# First Report of Injury (FROI) Form

402 Gammon Place, Suite 225
Madison, Wisconsin 53719

## To Report a Claim

**Phone: 1-888-881-8242**
**Fax: 1-866-814-5595**
**Email: ClaimsExpress@UnitedHeartland.com**

## Administered by United Heartland

### Employee

| Employee Name (First, Middle Last) | Social Security Number | Sex ☐ M ☐ F | Employee Home Telephone No. |
|---|---|---|---|

| Employee Street Address | City | State | Zip Code |
|---|---|---|---|

| Birth Date | Date of Hire | County where accident or exposure occurred |
|---|---|---|

**Occupation (Check One)**

- ☐ Admin/Office Personnel
- ☐ Building Maintenance
- ☐ Electric Utility – All Op/Meter Reading
- ☐ Engineering
- ☐ Fire Dept. – Dispatcher
- ☐ Fire Dept. – EMS-Paid
- ☐ Fire Dept. – EMS-Volunteer
- ☐ Fire Dept. – Fire Inspector
- ☐ Fire Dept. – Firefighter-Paid
- ☐ Fire Dept. – Firefighter-Volunteer
- ☐ Gas Utility – All Op/Meter Reading
- ☐ Inspectors/Assessors
- ☐ Police Dept. – Auxiliary Volunteer
- ☐ Police Dept. – Chief/Detective
- ☐ Police Dept. – Dispatcher
- ☐ Police Dept. – Parking Enforcement
- ☐ Police Dept. – Patrol Officer
- ☐ Police Dept. – School Crossing Guard
- ☐ Public Works – Landfill Op/Waste Disposal
- ☐ Public Works – Mechanic
- ☐ Public Works – Other
- ☐ Public Works – Park & Rec.
- ☐ Public Works – Solid Waste/Refuse Collect.
- ☐ Public Works – Streets & Roads
- ☐ Sewerage/Waste Water Treatment – All Op.
- ☐ Transit Operations – Bus
- ☐ Water Utility – All Op/Meter Reading
- ☐ Other ____________________

**Department (Check One)**

- ☐ Administration
- ☐ Electric Utility
- ☐ EMS
- ☐ Fire – Paid
- ☐ Fire – Volunteer
- ☐ Other ______________
- ☐ Police
- ☐ PW – Other ______________
- ☐ PW – Park & Rec.
- ☐ PW – Streets-Snow/Maintenance
- ☐ PW – Solid Waste
- ☐ PW – Tree Care
- ☐ Sewer
- ☐ Water

### Employer

| Employer Name | WI Unemployment Insurance Account No. |
|---|---|

| Employer Mailing Address | City | State | Zip Code | Fed. Employer ID No. (FEIN) |
|---|---|---|---|---|

Name of Worker's Compensation Insurance Co. if not Self-Insured
☒ **League of Wisconsin Municipalities Mutual Insurance**

| Name and Address of Third Party Administrator used by the Insurance Company or Self-Insurer | TPA FEIN No. |
|---|---|
| **UNITED HEARTLAND, PO Box 40790, Lansing, MI 48901-7990** | **39-1616714** |

### Wage Information

| Wage at Time of Injury | Specify per hr., wk., mo., yr., etc. | In addition to Wages, Check box(es) if Employer Received | | |
|---|---|---|---|---|
| $ | | | ☐ Meals | No. of Meals/wk. |
| | | | ☐ Room | No. of Days/wk. |
| | | | ☐ Tips | Avg. Weekly Amt. $ |

Is worker paid for overtime? ☐ Yes ☐ No If yes, after how many hours per week?

| | Start Time | Hrs. Per Day | Hrs. Per Week | Days Per Week | For the 52 week period prior to the date the injury occurred, report the number of weeks worked in the same kind of work, and the total wages, salary, commission and bonus or premium earned for such weeks. | |
|---|---|---|---|---|---|---|
| Employee's Work Schedule when injured | | | | | | |
| Normal Full-Time Schedule for Injured's Work | | | | | No. of Weeks | Gross Amount Excluding Tips |

| Part-Time Employment Information | | Are there other part-time workers doing the same work with the same schedule? ☐ Yes ☐ No If yes, how many? | Number of full-time employees doing the same type of work. |
|---|---|---|---|

### Injury Information

| Injury Date: Mo \| Day \| Yr | Time of Injury AM PM | Last Day Worked | Date Employer Notified | ☐ Date Returned to Work ☐ Estimated Date of Return | Mo Day Year |
|---|---|---|---|---|---|

| Did Injury Cause Death? ☐ Yes ☐ No | Date of Death: | Was this a lost time or other compensable injury? ☐ Yes ☐ No | Did injury occur because of: ☐ Substance Abuse ☐ Failure to use Safety Devices ☐ Failure to obey Rules |
|---|---|---|---|

Was employee treated in an emergency room? ☐ Yes ☐ No Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Name and Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

| | **Injury Description-** Describe activities of employee when injury or illness occurred and what tools, machinery, objects, chemicals, etc. were involved.<br><br>What happened to cause this injury or illness? (Describe how injury occurred)<br><br>What was the injury or illness? (State the part of body affected and how it was affected) | | | |
|---|---|---|---|---|
| | Report Prepared By | Work Phone Number | Position | Date Signed |

WKC-12 (R. 3/2002)

**SEND REPORT IMMEDIATELY DO NOT WAIT FOR MEDICAL REPORT**

## EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

### MANDATORY INFORMATION

**In order to accurately administer claims, each of the following sections of this form must be completed.** The First Report of Injury will be returned to the sender if the mandatory information is not provided.

**Employee Section:** Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

**Employer Section:** Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

**Wage Information Section:** Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

**Injury Information Section:** Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

## EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

An employer subject to the provisions of ch. 102, Wis. Stats., shall within one day after the death of an employee due to a compensable injury, report the death to the Department of Workforce Development (DWD) and to the employer's insurance carrier, if insured. In cases of permanent disability or where temporary disability results beyond the 3-day waiting period, an insured employer shall also notify its insurance carrier of a compensable injury or illness within 7 days after the injury or beginning of a disability from occupational disease related to the employee's compensable injury.
Insurance carriers and self-insured employers must report all compensable claims to DWD on this form, the EDI system, or the Internet within 14 days of the date of injury.

The provision of your social security number is voluntary. Failure to provide it may result in information processing delay. Personal information you provide may be used for secondary purposes Privacy Law, s. 15.04(1)(m).

**Department of Workforce Development**
**Worker's Compensation Division**
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