method

EMPLOYEE REPORT OF INJURY

Phone (888) 981-1702 FAX to (972) 934-3091 Email: nsclaims@methodinsurance.com

*A complete First Notice of Loss must be submitted immediately

We also need a copy of your signature page from the Summary Plan Description and Arbitration Agreement

Please Print

EMPLOYER INFORMATION

Group Name _____ Group Policy Number _____

Supervisor/Manager Name _____ Supervisor/Manager Number _____

EMPLOYEE INFORMATION

Injured Employee Name _____ Soc. Sec. Num. _____ Date of Birth _____

Home Address (incl. city, state, zip) _____

Home Phone Number _____ E-mail Address _____

Employment Status

☐ Active ☐ Disabled ☐ Terminated Job Title/Description _____

Date Hired _____ Date Last Worked _____ Date Disibility Began _____

EMPLOYEE'S STATEMENT OF INJURY

Date of Accident _____ What time did the accident happen? (Specify am or pm) _____ Date of Report _____

When was the accident reported to Supervisor? _____ Name of Supervisor in charge at the time _____

Name of person filing report _____ WHERE did the accident occur (PHYSICAL ADDRESS) _____

What was the CAUSE of the accident? _____

What BODY PART(s) were injured? _____ What Type of Injury (ex.: Cut, Sprain, Fracture...) _____

Describe the DETAILS of the accident and how it happened. *Attach additional paper if necessary.*

_____

_____

_____

Did the injury require immediate emergency treatment? ☐ Yes ☐ No

Was offered medical attention but employee refused. ☐ Yes ☐ No

EMPLOYEE SIGNATURE _____

Date of 1st Medical Treatment _____

Treating physician and treating facility (name, address and phone number) _____

Have you ever been treated for this before? If yes, please explain. _____

Give full name, address and phone number of ALL other physicians consulted in the past three years.

_____

EMPLOYEE NAME (PRINT) _____ **DATE OF INJURY** _____

ACKNOWLEDGMENT

I ACKNOWLEDGE THAT MY EMPLOYER HAS A MANDATORY ARBITRATION AGREEMENT OR POLICY IN PLACE AT THIS TIME THAT COVERS MY INJURY CLAIM THAT I HAVE REPORTED AS OF THE DATE SHOWN BELOW. THAT AGREEMENT OR POLICY COVERS ANY CLAIMS I HAVE AGAINST MY EMPLOYER, ITS EMPLOYEES, AGENTS, OWNERS, PARENT ENTITIES, SUBSIDIARIES, DIVISIONS OR OTHER AFFILIATED OR RELATED INDIVIDUALS OR ENTITIES ARISING FROM ANY INJURY I INCUR IN THE COURSE AND SCOPE OF MY EMPLOYMENT (EXCEPT BENEFIT CLAIMS UNDER THE EMPLOYER'S BENEFIT PLAN AND CERTAIN CLAIMS THAT ARE NOT ARBITRABLE) AND PROVIDES THAT THOSE CLAIMS SHALL BE EXCLUSIVELY RESOLVED IN A BINDING ARBITRATION ADMINISTERED BY JUDICIAL WORKPLACE ARBITRATIONS. TO THE EXTENT I HAVE NOT BEEN PREVIOUSLY NOTIFIED OF THIS AGREEMENT OF POLICY, I UNDERSTAND AND AGREE THAT CONTINUING TO WORK FOR EMPLOYER AFTER RECEIVING THIS NOTICE OR ACCEPTING ANY BENEFITS UNDER MY EMPLOYER'S BENEFIT PLAN FOR INJURIES IN THE COURSE AND SCOPE OF MY EMPLOYMENT CONSTITUTES IRREVOCABLE ACCEPTANCE OF MY EMPLOYER'S ARBITRATION AGREEMENT OR POLICY.

EMPLOYEE SIGNATURE _____ **DATE** _____

RIGHT OF SUBROGATION AND REFUND

The injured employee may incur expenses due to injuries for which benefits are paid by the Injury Benefit Plan. If the injuries are caused by the wrongful act, omission or negligence of another person, the employee may have a claim against that other person for payment of the expenses. The Plan will be subrogated to all rights the employee may have against that other person and the employee must repay us out of the recovery made from: (a) the other person; or (b) the other person's insurer; or (c) any carrier providing uninsured or underinsured motorist coverage. The employee agrees to assist us in any recoveries and to not take any action that would prejudice our subrogation rights. The subrogation rights only apply to the amount of the Injury Benefit Plan paid because of that injury or death. Name and address of third party or other party involved: _____

EMPLOYEE SIGNATURE _____ **DATE** _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I certify that the information is true and correct to the best of my knowledge. I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, or other organization, institution or person that has any records or knowledge of me or my health to give to my Occupational Injury Benefit Plan Administrator, Method Claims Management, their legal representative, or designees any such information. Such release may include information that may be considered a communicable and/or venereal disease, hepatitis, HIV related, AIDS, AIDS related disorders, mental/nervous disorders, drug abuse and/or alcoholism. I understand the information obtained using this Authorization will be used by my Occupational Injury Benefit Plan Administrator or Method Claims Management to determine eligibility for benefits under the Group Policy. Any Information will not be released to any person or organization except insurance companies, or any other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

A photocopy of this Authorization shall be as valid as the original.

I understand that I am entitled to a copy of this Authorization.

EMPLOYEE SIGNATURE _____ **DATE** _____

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.