Employer's Report of Employee's Change in Employment Status Resulting From Injury/Illness

Oriska Insurance
1310 Utica St.
PO Box 855
Oriskany, NY 13424
(866)808-3933
Claims@Oriska.com

Injury/Illness Information

Date of Injury/Illness _____ Carrier Case # _____

Employee Information

Last Name _____ First Name _____ MI _____

Mailing Address _____ Line 2 _____

City _____ State _____ Zip Code_____

Country _____

Daytime Phone Number _____

Email Address _____

Social Security # _____ Date of Birth _____

Gender: ☐ Male ☐ Female ■ Unknown

Employer Information

Employer Name _____

Mailing Address _____ Line 2 _____

City _____ State _____ Zip Code_____

Employer Information Continued

Country _____

Employer Phone # _____

Federal Tax ID # _____ Tax # is (Check One) ☐ SSN ☐ FEIN

Insurer Information

Insurer Name Oriska Insurance Company Insurer ID # 30175

Mailing Address 1310 Utica St. PO Box 855 City Oriskany State NY Zip Code 13424

Country United States of America Insurer Phone # (866)808-3933

Date of First Full Day Employee Lost From Work _____

Date Employee First Returned To Work _____

Loss of Time Start Date	Return to Work Date	Reason

As a result of the above injury/illness, was there an increase or decrease in hours worked or wages paid? ☐ Yes ☐ No

If yes, enter status of change below

Employment Status	Effective Date	Hours Per Day	Days Per Week	Earnings	Remarks
Prior to Injury					
Changed To					

Signing below attests that the above information is true and accurate to the best of my knowledge and belief.

Prepared By:

Signature _____

Print Last Name _____ Print First Name _____MI __

Employer Name _____

Official Title _____ Phone # _____

Email Address _____ Date of This Report _____