

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)

