

**PROGRAM FOR SOVEREIGN INDIAN NATIONS
TRIBAL WORKERS' BENEFITS CLAIM FORM**

To submit your claim form after entering all			requested information click on "Submit Form"			
11. Name (Last, First, MI)		2. Sex	12. Date of Injury	13. Time of Injury	14. Date Lost Time Began	
3. Social Security Number	*4. Home Phone*	5. Birthdate	*15. Nature of Injury*	*16. Part of Body Injured or Exposed*		
6. Does the Employee Speak English? If No, Specify Language Yes <input type="checkbox"/> No <input type="checkbox"/>			*17. How and Why Accident/Injury Occurred*			
7. Mailing Address (Street or P.O. Box)			18. Was Employee Doing his Regular Job? Yes <input type="checkbox"/> No <input type="checkbox"/>	*19. Worksite Location of Injury (stairs, etc.)*		
City	State	Zip Code	20. Address Where Injury or Exposure Occurred (Name of Business if incident occurred on a business site)			
8. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>						
9. Number of Dependent Children	10. Spouse's Name		*21. Cause of Injury (fall, tool, etc.)*			
11. Physician's Name and Address			22. List Witnesses			
			23. Return to Work Date Or Expected	24. Did Employee Die?	25. Supervisor's Name	26. Date Report
27. Date of Hire	28. Is the Employee entitled to IHS benefits?		29. Length of Service In Current Position		30. Length of Service in Occupation	
31. Occupation of Injured Worker						
32. Rate of Pay at This Job \$ _____ Hourly \$ _____ Weekly		*33. Full Work Week Is* _____ Hours _____ Days		34. Last Paycheck Was \$ _____ for _____ Hours or _____ Days		
35. Name and Title of Person Completing This Form			36. Name of Business			
36. Business Mailing Address and Telephone Number			37. Business Location (If different from Mailing Address)			
38. Standard Industrial Classification Code (SIC)						
39. Workers' Compensation Insurance Company			40. Policy Number			
41. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)						
X _____						

The Named Insured is a Federally recognized Tribal Government and/or Tribal Entity; and is exempt from State law. The Tribe is NOT a "State Employer" and DOES NOT insure employees subject to any State Workers' Compensation laws.

*Special instructions on back

SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS

- Item 4: If no home phone, please provide a phone number where the employee can be reached.
- Item 15: List nature of accident or exposure, e.g. fall from scaffold, contact with radiation, etc..
- Item 16: List specific body part, e.g. chin, right leg, forehead, left upper arm, etc.. If more than one body part is affected, list each part.
- Item 17: Describe in detail (1) the events leading up the accident/injury, (2) the actual injury, e.g. cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
- Item 19: State the exact work site location of the injury, e.g. construction site, office area, storage area, etc..
- Item 21: List object, substance, or exposure that directly inflicted the injury or illness, e.g. floor, hammer, chemicals, etc..
- Item 33: Enter the number of days or hours that make up a full work week for your employees.