MOHAWK SELF INSURANCE

MSI-2 EMPLOYERS FORM

1) WORKER INFORMATION

Employee Name	John Smith
Address:	P.O. Box 123
Postal Code: JOL 1BO	Telephone #: 450 (635-0000)
Date of Birth:	January 1, 1963

2) Employer Information

Employer Name:	ABC Lumber Yard
Employer Contact Person:	John Doe
Address:	123 maple street P.O. Box ...
Postal Code: JOL 1BO	Telephone #: 450 (632-0000)
Does your company have 20 or more workers/employees? ☐ Yes	☒ No

3) Accident/Illness Details

Date and Hour of Accident/Awareness of Illness: 8:00am March 1, 2010	**Who was the Accident Reported to: Name and Telephone #** John Doe 632-0000
Date and Hour Reported to Employer: 8:10am March 1, 2010	**Were there any witnesses to the accident? If so, please provide contact name and telephone #.** no witnesses

Describe what happened to cause the accident/illness and what the worker was doing at the time. Include what the injury is and any details of equipment, materials, environmental condition that may have contributed (attach additional page if required)

Employee was moving 2x4's by hand in the lumber yard, when he tripped and fell injuring his left knee. The ambulance was called and he was taken to the emergency. It was a fairly cold and snowing day. The ground was ice covered in some areas.

4) EMPLOYEE DATA:

Trade or Profession at time of Accident: _____

EMPLOYEE STATUS *(Check one box)*

Permanent full time: X	Contract part-time:	Permanent part-time:
Contract full-time:	Permanent seasonal:	Sub-Supplier?

Number of Years and months at current position: Years: 5 Months: 6

Does Employee have other insurance coverage? _____ yes X no (if yes name, address and phone of other insurance coverage.

If yes Contact person: _____ Phone number: _____

Effective date of employee's coverage: March 2005

Date employee ceased work because of accident: March 1, 2010

Was claimant regularly employed and working for you when disability began? yes X no: _____

Is this being reported under workmen's compensation (CSST) yes _____ no: X

Salary at commencement of disability: $ 15.00 hourly _____ weekly _____ monthly _____

If hourly, how many hours per week? 40

Official Position of Employer: (title): Owner

5) Lost Time – No Lost Time

Please choose one of the following indicators. After the day of the accident/awareness of illness, this worker:

☐ Returned to hi/her regular job and **has not** lost any time and/or earning

☐ Returned to **modified work** and **has not** lost any time and/or earnings

☒ **Has** lost time and/or earnings. Provide date worker first lost time March 1, 2010

Date worker returned to work (if known) _____ ☐ Regular Work ☐ Modified Work

6) Return to Work

Have you been provided with work limitations for this worker's injury? ☐ **Yes** ☒ **No**	**Has modified work been discussed with this worker?** ☐ **Yes** ☒ **No**
Have Modified Work been offered to this worker? ☐ **Yes** ☒ **No** **If yes, was it** ☐ **Accepted** ☐ **Declined**	**Who is responsible for arranging worker's return to work.?** ☒ **Myself** ☐ **Other** _____ **Name** 632-0000 **Phone #**

Employer Representative Name (Please Print): John Doe

Signature of **Employer**: John Doe Date: March 2, 2010

M.S.I. reserves the right to bring action to recover any benefits paid to an injured employee resulting from an accident caused by a third party. The beneficiary accepts to transfer all his/her rights to recover and authorize M.S.I. to enforce such rights in his/her name.

I hereby authorize the release to MSI any information requested in respect of this claim.