

# EMPLOYEE QUESTIONNAIRE

To be completed by injured employee and submitted to MCIM

## EMPLOYEE INFO

First name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Please provide full given name

Street/P.O. Box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Circle one: Male / Female Circle one: Married / Single / Divorced

Drivers license #: \_\_\_\_\_

Spouse's name: \_\_\_\_\_

Name and date(s) of birth of any dependents: \_\_\_\_\_

## ACCIDENT OR OCCUPATIONAL DISEASE & MEDICAL TREATMENT

Date of injury: \_\_\_\_\_ Day of week: \_\_\_\_\_ Approximate time: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Last day of work: \_\_\_\_\_ Return to work date: \_\_\_\_\_ or Estimated RTW: \_\_\_\_\_

Nature of injury or occupational disease and/or diagnosis: \_\_\_\_\_

Date and place of first treatment: \_\_\_\_\_

List name, address & phone numbers of all doctors with whom you've treated for this accident.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please give full description of how accident or occupational disease occurred. Use an additional piece of paper if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you receiving Social Security Disability Benefits (SSDB)? If so, please indicate the amount of monthly benefit and the date you started receiving SSDB. Monthly benefit: \$ \_\_\_\_\_ Date you began receiving benefit: \_\_\_\_\_

Have you applied for Social Security or Social Security Disability Benefits? If yes, please indicate the date applied: \_\_\_\_\_

## EMPLOYMENT INFO

Name of current employer: \_\_\_\_\_ Supervisor: \_\_\_\_\_ Date of hire: \_\_\_\_\_

Street/P.O. Box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Rate of pay: \$ \_\_\_\_\_ Do you have health insurance? \_\_\_\_\_ Did your wages continue? \_\_\_\_\_

Name of second employer: \_\_\_\_\_ Additional income: \_\_\_\_\_

Please list prior employers, addresses, phone numbers, job duties and wage information:

Please note the questionnaire continues on the back of this form



EMPLOYEE QUESTIONNAIRE (cont.)

**EMPLOYMENT INFO CONTINUED**

Please list prior employers, addresses, phone numbers, job duties and wage information:

---

---

---

Please list any other job skills (i.e. computer skills, etc) that are not already listed (see previous question)

---

---

---

Please list any volunteer work or hobbies you do or have done in the past:

---

---

---

**NOTIFICATION OF INCIDENT**

Name & title of person you reported accident to: \_\_\_\_\_ Date Reported: \_\_\_\_\_

Name(s) of witness(es) to accident: \_\_\_\_\_

Where & how can we contact them? \_\_\_\_\_

Are you still under medical care for this incident? Yes / No

If yes, when, where and with whom is your next appointment? \_\_\_\_\_

If no, when, where and with whom was your last appointment? \_\_\_\_\_

Street/P.O. Box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_ ) \_\_\_\_\_

Did you obtain a work status slip from your doctor and give it to your employer? Yes / No

List all previous injuries, surgeries and serious illnesses:

---

---

---

---

---

---

Additional comments:

---

---

Signature

Date

*Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.*

Submit to MCIM Claims: P.O. Box 80740 - Lansing, MI 48908-0740 (FAX: 517.886.3499)

