

MACo JPA

MACO CLAIMS DEPARTMENT
P. O. Box 7059
Helena, MT 59604

Worker

LAST NAME		FIRST NAME		MI.	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
HOME ADDRESS			CITY	STATE	POSTAL CODE		
PHONE NUMBER	EDUCATION	<input type="checkbox"/> LESS THAN HIGH SCHOOL <input type="checkbox"/> GED OR HIGH SCHOOL DIPLOMA <input type="checkbox"/> BEYOND HIGH SCHOOL	GENDER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS	<input type="checkbox"/> MARRIED <input type="checkbox"/> NOT MARRIED	NUMBER OF DEPENDANTS

Wages

DATE HIRED	GROSS EARNINGS FOR HOUR PAY PERIODS PRECEDING THE INJURY	DATE/AMOUNT	DATE/AMOUNT	DATE/AMOUNT	DATE/AMOUNT	DATE/AMOUNT
EMPLOYMENT STATUS	PERIODS PRECEDING THE INJURY	DATE/AMOUNT	NUMBER OF DAYS WORKED PER WEEK	WAGE	ESTIMATED VALUE IF ANY	DATE/AMOUNT
<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER						
IN ADDITION TO GROSS EARNINGS LISTED ABOVE WORKER RECEIVED:						
<input type="checkbox"/> BOARD & ROOM	<input type="checkbox"/> OVERTIME	<input type="checkbox"/> BONUS	<input type="checkbox"/> COMMISSIONS	<input type="checkbox"/> OTHER		
WORKED NEXT SCHEDULED SHIFT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	OFF WORK MORE THAN 5 WORK DAYS	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	DATE LAST WORKED	DATE OF RETURN TO WORK	FULL WAGES PAID FOR DATE OF INJURY?
						<input type="checkbox"/> YES <input type="checkbox"/> NO
						SALARY CONTINUED?
						<input type="checkbox"/> YES <input type="checkbox"/> NO

Accident Description

JOB TITLE	DESCRIPTION OF ACCIDENT					
Dept.						
CAUSE OF INJURY	CAUSE CODE	PART OF BODY	PART CODE	NATURE OF INJURY	NATURE CODE	DATE AND TIME OF INJURY
DATE DISABILITY BEGAN	DATE OF DEATH	NAMES OF WITNESSES		1) _____	2) _____	3) _____
ACCIDENT ON EMPLOYER'S PREMISES?	ACCIDENT ADDRESS OR LOCATION		POSTAL CODE			
<input type="checkbox"/> YES <input type="checkbox"/> NO	CITY	STATE				
DATE EMPLOYER NOTIFIED	ACCIDENT REPORTED TO					

Medical

ATTENDING PHYSICIAN'S NAME	ADDRESS	STATE	POSTAL CODE	PHONE NUMBER
HOSPITAL NAME	ADDRESS	STATE	POSTAL CODE	PHONE NUMBER
TYPE OF INITIAL MEDICAL TREATMENT RECEIVED				
<input type="checkbox"/> NO TREATMENT		<input type="checkbox"/> EMERGENCY ROOM	<input type="checkbox"/> TREATMENT ON-SITE BY EMPLOYER OR MEDICAL STAFF	
		<input type="checkbox"/> CLINIC/DR. OFFICE		<input type="checkbox"/> HOSPITAL

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 of rehabilitation records, Social Security records and health care information relevant to this claim to the workers' compensation insurer and the insurer's agents (medical records pursuant to HIPAA, Public Law 104-191, 42 U.S.C. 1301 et seq. and Section 50-16-527(4)&(5)). I also understand that if I obtain or exert unauthorized control over workers' compensation benefits, I may be fined and/or imprisoned."

Signature of Injured Worker or Beneficiary:

Date

Employer

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						
EMPLOYER IS A		<input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> CORPORATION	<input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> LIMITED LIABILITY COMPANY	<input type="checkbox"/> INJURED WORKER IS A	<input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> CORPORATION	<input type="checkbox"/> A MEMBER OF THE EMPLOYER'S (SOLE PROPRIETOR OR PARTNER) FAMILY LIVING IN THE EMPLOYER'S HOUSEHOLD.
DO YOU HAVE ANY REASON TO QUESTION THIS ACCIDENT?				<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE EXPLAIN FULLY. USE SEPARATE SHEET IF YOU NEED ADDITIONAL SPACE.	
PREPARED BY	OFFICIAL TITLE			DATE		
PAYROLL CLASSIFICATION CODE	AUTHORIZED EMPLOYER'S SIGNATURE			DATE		
UNDER WHICH YOU REPORT EMPLOYEE'S WAGES						

Insurer

CLAIM ADMINISTRATOR'S CLAIM NUMBER	DATE REPORTED TO CLAIM ADMINISTRATOR	CLAIM ADMINISTRATOR'S ADDRESS	INSURER FEIN
THIRD PARTY CLAIM ADMINISTRATOR'S NAME		CLAIM ADMINISTRATOR'S ADDRESS	
MACO CLAIMS DEPARTMENT		PO BOX 7059	HELENA, MT 59604
INSURER NAME	THIRD PARTY ADMINISTRATOR FEIN		INSURER FEIN
POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	

THE ABOVE INFORMATION IS CORRECT WITH THE FOLLOWING EXCEPTIONS
(ATTACH EXTRA SHEETS IF BOX AT RIGHT IS CHECKED)