DISABILITY BEGAN, DATE OF DEATH, NAMES OF WITNESSES, ACCIDENT ON EMPLOYER'S PREMISES, ACCIDENT ADDRESS OR LOCATION, DATE EMPLOYER NOTIFIED, ACCIDENT REPORTED TO, SAFETY EQUIPMENT PROVIDED, SAFETY EQUIPMENT USED

Medical

Form with fields: ATTENDING PHYSICIAN'S NAME, ADDRESS, STATE, POSTAL CODE, PHONE NUMBER, HOSPITAL NAME, ADDRESS, STATE, POSTAL CODE, PHONE NUMBER, TYPE OF INITIAL MEDICAL TREATMENT RECEIVED

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 Worker or Beneficiary Date

Employer

Form with fields: EMPLOYER NAME, DOING BUSINESS AS, FEDERAL EMPLOYER IDENTIFICATION NUMBER (TAX ID), MAILING ADDRESS, CITY, STATE, POSTAL CODE, PHONE NUMBER, LOCATION OF OPERATION, IF DIFFERENT FROM MAILING ADDRESS, NATURE OF BUSINESS NAICS CODE, SELF-INSURED?, EMPLOYER IS A, INJURED WORKER IS A, DO YOU HAVE ANY REASON TO QUESTION THIS ACCIDENT?, WAS WORKER INJURED WHILE IN YOUR EMPLOY?, Prepared By, Official Title, Phone Number, Date, PAYROLL CLASSIFICATION CODE UNDER WHICH YOU REPORT EMPLOYEE'S WAGES, AUTHORIZED EMPLOYER'S SIGNATURE, DATE

Insurer

Form with fields: CLAIM ADMINISTRATOR CLAIM NUMBER, DATE REPORTED TO CLAIM ADMINISTRATOR, THE ABOVE INFORMATION IS CORRECT WITH THE FOLLOWING EXCEPTIONS, CLAIM ADMINISTRATOR'S NAME, CLAIM ADMINISTRATOR ADDRESS, CLAIM ADMINISTRATOR FEIN, INSURER NAME, INSURER FEIN, POLICY NUMBER, POLICY EFFECTIVE DATE, POLICY EXPIRATION DATE