

MMTA WCT WCB-1 FROI Guidelines

Section One: Reason for Report

2a. Lost time- one or more days

If the employee is out of work because of the injury, OR if they were placed on modified duty restrictions and are out of work for any reason (related to the injury or not), please check off this box.

2b. Was employee paid for ½ day or more on day of injury

Check "yes" or "no". IF NO, please also check off box 2a as this would make this a lost time claim.

4. Medical/health care

If the employee went to a medical facility for treatment of this injury, please check off this box.

Section Two: Employer

8. State UIAN

If you do not have it, you can leave blank, MMTA has the number.

9. FEIN

If you do not have it, you can leave blank, MMTA has the number.

10. Employer name

11. Employer mailing address

12. Employer city mailing address

13. Employer state mailing address

14. Employer state mailing zip

15. Employer telephone

16. Nature/type of business

17. Employer address if different from mailing

18. Did injury occur on employer's premises?

Please check "yes" or "no". If no, please list the name and address of the location where the injury happened.

Section Three: Insurer

MMTA can fill this in. If you choose to fill it in:

Type of insurer: Self-Administered Employer

19. MMTA Workers' Comp Trust

20. Your policy number with the trust

21. Insurer file number

Please leave blank- MMTA will fill this in when a claim number has been assigned.

22-25. PO Box 5198, Augusta, ME, 04332

26. 207-623-1807

Section Four: Employee

27. Employee's full legal last name

28. Employee's full legal first name

Please do not use nicknames/shortened names

29. Employee's middle initial

30. Employee's personal telephone number

31. Employee's social security number

32. Employee's legal gender

33. Employee's mailing address

If they have a separate physical address, please let us know when you email the FROI

34. Employee's mailing city

35. Employee's mailing state

36. Employee's mailing zip code

37. Employee's date of birth

38. Employee's job title

39. Employee's date of hire

If an employee is seasonal, please use their original date of hire and let us know.

40. Employee's weekly wage at the time of injury

This can be an average, it does not need to be their exact pay amount for the week of injury.
Please do not enter an hourly rate, but a weekly gross amount (ex. \$850.00)

41. Does the employee work for another employer?

Please check "yes" or "no"- if yes, please list the name and address of any concurrent employers at the time of injury.

Section Five: Claim Information

42. Date of injury and date employer notified of injury.

For date employer notified of injury- this needs to be the first date the employee reported the injury to anyone in a supervisory role. The person completing the FROI may not find out until a later date, but if a supervisor knew about the injury at an earlier date, that is the date you need to use.

43. Date of incapacity and date employer notified of incapacity.

Incapacity refers to lost time. If any employee is out of work, please list the first day out. If they were not paid for more than ½ a day on the date of injury, the date of incapacity will be the same as the date of injury.

*Modified duty- If an employee is out of work for ANY reason at all (related or unrelated to the injury) and is on modified duty, we need to file lost time. If the employee is losing time from work because of unrelated reasons, we can deny the lost time portion.

For date employer notified of incapacity- this needs to be the first date anyone in a supervisory role knew the employee was out of work. The person completing the FROI may not find out until a later date, but if a supervisor knew about the lost time at an earlier date, that is the date you need to use.

44. Time employee began work

45. Date employer notified insurer

This is the date you are submitting the FROI to MMTA

46. Time of injury

47. Has the employee returned to work?

Please check "yes" or "no"

For medical only claims- if the employee continued to work their entire shift, or came back to work after getting medical treatment, you can enter the same date as the date of injury.

For lost time claims where the employee has not returned to work, check off "no" and leave the date field blank.

For lost time claims where the employee has returned to work- please enter the first day back to work after being out.

48. Specific injury or illness

Strain, fracture, burn, contusion, etc

49. Body part(s) injured

Back, wrist, knee, etc

50. All equipment, materials, chemicals employee was using when event occurred

Specific hand tool, powered tool, cleaning products, etc

51. Specific activity the employee was engaged in when the event occurred

Example: delivering product to customer, driving tractor trailer, stocking shelves, etc

Was the activity part of normal job duties- please check "yes" or "no"

52. How the injury or illness occurred

Please be specific with description. Please specify right/left for injured body parts (left shoulder, right knee, etc). The more details we have, the better.

53. Hospitalized overnight as inpatient?

Please check "yes" or "no".

54. Was the employee treated in an emergency room?

Please check "yes" or "no".

55. Health care provider

Please list the first medical facility they treated in.

56. Health care provider's mailing address

57. Health care provider's telephone number.

Section Six: Preparer Information

58. Preparer name and title

59. Preparer telephone number

60. Date sent to WCB

Please leave blank, MMTA will fill this in with the date we submit the FROI to the WCB.

*Once you have completed the FROI, please “save as” to your desktop and attach it in an email to bperkins@workerscompme.com.