**ADJUSTER INFORMATION**

|  |  |
| --- | --- |
| NAME |  |
| COMPANY |  |
| ADDRESS |  |
| CITY, STATE AND ZIP |  |
| EMAIL |  |
| PHONE |  |
| FAX |  |
| CLAIM NUMBER |  |

**CARRIER INFORMATION**

|  |  |
| --- | --- |
| CARRIER NAME |  |
| INSURER NAME (if different from above) |  |
| PERMISSIBLY SELF INSURED? CERTIFICATE NO. |  |
| COVERAGE PERIOD |  |

**EMPLOYER INFORMATION**

|  |  |
| --- | --- |
| COMPANY NAME |  |
| CONTACT |  |
| EMAIL |  |
| ADDRESS |  |
| CITY, STATE AND ZIP |  |
| PHONE |  |
| FAX |  |
| DATE OF HIRE |  |

**APPLICANT INFORMATION**

|  |  |
| --- | --- |
| NAME |  |
| ADDRESS |  |
| CITY, STATE AND ZIP |  |
| PHONE |  |
| SSN |  |
| DOB |  |
| DOI |  |
| DATE OF KNOWLEDGE |  |
| DECISION DATE |  |
| OCCUPATION |  |
| AWW |  |
| ACCEPTED, DELAYED OR DENIED |  |
| ACCEPTED BODY PARTS |  |
| DENIED BODY PARTS |  |

**APPLICANT’S ATTORNEY**

|  |  |
| --- | --- |
| NAME |  |
| FIRM |  |
| ADDRESS |  |
| CITY, STATE AND ZIP |  |
| PHONE |  |
| FAX |  |

**CODEFENDANT**

|  |  |
| --- | --- |
| CARRIER NAME |  |
| CODEFENSE COUNSEL |  |
| FIRM |  |
| ADDRESS |  |
| CITY, STATE AND ZIP |  |
| PHONE |  |
| FAX |  |

**COMMENTS:** (Please indicate any special instructions below)

|  |
| --- |
|  |