Form 122C

FIRST REPORT OF INJURY OR ILLNESS

Rev 10/2019

TO BE COMPLETED BY INSURANCE CARRIER OR SELF-INSURED EMPLOYER

NOTICE TO INJURED WORKER: This form is to notify you, the injured worker, the insurance carrier has received initial notice of an industrial accident or occupational disease claim. This form does not indicate acceptance or denial of the claim. If you have questions please contact the claim administrator assigned to your claim as listed below. If further assistance is required you may then contact the Labor Commission, Division of Industrial Accidents.

INJURED WORKER INFORMATION:

Name:	Phone:		
Address:	City:	State:	Zip:
Occupation / Job Title:	Employment Status:		
Wage: Wage Period:	Daily ☐ Weekly ☐ Monthly ☐		
Full Pay for Day of Injury: Yes ☐ No ☐	Number of Days Worked per Week:		

EMPLOYER INFORMATION:

Business Name:	Phone:		
Employer Contact:	Phone:		
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:

INSURANCE INFORMATION:

Carrier:	Phone:		
Carrier Address:	City:	State:	Zip:
Claim Administrator:	Phone:		
Administrator Address:	City:	State:	Zip:
Policy / Self-Insured Number:	Jurisdiction Claim Number (JCN):		
Claim Administrator Claim Number:			

OCCURRENCE:

Date of Injury / Disease:	Time of Injury:	Date Employer Notified:
Nature:	Body Part:	Cause:
Last Day Worked:	Date Disability Began:	Date Returned to Work:
Fatality: Yes ☐ No ☐	Date of Death:	Date Administrator Notified:

Address of Occurrence:	City:	State:	Zip:

Premises: Employer's ☐ Other ☐ Description:

Accident Description:

Witnesses: Yes ☐ No ☐ If yes list their names and phone number:

For your protection, it is required by Utah Law to give notice that workers' compensation fraud is a crime. See next page for full fraud statement.

UTAH LABOR COMMISSION
Industrial Accidents Division

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 www.laborcommission.utah.gov

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INSTRUCTIONS TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER

This form is to be completed by the insurance carrier or self-insured employer within 14 days of the initial notice of the injury for all claims not being denied or investigated.

An insurance carrier or self-insured claim administrator has notice of a work injury upon receipt of verbal or written information that includes:

1. the name of the employer;
2. the name of the employee; and
3. the date of injury.

Notice may come from the employer, the injured worker, a medical provider, or the Industrial Accidents Division.

If the initial filing is to be a denial (form 089/MTC 04) or under investigation (form 441/MTC UI), please ensure that the required filing is processed within 14 days of notice as described above to avoid a penalty assessment pursuant to Utah Code Ann. §34A-2-407(8)(a).

Form 100 Injured Workers' Rights and Responsibilities must be sent by the insurance carrier/self-insured employer to the injured worker accompanying the initial report of injury filing (form 122C/MTC 00, form 089/MTC 04, or form 441/MTC UI).

Mandatory Reporting Requirements:

Injured Worker: Carrier must mail Form 122C to the injured worker on the same date the first report of injury or illness is submitted to the Division.

Labor Commission Filing: The first report of injury or illness on claims with a date of injury of December 31, 2012 and forward must be filed with the Labor Commission using EDI (MTC 00). Claims prior to this date may be filed using EDI or on paper form 122E and mailed, if preferred.

FRAUD WARNING:

Any person who knowingly presents false or fraudulent underwriting information, files, claim for disability compensation, medical benefits, health care fees, or other professional services are of guilty of a crime and may be subject to fines and confinement in state prison.

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