EMPLOYER'S BASIC REPORT OF INJURY

An employer shall report immediately to the agency on Form WC-100 all injuries, including diseases, which arise out of and in the course of the employment, or on which a claim is made and result in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific losses. In case of death, an employer shall also immediately file an additional report on WC-106. Contact CompOne if you have any questions or if we can be of any assistance.

I. EMPLOYEE DATA

1. Social Security Number	2. Date of injury	3. Employee name (Last, First, MI)		
4. Address (Number & Street)		5. City	6. State	7. ZIP Code
8. Date of birth (MM/DD/YYYY)	9. Sex ☐ Male ☐ Female	10. Number of dependents	11. Telephone number	
12. Tax filing status: ☐ A. Single ☐ B. Single, Head of Household ☐ C. Married, Filing Joint ☐ D. Married, Filing Separate				

II. EMPLOYER/CARRIER DATA

13. Employer name			14. Federal ID Number	
15. Injury location code	16. Mailing location code	17. UI number	18. Type of business (SIC/NAICS)	
19. Employer street address		20. City	21. State	22. ZIP code
23. Account #			24. Policy Number	

III. INJURY/MEDICAL DATA

25. Last day worked	26. Date employee returned to work (if applicable)		27. Did employee die? ☐ Yes ☐ No	28. If yes, date of death
29. Injury city	30. Injury county	31. Scheduled Work Shift	32. Did injury occur on employer's premises? ☐ Yes ☐ No (If no, see item 53)	
33. What were environmental conditions? (Rain, Snow, etc.)		34. Time employee began work ☐ a.m. ☐ p.m.	35. Time of event ☐ a.m. ☐ p.m.	If time cannot be determined, check here ☐
36. Where did the Injury occur? (Examples include Roadside, Hospital, House, Apartment, Mobile Home, Business, Factory, Inside Vehicle, M.V.A.) Be specific.				
37. What type of transport was being conducted? (examples include Patient Transfer, Emergency Call 911 or Other)				
38. Describe the nature of injury / illness (and) if proper PPE was worn at time of incident			39. Part of body directly affected by the injury or illness	
40. What equipment was being used (Examples include Stretcher, Powered Stretcher, Stair Chair, Transfer Sheet, Bariatric Cot, Backboard)? List all that apply.				
41. If lifting Injury, what was weight of patient?		42. Was employee treated in an emergency room? ☐ Yes ☐ No	43. Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No	
44. If treatment was given away from the worksite, where was it given? (Include name, address, city, state and ZIP code of facility)				

IV. ADDITIONAL INFORMATION

45. Employee Occupation	46. Occupation Code	47. Length in position (Yr's / Mo's)	48. Name of witness (if applicable)
49. Supervisor Name	50. Was Supervisor on Scene? ☐ Yes ☐ No	51. Was Supervisor immediately notified on the injury / illness? ☐ Yes ☐ No	
52. Date employer notified by employee	53. Supervisor comments based on post investigation findings he/she conducted.		

V. PREPARER DATA

I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

54. Preparer's name (Please print or type)	55. Preparer's signature	56. Telephone number	57. Date prepared

Notice to employee: Questions or errors should be reported immediately to the individual listed above in space 54

EMAIL THIS CLAIM FORM TO: expressclaims@compone.net

The MAAS Fund works with CompOne Administrators, a Third Party Administrator, to handle the processing and adjusting of claims. MAAS Fund members should make every effort to report claims within 24 hours of the injury.

When filing a claim, complete a Report of Injury form and forward to the following contact. This form may be sent by email, fax or mail to:

CompOne Administrators, Inc.

PO Box 2530

Okemos, MI 48805

Email: expressclaims@compone.net

Fax: 248-675-4627

If you have any questions, or require additional assistance, please contact (888) 298-9043

MIOSHA Reporting Requirements:

Employers in the state of Michigan are required to report any work-related amputation, loss of an eye, or in-patient hospitalization of any employee, within 24 hours of the incident.

Employers can go to the MIOSHA Recordkeeping website to report an in-patient hospitalization, amputation, or loss of an eye incident or call the new injury report line: 844-464-6742.

This system should NOT be used for reporting work related fatalities. All work-related fatalities must still be reported within eight hours to the current fatality line: 800-858-0397.

If you have any questions, please contact MIOSHA Information Services Section staff at 517-284-7788.