

	CLAIM NO
For SAIF Customer Use	SUBJECT DATE
Aron	CLASS
	DEFAULT DATE
Dept CC	EMPLOYER'S ACCOUNT NO.

 Email:
 saif801@saif.com

 Toll-free phone:
 1.800.285.8525

 Toll-free FAX:
 1.800.475.7785

Report of Job Injury or Illness

Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. If you do not intend to file a workers' compensation claim with SAIF Corporation, do not sign the signature line. Your employer will give you a copy.

file a workers' compen	satio	n claim with SAIF C	Corpora	ation	ı, do not sigi	n the signat	ture line.	Your em	ıployer	will g	ive you a	cop	y.	
1. Date of injury or illness:				3. Time you began work on day of injury:				a.m. 4. Regul days off:		larly scheduled		DEPT USE:		
5. Time of injury	a.m.	6. Time you	a.m.		Shift on		(from) a.m.		p.m.	ППГ			Emp	
or illness:	p.m.	left work:	p.m.		of injury:		(to)	a.m.	p.m.	МТ	W T F S	s	S Ins	
8. What is your illness or injury? W	/hat par	t of the body? Which side? (Exa	mple: sprai	ined ri	ght foot)	Left Ri	ght				here if you ha	ive	Occ	
more than one job:											Nat			
12												Part		
												Ev		
													Src	
													2src	
Information ABOVE this line: date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.														
			_	. Worker's language preference other than English: Spanish Other (please specify):					rthdate:		14. Gender: M F			
15. Your mailing address, city, state and zip:										one:				
17. Social Security no. (see back*)					18. Occupation:						19. Work phone:			
20. Names of witnesses:														
21. Name and phone number of health insurance company: 22. Name and address of health care provider who treated are now reporting:								ated you	d you for the injury or illness you					
23. Have you previously injured this body part?														
24. Were you hospitalized overnight as an inpatient?														
25. Were you treated in the emergency room? Yes No														
26. By my signature, I am making a claim for worker's compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Businesss Services. Notice: Relevant medical records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.														
27. Worker signature:				28. Completed by (please print):						29. Da	29. Date:			
				L`		ver								
Employer Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.												of the claim.		
30. Employer legal business name:							31. Phone:			32. FI	EIN:			
33. If worker leasing company, list client business name:						-				34. CI FEIN				
35. Address of principal place of business (not P.O. Box):										36. In policy	surance / no.:			
37. Street address from which worker is/was supervised:							ZIP:			38. Na superv		ess in w	hich worker is/was	
39. Address where event occurred:														
40. Was injury caused by failure of	a mach	ine or product, or by a person of	her than th	e injur	ed worker?		Yes	No		41. C	lass code:			
12. Were other workers injured? Yes No 43. Did injury occur during course Unknown Yes No 44. OSHA 300 log case no:):			

45. Date employer knew of claim:

51. Employer signature:

49. Return-to-work status: Not returned

47. Date worker

hired:

Modified Date:

and scope of job?

52. Name and title

(please print):

46. Worker's weekly wage: \$

Regular Date:

Yes No

48. If fatal, date of death

50. If returned to modified work,

is it at regular hours and wages?

53. Date:

A guide for workers recently hurt on the job

The following information is provided by SAIF Corporation at the request of the Workers' Compensation Division

saifcorporation 400 High St. SE, Salem, OR 97312

If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modifiedor light-duty job.

What if I have questions about my claim?

- SAIF Corporation or your employer should be able to answer your questions. Call SAIF Corporation at 800.285.8525.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

Ombudsman for Injured Workers:

An advocate for injured workers

Toll-free: 800.927.1271

Email: oiw.questions@state.or.us

Workers' Compensation Compliance Section

Toll-free: 800.452.0288

Email: workcomp.questions@state.or.us

How do I file a claim?

- Notify your employer and a health care provider of your choice about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete Form 801, "Report of Job Injury or Illness," available from your employer and Form 827, "Worker's and Physician's Report for Workers' Compensation Claims," available from your health care provider.

How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
 - Authorized nurse practitioners
 - Chiropractors
 - Medical doctors
 - Naturopaths
 - Oral surgeons
 - Osteopathic doctors
 - Physician assistants
 - Podiatrists
 - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

Are there limitations to my medical treatment?

- Health care providers may be limited in how long they may treat you and whether they may authorize payments for time off work. Check with your health care provider about any limitations that may apply.
- If your claim is denied, you may have to pay for your medical treatment.

Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for?

You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).