Please complete all copies (type, if possible).

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Mail original and two copies to:

FARMERS INSURANCE GROUP OF COMPANIES
WORK COMP CLAIMS - W6
(888) 754-3260
(925) 416-0948 FAX
(925) 847-3141
P.O. BOX 5040
PLEASANTON, CA 94566

☐ **TRUCK INSURANCE EXCHANGE** ☐ **FARMERS INSURANCE EXCHANGE** ☐ **MID-CENTURY INSURANCE COMPANY**

OSHA Case No. _____

☐ Fatality

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported **immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1A. POLICY NUMBER
2. MAILING ADDRESS (Number and Street, City, Zip)
2A. PHONE NUMBER
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, Zip)
3A. LOCATION CODE
4. NATURE OF BUSINESS, e.g. painting contractor, wholesale grocer, sawmill, hotel etc.
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
6. TYPE OF EMPLOYER
☐ PRIVATE ☐ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DISTRICT ☐ OTHER GOVERNMENT - SPECIFY _____

DO NOT USE THIS COLUMN
Case No.
Ownership
Industry
Occupation

EMPLOYEE

7. EMPLOYEE NAME
8. SOCIAL SECURITY NUMBER
9. DATE OF BIRTH (mmddyy)
10. HOME ADDRESS (Number and Street, City, Zip)
10A. PHONE NUMBER
11. SEX ☐ MALE ☐ FEMALE
12. OCCUPATION (Regular job title — NO initials, abbreviations or numbers)
13. DATE OF HIRE (mmddyy)
14. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours
14A. EMPLOYMENT STATUS (check applicable status at time of injury) _____ regular full-time _____ part-time _____ temporary _____ seasonal
14B. Under what class code of your policy were wages assigned?
15. GROSS WAGES/SALARY $ _____ per _____
16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES $ _____ per _____ ☐ NO

Sex
Age
Daily hours
Days per week
Weekly hours

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mmddyy)
18. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M
19. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.
20. IF EMPLOYEE DIED, DATE OF DEATH (mmddyy)
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
22. DATE LAST WORKED (mmddyy)
23. DATE RETURNED TO WORK (mmddyy)
24. IF STILL OFF WORK CHECK THIS BOX ☐
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
26. SALARY BEING CONTINUED? ☐ YES ☐ NO
27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mmddyy)
28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mmddyy)
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
30A. COUNTY
30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.
32. OTHER WORKERS INJURED IN THIS EVENT? ☐ YES ☐ NO
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.
35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.

Weekly wage
County
Nature of injury
Part of body
Source
Event
Sec. Source
Extent of injury

36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, Zip)
36A. PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, Zip)
37A. PHONE NUMBER

Completed by (type or print)	Signature	Title	Date

FORM 5020 (REV.6) 1992

23-1289 1-02 1101

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY