(OFFICE USE ONLY)
CLAIM #: _____

OCCUPATIONAL ACCIDENT FIRST REPORT OF INJURY

Please refer to page 4 for Instructions in completing this form.

Date of Report: _____ Time Reported:_____

(OFFICE USE ONLY)
Customer Service Team: _____

Plan: _____ Policy #:_____

MEMBER INFORMATION:

***Name:** _____ NAIT Member #: _____

***Address:** _____

Apt. #: _____ City, State, Zip: _____

***Primary Phone #:** _____ Secondary Phone #: _____ Email: _____

How long at current address? _____

If less than five years, provide previous addresses and phone numbers**:** _____

_____

DOB: _____ ***SSN:** _____

***Gender:** Male ☐ or Female ☐

***Check all that apply:** Independent Contractor ☐ Owner/Operator ☐ Driver ☐ Courier ☐ Helper ☐
Casual Laborer ☐ Other ☐ If other, describe: _____

***Please list length of relationship with Motor Carrier?** _____

CDL#: _____ Date Issued: _____ State of Issuance: _____

***Are you a Medicare recipient?** YES ☐ or NO ☐

***Do you receive Social Security or similar benefits?** YES ☐ or NO ☐

CLAIMANT INFORMATION – IF DIFFERENT FROM MEMBER:

Name: _____ NAIT Member #: _____

Address: _____

Apt. #: _____ City, State, Zip: _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

How long at current address? _____

If less than five years, provide previous addresses and phone numbers**:** _____

_____

DOB: _____ SSN: _____

Gender: Male ☐ or Female ☐

Relationship to member (check all that apply): Independent Contractor ☐ Owner/Operator ☐ Driver ☐ Courier ☐
Helper ☐ Casual Laborer ☐

Please list length of relationship with Motor Carrier? _____

CDL#: _____ Date Issued: _____ State of Issuance: _____

Are you a Medicare recipient? YES ☐ or NO ☐

Do you receive Social Security or similar benefits? YES ☐ or NO ☐

MOTOR CARRIER INFORMATION:

***Motor Carrier Name**: _____ Motor Carrier #: _____

Address of Motor Carrier: _____

OCCURRENCE:

***Date of Accident:** _____ ***Time of Accident:** _____

***Location of accident, include street location, city and state:** _____

_____

***Description of accident site:** _____

_____

_____

_____

At the time of the accident, the claimant's truck was loaded ☐, loading ☐, unloading ☐ other ☐. Describe other: _____

_____

***What job duties was the claimant performing at the time of the accident?** _____

_____

_____

***Detailed accident description:** _____

_____

_____

_____

_____

_____

_____

***Was a police report completed?** YES ☐ or NO ☐ ***If Yes, What police agency completed the report?** _____

_____

Police report number: _____

***Witnesses:** YES ☐ or NO ☐ ***If Yes, completely fill out information for at least one witness below:**

Witness Name: _____ Phone #: _____

Address: _____

_____

Witness Name: _____ Phone #: _____

Address: _____

_____

***Was a machine or equipment involved in this injury?** YES ☐ or NO ☐ ***If Yes, please describe:** _____

_____

***Were there any other parties involved in this injury?** YES ☐ or NO ☐ ***If Yes, fill out Name, Address, and injury information below:**

Name: _____

Address: _____

Who was the injury reported to? _____ Date reported: _____

MEDICAL INFORMATION:

***Please list all injuries related to this accident:** _____

Did the claimant have immediate pain? Yes ☐ or No ☐ ***If yes, where was the pain?** _____

***Has the claimant seen a physician?** Yes ☐ or No ☐ **If yes, what was the first date of treatment?** _____

***If yes, Physician's name, address, and phone number:** _____

_____

_____

***Has the claimant stopped working due to the injury?** Yes ☐ or No ☐ ***If yes, what was the last day worked?** _____

***Has the physician authorized the claimant to be off work?** Yes ☐ or No ☐ ***If yes, as of what date?** _____

What is the diagnosis? _____

What treatment has been received? _____

***Is the claimant planning on seeing another doctor?** Yes ☐ or No ☐ ***If yes, please provide doctor information below:**

Contact information for other doctor: _____

_____

_____

Has the claimant ever been injured before? Yes ☐ or No ☐ If yes, please answer injury questions below:

What were the cause of the injury(ies)? _____

Describe the injury(ies): _____

Was time lost due to the injury(ies)? Yes ☐ or No ☐ If yes, how much time was lost: _____

OTHER INFORMATION:

Was the claimant under dispatch: Yes ☐ or No ☐

Was the claimant on duty: Yes ☐ or No ☐

***Claim reported by:** _____ ***Relationship to claimant:** _____

***Telephone #:** _____

***Dispatcher's Name:** _____ ***Dispatcher's Phone #:** _____

(OFFICE USE ONLY)
Dispatch Verified by: _____

ADDITIONAL INFORMATION PERTINANT TO CLAIM: _____

_____

_____

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.

NY - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

***MANDATORY AGREEMENT FOR INDEPENDENT CONTRACTORS:**

☐ **I warrant and represent that at the time of the alleged accident to which this Report pertains; I was an independent contractor, and not an employee, of my motor carrier. As such, I understand and agree that I am not eligible for worker's compensation benefits as a result of the alleged accident.**

***☐ I certify that I have read and agree to all fraud warnings contained in this form and that all statements made in this Occupational Accident First Report of Injury, and any attached documents are true and correct to the best of my knowledge and belief. No material information has been withheld.**

_____ _____ ***Date** _____

***CLAIMANT/MEMBER'S SIGNATURE** ***CLAIMANT/MEMBER'S PRINTED NAME**

TRANSGUARD INSURANCE COMPANY OF AMERICA, INC.

1-800-474-2526

Email: claims.reporting@transguard.com

INSTRUCTIONS: This claim form needs to be completed, signed, and returned as soon as possible. * Items marked with an asterisk are mandatory fields.

FRAUD WARNING

AK - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ – For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR & LA - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CA – For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of Insurance.

DE – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

ID – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

IN – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KY - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

ME, TN & VA - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MN – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH – Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TX – Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

WA – It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.