INSURANCE COMPANY
Intelligent Risk Management

EMPLOYEE QUESTIONNAIRE

To be completed by injured employee and submitted to MCIM

EMPLOYEE INFORMATION

First name: _____ Middle Name: _____ Last Name: _____

Maiden name and/or any other previous last names: _____

Address: (If using a PO Box, please provide both the street and PO Box addresses)

Street / PO Box: _____ City:_____ State: _____ Zip: _____

Have you ever applied for or are you currently receiving Social Security Disability, Medicare or Medicaid Benefits?: Y / N Please also complete the following questions and specify which type(s) of benefit(s) apply:

If yes, when did you apply?: _____ Approved, denied or appealed?: _____

If approved, when did your benefits begin? _____ What is your monthly rate? _____

Have you lived in any other states? Y / N If yes, provide names of states: _____

Phone #'s: Home: _____ Cell: _____ Work: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Height: _____ Weight: _____ Ethnic Background: _____ Hair color: _____

U.S. Citizen?: Y / N If no, country born in: _____ Greencard #: _____

Circle one: Male / Female Circle one: Married / Single / Divorced

Spouse's Full Name: _____

Driver's license or ID #: _____

Type of vehicles currently owned: _____

Recreational vehicles owned: _____

Names and date(s) of birth of any dependents: _____

Do you pay child support? _____ Name of Child Support Agency: _____

State(s) to which support is paid: _____ Amount & frequency of payment: _____

Hobbies / sports / activities within the last 5 years: _____

Gym Membership: Y / N If yes, provide name /address of gym: _____

High school graduate? Y / N If no, do have a GED or equivalency?: Y / N

College or Technical School(s) attended?: _____ When? _____ Did you Graduate? Y / N Degrees received?: _____ Have you been in the military? Y / N If yes, which branch?: _____ When? _____ Where were you stationed?: _____

EMPLOYEE QUESTIONNAIRE (cont.)

Do you have a family doctor: Y / N If yes, provide his/her name, address & phone number: _____

_____

If no, please list any clinics/hospitals you go to if ill or in need of treatment: _____

_____

Prior medical condition(s) along with the name, address & phone number for medical providers for the condition(s): _____

_____

Pre-existing condition(s) along with the name, address & phone number for medical providers for the condition(s): _____

_____

List any medications you were taking prior to or on the date of injury and provide then name of the doctor(s) that prescribed the medication(s): _____

_____

Do you have health insurance? Y / N Name of carrier: _____ Smoker: Y / N

EMPLOYMENT INFORMATION:

Name of current employer: _____

Street address: _____ City: _____ State: _____ Zip: _____

Date of Hire: _____ Job Title: _____ Rate of pay: _____

Name of second employer: _____

Date of Hire: _____ Job Title: _____ Rate of pay: _____

Scheduled # of hours per week: _____ Start time: _____ End time: _____

Provide a list of any additional sources of income: _____

PRIOR EMPLOYMENT

Provide a list of prior employers for the past 10 years. Include addresses, phone number, job title(s), job duties and wage information:

_____

_____

List any job skills not already listed: _____

ACCIDENT OR OCCUPATIONAL DISEASE

Date of injury: _____ Day of week: _____ Approximate time: _____

Location - Address: _____ City: _____ State: _____

EMPLOYEE QUESTIONNAIRE (cont.)

Body part(s) injured / Nature of injury: _____

Full description of how accident or occupational disease occurred. Use an additional sheet of paper if needed: _____

_____

_____

_____

Was personal protective equipment required? Y / N Was it provided? Y / N Was it used? Y / N

Last day of work: _____ Return to work date: _____ Est return to work date: _____

Did your wages continue?: Y / N

NOTIFICATION OF INCIDENT

Name & title of person accident / incident was reported to: _____

Date reported: _____ Written accident / incident report completed: Y / N

Name(s) / phone numbers of witnesses to incident: _____

MEDICAL TREATMENT

Initial treatment date: _____ Name of hospital or clinic: _____

Address: _____ City: _____ State: _____

Diagnosis?: _____

Taken by ambulance?: Y / N If yes, name of ambulance service: _____

List name, address & phone numbers of all doctors, hospitals, clinic, chiropractors, therapy locations with whom you have received or will be receiving treatment for this accident/incident: _____

_____

Are you still under medical care for this accident / incident?: Y / N

Date of most recent visit: _____ Location: _____

Current diagnosis: _____

Date of next appointment: _____ Location: _____

Did you obtain work status slips at each of your appointments? Y / N If so, were they given to your employer? Y / N

PRIOR TREATMENT

Any prior injuries and/or medical treatment to the injured body part(s)? Y / N If yes, please provide the following:

Type of injury(s): _____

EMPLOYEE QUESTIONNAIRE (cont.)

Date(s) of injury(s): _____

Name / address / phone number of all medical providers: _____

_____

Did you recover completely?: Y / N If no, please provide details: _____

PRIOR WORK COMP INJURIES

Please provide a list of all prior worker's compensation injuries for all employers. Include the following for each injury:

Date of injury(s): _____

Description of how the injury(s) occurred: _____

Type of treatment received along with the name, address and phone numbers of all medical providers: _____

_____

Current treatment status: _____

Any permanent restrictions given? _____

Name of employer at the time of the injury: _____

Name of the worker's compensation company that handled the claim: _____

Was claim accepted or denied? _____

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.