Important Note: 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.

EMPLOYEE'S REPORT OF ACCIDENT

Name_____ Address_____

Tel. #_____ Social Security #_____ D. O. B._____

Employer's Name & Address_____

_____ Employer's Telephone #_____

Occupation_____ How Long Employed_____

Wages_____ Date & Time of Accident_____

Where & How Accident Happened (address)_____

_____

_____

Name of Witness (if any)_____

Was the accident caused by someone other than co-worker?_____

If yes, Name & Address _____

What part of the body did you injure?_____

Length of scar, number of stitches, color and description_____

_____

Name of hospital you went to_____

Name & Address of Doctor(s) who treated you_____

_____

Are you still under treatment?_____ Date last treated _____

Did you lose wages due to accident?_____ Date last paid_____

Date you stopped working_____ Date returned to work_____

Who did you return to work for?_____

List prior accidents (with dates)_____

_____

List prior Doctors_____

_____

Date_____ Signed_____

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A.I.M. Mutual
INSURANCE COMPANIES

A.I.M. Mutual Insurance Company
Massachusetts Employers Insurance Company
New Hampshire Employers Insurance Company
Associated Employers Insurance Company

HOSPITAL) PERMISSION SLIP
DOCTOR)

To:

Claimant :
Insured :
Date of Acc. :
Claim No. :

Permission is granted to furnish A.I.M. Mutual Insurance Cos. and their authorized agents or representatives, as well as the above named insured/employer, with a copy of my record of treatment for the above date of accident.

Lab Rule 503.01(b): This request is strictly limited to medical information relevant to the occupational injury or illness that underlies the patient's workers compensation claim, including any past history of complaints of, or treatment of, a condition similar to that claim.

A.I.M. Mutual Insurance Cos. will be responsible for payment of your usual charge for such a copy.

You are authorized to permit the examining physician for A.I.M. Mutual Insurance Cos. to examine any x-ray or films you may have concerning my condition.

My permission is also given for you to accept a photocopy of this authorization.

_____
(Signature)

_____
(Date of Birth)

_____
(Date)

Send Record to:

A.I.M. Mutual Insurance Cos.
P.O. Box 4070
Burlington, MA 01803-0970

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