STATE OF MICHIGAN

Workers' Compensation Claim Form

Instructions on back

York Risk Services Group is the State of Michigan's Workers' Compensation Third Party Administrator (TPA)

1. Employee Information

Last Name	First Name	M.I.	Employee I.D

Home Address	City	State	Zip Code

☐ Male ☐ Female	Date of Birth	Home/Cell Telephone Number	Work Telephone Number	Date of Hire (mm/dd/yy)

Job Classification

Department/Agency	Location/Work Site

Supervisor's Name	Supervisor Contact Information Phone: Email:

2. Injury/Illness Information

Date of injury or illness	Time of Injury or Illness ☐ A.M ☐ P.M	Time employee began work ☐ A.M. ☐ P.M.	Did the injury cause employee death? ☐ No ☐ Yes Date of death:

What were you doing just before the injury occurred? Describe the activity, as well as the tools, equipment, or material the employee was using.

What happened? Examples: "When ladder slipped on wet floor, worker fell 20 feet;" "Worker was sprayed with chlorine when gasket broke during repair."

What was the injury, including all affected body parts in order of severity? ***Please designate right or left.*** (Example: burn left index finger, puncture right arm, scratch left leg, fracture right ankle, strained lower back, contusion head, etc.)	What object or substance directly harmed you? (Example: grease, chair, needle, inmate, client, fumes, concrete floor, etc.)

Injury or illness reported to (Name and Title)	Date reported to employer	Did you take time off work? ☐Yes ☐No

Name of witness(es)	Was this injury the result of an automobile accident? ☐Yes ☐No If yes, was it a state owned vehicle? ☐ Yes ☐ No	Last Day worked Return to Work Date Date of next doctor appointment

Occurred on Employer Premises ☐ Yes ☐ No	Location of Injury/Illness (Building, Address, Location within the building)	County

Did you receive medical treatment? ☐ Yes ☐ No	Did injury require treatment in an emergency room? ☐ Yes ☐ No

Medical provider name, address and telephone number

Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No	Name and address of healthcare facility

How many days in the hospital?	Medical Provider's Diagnosis

Was a prescription given? ☐ Yes ☐ No	Did you return to your regular job? ☐ Yes ☐ No	Work restrictions related to the injury/illness? ☐Yes ☐No

In consideration for receiving disability benefits under the State of Michigan Disability Benefit Program before providing all required proof of other income, and understanding that such payment may later be determined to exceed benefits due under the Program, I hereby agree to reimburse the State any benefits paid under the Program for which I am ineligible because of benefits received from any source that the Program terms require offset from disability benefits.

The State will deposit my first Workers Compensation payment to re-credit the proper amount of any leave credits used to keep me in full pay status and process other necessary adjustments consistent with Civil Service rules and appropriate law. I will receive a check for any remaining balance. After my first check, York Risk Services will send any subsequent Workers' Compensation payment directly to me.

_____ _____

Employee Signature Date

3. HR/DMO/DMU use only

Reported to TPA by (Name and Classification)	Date reported to TPA

Telephone Number	Email Address	Case number from the MIOSHA log

State of Michigan Workers' Compensation Claim Form Instructions

Department	Employee
Agriculture and Rural Development Civil Rights Civil Service Commission Education Environmental Quality Gaming Control Board Insurance and Financial Services Licensing and Regulatory Affairs Lottery Michigan Land Bank Authority Military and Veterans Affairs Natural Resources DTMB Transportation Treasury Unemployment Insurance Agency Workforce Development Agency	1. Immediately notify your supervisor of the work related injury/illness. 2. Complete sections 1 and 2 of the claim form including your signature and the date of signature. 3. Fax the completed form to the Civil Service Commission Disability Management Office (DMO) at 517-241-9926. 4. Provide a copy of the claim form to your supervisor and retain a copy for your records. **For questions, contact the DMO at 877-766-6447, select option 2.**
Attorney General Auditor General Community Health Legislative Service Bureau MEDC MSHDA Michigan State Capitol Commission Michigan Strategic Fund Secretary of State State Police	1. Immediately notify your supervisor of the work related injury/illness. 2. Complete sections 1 and 2 of the claim form including your signature and the date of signature. 3. Provide a copy of the completed claim form to your supervisor and HR office. 4. Retain a copy for your records. **For questions, contact your HR office.**
Department of Corrections	1. Immediately notify your supervisor of the work related injury/illness. 2. Complete sections 1 and 2 of the claim form including your signature and the date of signature. 3. Provide a copy of the claim form to your supervisor and HR office. 4. Retain a copy for your records. **For questions, please contact the DMU at 877-443-6362.**