Appendix W. PACIFIC INDEMNITY INSURANCE COMPANY WORKERS COMPENSATION

348 W. O'BRIEN DRIVE HAGATNA, GUAM 96910 Tel: (671) 477-8801/2 * Fax: (671) 477-6290

INSTRUCTIONS: This form may be used by the Employer to report an injury or illness. Pacific Indemnity Insurance Company requires the Employer to report to Actouka Executive Insurance Underwriters within ten (10) days from the date of knowledge of injury/illness. Failure or refusal to file this report may subject the Employer to coverage denial under the WC policy. PLEASE PRINT OR TYPE

the Employer to coverage denial under the \		YPE.	refusal to the this report may subject				
Name of injured Employee, DOB & SSN:		2. Name of Employer & EIN:					
3. Employee's address & telephone no: ()	4. Employer's address & Telephone no.: ()					
5. Date & time of alleged injury/illness:		Date of Employer's first knowledge of injury:					
7. Date & hour Employee first lost time because	ause of injury/illness:	Date & hour Employee returned to work:					
9. Date & hour pay stopped:		Days usually worked per week (x days): S M T W TH F S Average hours per week:					
11. Employee's occupation:		12. Employee's wages/earnings (overtime, etc):					
13. Is another person not of your employme		a. Hourly: \$	b. Weekly: \$				
	nd how it happened. Name any o	events, which resulted in the injury/illness. To be presented and tell how the equired and attach to this report.					
15. NATURE OF INJURY/ILLNESS (Name	part of body affected - fractured le	eg, bruised arm, lacerated finger, etc) Note a	ny amputations.				
16. Has medical attention been authorized?	17. Date authorized:	18. Has insurance carrier been notified?	19. Date notified:				
[] YES [] NO 20. Name of treating physician:		[] YES [] NO 21. Name of insurance carrier:					
20. Name of freating physician.		21. Name of insurance carrier.					
22. Name of treating facility:		23. Name & signature of person completing report:					
24. Title of person completing report:		25. Date of this report:					
	FOR STATISTICA	L PURPOSES ONLY					
Please choose ONE ETHNICITY:		Please choose ONE CITIZENSHIP:					
Yapese Marshallese Chuukese Palauan Kosraean Chamorro	African American Japanese Chinese	United States Permanent Resident Alien Other (specify):					
Pohnepian Filipino Korean Other (specify):	American	Strict (specify).					

Form GWC-202: EMPLOYER'S REPORT of OCCUPATIONAL INJURY or ILLNESS (Revised 01/2004)

A FLIFAIT CODE											
A. EVENT CODE 01 Fatality				02 No Time Loss				03 Time Loss			
	005										
B. NATURE OF INJURY C 01 Amputation	ODE			08 Disease/	/Illness		15 (Hearing Loss			
02 Asphyxia			09 Dislocation				16 Hernia				
03 Bruise/Contusion/Abrasion			10 Electric Shock				17 Poisoning (Systemic)				
04 Burn (Chemical)			11 Exertion				18 Puncture				
05 Burn (Heat)			12 Foreign Body in Eye/Conjunctivitis				19 Radiation Effects				
06 Concussion 07 Cut/Laceration/Puncture			13 Fracture 14 Freezing/Frostbite				20 Strain/Sprain 21 Other (Specify)				
C. BODY PART CODE L	 	HT	Thumb		14	15	Crost Tax		24	1 25	
Abdomen Ankle(s):	01 02	03	Thumb Fingers I	ndex-Small	14	15	Great Toe Toes		34	35	
Back	04		(First-Fou		16 17 18 19	20 21 22 23	(First-Fourth)		36 37 38 39	40 41 42 43	
Body	05		`	,			(33.30.01)				
System	06		Wrist		24	25	Ankle		44	45	
Chest	07		Hand		26	27	Foot		46	47	
Head	08		Elbow		28	29	Knee		48	49	
Ear(s)	09	10	Arm		30	31	Leg		50	51	
Eye(s)	11	12	Shoulde	r	32	33	Hip(s)		52	53	
Face	13										
D. TYPE OF EVENT CODE											
01 Absorption				05 Fall (San	ne level)		10 F	10 Rubbed/Abraded			
02 Bite/Sting/Scratch				06 Fall (From elevation)			11 9	11 Shock			
03 Cardio-Vascular/Respiratory			07 Ingestion				12 Struck Against				
System Failure			08 Inhalation				13 Struck By				
04 Caught In or Between			09 Repeated Motion/Pressure				14 Other (Specify)				
E. SOURCE INJURY CODE											
01 Aircraft				15 Electrical Apparatus/Wiring				29 Metal Products			
02 Air Pressure				16 Explosives				30 Motor Vehicle (Highway)			
03 Animal/Insect/Bird/Reptile/Fish				17 Fire/Smoke				31 Motor Vehicle (Industrial)			
04 Boat				18 Food				32 Motorcycle			
05 Bodily Motion				19 Furniture/Furnishings				33 Person			
06 Boiler/Pressure Vessel				20 Gases				34 Petroleum Products 35 Pump/Prime Motor			
07 Boxes/Barrels, Etc.				21 Glass				35 Pump/Prime Motor 36 Radiation			
08 Buildings/Structures 09 Chemical Liquid/Vapor				22 Hand Tool (Manual) 23 Hand Tool (Powered)				37 Vegetation			
10 Cleaning Compound				23 Hand Tool (Powered) 24 Heat (Environmental/Mechanical)				38 Waste Products			
11 Cold (Environment/Mechanical)				25 Hoisting		citatiicai)		Waste Produc Water	· ·		
12 Dirt/Sand/Stone			26 Ladder				40 Weapons				
13 Drugs/Alcohol				27 Machine	e			41 Working Surface			
14 Dust/Particles/Chips			28 Materials Handling Equipment				42 Other (Specify)				
. CONTRIBUTING ENVI	RONMENT	AL FACTO	R CODE								
01 Catch Point/Pointer Action						10 Pinch Point Action					
02 Chemical Action/Reaction Exposure						11 Radiation Condition					
03 Flammable Liquid/Solid Exposure						12 Shear Point A	ction				
04 Flying Object Motion						13 Sound Level					
05 Gas/Vapor/Mist/Fume/Smoke/Dust Condition						14 Squeeze Point					
06 Illumination						15 Temperature			rel		
07 Materials Handling Equipment/Method						16 Weather/Earthquake, Etc. Condition					
08 Overhead Moving and/or Falling Object Action 09 Overpressure/Under pressure Condition						17 Working Surface/Facility Layout Condition 18 Other (Specify)					
6. TASK ASSIGNMENT C	ODF				•						

Form GWC-202: EMPLOYER'S REPORT of OCCUPATIONAL INJURY or ILLNESS (Page 2): Rev 01/2004