# Workersâ€™ Compensation Coordination of Health Benefits Form

## Employee Information

Employee Name

Date of Birth

Phone Number

Address

City

State

Zip Code

Employee ID

Social Security Number

## Workersâ€™ Compensation Information

Date of Injury/Illness

Claim Number

Employer Name

Employer Contact

## Health Insurance Information

Primary Health Insurance Carrier

Policy/Group Number

Subscriber Name

Relationship to Employee

## Details Regarding the Illness or Injury

Description

## Coordination Information

Have you filed a workersâ€™ compensation claim for this injury/illness?

If no, reason for not filing

Employee Signature

Date