

**ACORD™ WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS**

EMPLOYER (NAME & ADDRESS INCL ZIP) <b>City of Beaufort</b> <b>P O Drawer 1167</b> <b>Beaufort, S C 29901-1167</b>		CARRIER CLAIM NUMBER	REPORT PURPOSE CODE
DEPARTMENT # (SEE BACK)		JURISDICTION	JURISDICTION CLAIM NUMBER
SIC CODE		LOCATION CODE	
EMPLOYER FEIN <b>57-6000223</b>	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	PHONE # <b>843-525-6016</b>	

**CARRIER/CLAIMS ADMINISTRATOR**

CARRIER (NAME, ADDRESS & PHONE NO) <b>SC Municipal Insurance Trust</b> <b>P.O. Box 11447</b> <b>Columbia, South Carolina 29211-1477</b>	POLICY PERIOD  TO  CHECK IF APPLICABLE <input type="checkbox"/> SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO) <b>Companion Third Party Administrators, L.L.C.</b> <b>P.O. Box 11447</b> <b>Columbia, South Carolina 29211-1477</b>  <b>(877) 825-2477</b> <b>FAX: 1-803-933-1295</b>
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

**EMPLOYEE/WAGE**

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	OCCUPATION/JOB TITLE	VOLUNTEER <input type="checkbox"/> YES <input type="checkbox"/> NO
PHONE #	# OF DEPENDENTS	EMPLOYMENT STATUS	INMATE/PRISONER <input type="checkbox"/> YES <input type="checkbox"/> NO	
RATE	<input type="checkbox"/> DAY <input type="checkbox"/> WEEK	<input type="checkbox"/> MONTH <input type="checkbox"/> OTHER:	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO
PER				DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO

**OCCURRENCE/TREATMENT**

TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/SUPERVISOR/PHONE NUMBER		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED	
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED	
DEPARTMENT OR LOCATON WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OF SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL					CAUSE OF INJURY CODE
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED	
WITNESSES (NAME & PHONE #)					
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER ( ) -