ARROWHEAD
General Insurance Agency, Inc.

Tribal Workers' Benefits Claim Form

CLICK HERE TO SUBMIT CLAIM FORM

Insured:			Policy Number:		
Client Code:			Effective Date:		Expiration Date:
Claim Number:			Carrier:		
1. Name (Last, ,First, M.I.)		2. Sex:	12. Date of injury:	13. Time of injury	14 Date lost time began:
3. Social Security Number:	*4. Home phone:*	5. Birthdate:	*15. Nature of injury*	*16. Part of body injured or exposed*	
6. Does the employee speak English? ☐ Yes ☐ No If no, please specify:			17. How and why accident/injury occurred		
7. Mailing Address (Street or PO Box)			18. Was the employee doing his regular job? ☐ Yes ☐ No	*19. Worksite location of injury (stairs, etc.)*	
City	State	Zip	20. Address where injury or exposure occurred (Name of business if incident occurred on a business site)		
8. Marital status: ☐ Married ☐Widowed ☐ Separated ☐Single ☐ Divorced					
9. Number of dependent children:	10. Spouse's name:		*21. Cause of injury (fall, tool, etc.)*		
11. Physician's name and address:			22. List witnesses		
			23. Return to work date or expected:	24. Did employee die?	25. Supervisor's name: / 26. Date report:
27. Date of hire:	28. Is the employee entitled to IHS benefits?		29. Length of service in current position:	30. Length of service in occupation:	
31. Occupation of injured worker:					
32. Rate of pay at this job: $_____ hourly $_____ weekly	*33. Full work week is:* _____ hours _____ days		34. Last paycheck was: $_____ for _____hours or _____ days		
35. Name and title of person completing this form:			36. Name of business:		
36. Business mailing address and phone number:			37. Business location (if different from mailing address):		
38. Standard Industrial Classification Code (SIC)					
Signature of person completing this form			Title		

IMPORTANT NOTICE - ELECTRONIC SIGNATURE

Transmission of signatory's name as presented in the Claim Form constitutes a binding electronic signature pursuant to C.R.S. § 24-71 et seq. and the Uniform Electronic Transactions Act. Once the completed Claim Form is transmitted, the document may be construed as a claim pursuant to the Insured's policy.

The Named Insured is a Federally recognized Tribal Government and/or Tribal Entity; and is exempt from State law. The Tribe is NOT a "State Employer" and DOES NOT insure employees subject to any State Workers' Compensation laws.

12/11/2009 3:59pm

*Special Instruction on next page

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Special Instructions for Certain Items

Item 4: If no home phone, please provide a phone number where the employee can be reached.

Item 15: List nature of accident or exposure, e.g. fall from scaffold, contact with radiation, etc..

Item 16: List specific body part, e.g. chin, right leg, forehead, left upper arm, etc.. If more than one body part is affected, list each part.

Item 17: Describe in detail (1) the events leading up the accident/injury, (2) the actual injury, e.g. cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.

Item 19: State the exact work site location of the injury, e.g. construction site, office area, storage area, etc..

Item 21: List object, substance, or exposure that directly inflicted the injury or illness, e.g. floor, hammer, chemicals, etc..

Item 33: Enter the number of days or hours that make up a full work week for your employees.