



**REPORT ALL WORKER'S COMPENSATION INJURIES TO LIBERTY MUTUAL**

The 1-800 CLAIMS SERVICE CENTER is open 24 hours a day including weekends and holidays. For efficient service, have the following information available for the Customer Service Representative.



Call: 1-800-362-0000

**ExPRSCall W C Report Form/National Mkt**

**CLAIM INFORMATION**

Date/Time of Injury:    /    /    :    am pm	<small>After the call write claim number here:</small>	<b>WC</b>
Is this claim work related? Yes <input type="checkbox"/> No <input type="checkbox"/>	Will the employee miss time from work? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Employer Name:		

**EMPLOYEE INFORMATION**

Employee's Social Security Number:    -    -    -		Employee's Name:	
Home Address: (Street)    (City)    (State)    (Zip)			
Home Phone Number: (    )    -    (    )		Male <input type="checkbox"/> Female <input type="checkbox"/>	
Date of Birth:    /    /	Marital Status <small>(circle one)</small> Single    Married    Widowed    Divorced		
Hire Date:    /    /	Number of Dependents:    Dependents Under 18:		
Occupation:		Department Name:	
State Hired:	Supervisor Name & Phone:		
Current Weekly Wage:	Hourly Wage:	Hours Worked Per Week:	
Days Worked Per Week:	Hours Worked Per Day:	Employment Status:	
Employer Report No:	Employee ID No:	Was Salary Continued:	
Was Employee Paid in Full for Date of Injury:		How often is employee paid:	
Education Level:	Any Prior WC Injuries:	OSHA Reference No.:	

**EMPLOYER INFORMATION**

Contact Name, Telephone Number, and Title: <b>Dayna Fico, Benefits Administrator</b>			
Work Location:	<b>1501 W. Bradley Ave</b>	(City) <b>Peoria</b>	(State) <b>IL</b> (Zip) <b>61625</b>
Mailing Addr:	<b>1501 W. Bradley Ave</b>	(City) <b>Peoria</b>	(State) <b>IL</b> (Zip) <b>61625</b>
Employer Location Code:	Employer SIC.:		
Employer FED ID.:	Employer Code:		
Nature of Business: <b>Higher Education</b>			
Policy Number: <b>WC 21414357091</b>			

**ACCIDENT INFORMATION**

Did the Accident Occur at the Work Location? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, where did the accident occur?			
Accident Address:    (Street)    (City)    (State)    (Zip)			
Nature of Accident:			
Give a Full Description of the Accident: <small>(Be As Complete As Possible)</small>			
Are Other WC Claims Involved? Yes <input type="checkbox"/> No <input type="checkbox"/>		Date and Time Reported to Employer:    /    /    :    AM/PM	
Person Reported To:			