NYSIF Electronic First Report of Injury (eFROI) Worksheet

- Please use this completed worksheet to help file your claim online at www.nysif.com.
- Fields in **BOLD** are required to complete the claim online.
- Do not forget (for WC claims only) to give the injured employee a Claimant Information Packet.

Policyholder Information		
Policyholder Name:		
Policy Number:	**Industry Type Code**:	**Phone**:
Policyholder Mailing Address:		
City:	**State**:	**ZIP Code**:

Claimant Information		
Claimant Name:		
Claimant Address:		
City:	**State**:	**ZIP Code**:
Phone:	SSN:	**Date of Birth**:
Gender:	Job Title:	

Did Employee give notice of accident/illness? ☐ **YES** ☐ **NO**	**If so, to whom?**	**Date given:**
Injured Employee's Supervisor's name:		

Employment Information *Some questions in this section do not apply to volunteer firefighters/ambulance workers*	
Date of Hire:	**Claimant's Gross Average Weekly Wage**: *Enter $0.00 for volunteer firefighter/ambulance worker*
Claimant's usual days worked:	Time claimant started work on date of incident:
Date claimant stopped working (due to injury):	**Last day paid, if lost time case**:
Is employer continuing to pay claimant while out? ☐ **YES** ☐ **NO**	Has claimant returned to work (RTW)?: ☐ **YES** ☐ **NO**
If yes (RTW), the date they returned to work:	
If claimant RTW, are there any restrictions?	
Has employer provided the Claimant Information Packet (CIP): ☐ **YES** ☐ **NO**	**If yes, what date was the CIP provided?**

Accident/Illness and Injury Information	
Date and time of accident/illness or injury:	**Where did the accident/illness happen?**
What was the employee doing at the time of injury?	
How did the accident occur?	
Is the accident location the same as the policy location?: ☐ **YES** ☐ **NO**	
If not, what is the accident address location?	
Did the accident occur where the employee normally worked? ☐ **YES** ☐ **NO**	
If not, why was he/she there?	
Nature of the injury (such as "Laceration" or "Fracture"):	
Body part(s) injured (up to six body parts may be selected):	
Cause of Injury:	**Type of Loss:**
To your knowledge, did the employee have another work-related injury to the same body part or similar illness while working for you: ☐ **YES** ☐ **NO**	
Did the injury/illness result in the employee's death? ☐ **YES** ☐ **NO**	
Was an object involved in the injury/illness? ☐ **YES** ☐ **NO**	
Was the injury the result of the use or operation of a licensed motor vehicle? ☐ **YES** ☐ **NO**	
Please include auto insurance information if accident involved employer's motor vehicle. (carrier, policy #, etc.):	

Accident/Illness and Injury Information (cont.)		
Did the claimant's supervisor see the injury? ☐ **YES** ☐ **NO**		
Any other witnesses to the injury?		
What was the claimant doing when injured?		
WCB/JCN number, OSHA accident number (if applicable):		
Medical Provider (if applicable)		
Did the employee receive medical care? ☐ **YES** ☐ **NO**	If so, what date was medical care received?	
Medical Care Provider/Hospital:		
Address:		
City:	State:	Zip Code:
Phone:	Contact:	
Signature of Employee Reporting Claim		Date
Completed by eMPLOYEE PREPARING THIS FORM		
Signature		**Date**
Print Name:	**Title:**	**E-Mail:**