Alabama Retail Comp
PO Box 240549 • Montgomery, AL 36124
(t) (800) 239-5423 • (f) (334) 263-1976
claims@alabamaretail.org
alabamaretailcomp.org

CLAIMANT QUESTIONNAIRE

PERSONAL INFORMATION

1. Full Name: _____
2. Maiden Name (if applicable): _____
3. Nickname or Name Goes By: _____
4. Social Security Number: _____ Driver's License No. & State: _____
5. Date of Birth: _____ Age: _____
6. Mailing/Street Address (Include City, State, Zip):

   _____

   _____
7. Home Phone: _____ Cell Phone: _____
8. Email Address: _____
9. Are your right or left-handed? Left ☐ Right ☐
10. Height: _____ Weight: _____
11. Do you have personal health insurance? Yes ☐ No ☐

    If yes, with who? _____
12. Do you receive Medicare Benefits? Yes ☐ No ☐

    If yes, as of what date? _____

OCCUPATION

13. What is the date you were hired? _____
14. Who is your direct supervisor/manager? _____
15. What is your hourly rate of pay? _____
16. How many hours per week do you work? _____
17. Are you a full-time or part-time employee? Full-time ☐ Part-time ☐
18. Are you allowed board, lodging, or other advantages besides your wages? Yes ☐ No ☐

    If yes, please explain: _____

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INJURY / ACCIDENT

19. Date of Accident/Injury: _____ Time of Accident/Injury: _____
20. When did you first report the accident/injury to your employer/supervisor? _____
21. To whom did you report this accident/injury? _____
22. Were you doing your regular job when injured? Yes ☐ No ☐
23. Were you on your employer's premises or at his job site when the injury/accident occurred? Yes ☐ No ☐

    If no, please provide the address where you were injured and a description:
    (Example: Customer's home at 123 Main Street, Ourtown, AL)

    _____
24. Describe fully what you were doing and how this injury/accident occurred:

    _____

    _____

    _____
25. Describe fully and give the exact body part, right or left, and type of injury:
    (Example: Strained lower back, sprained right ankle)

    _____
26. Have you returned to work? Yes ☐ No ☐ If yes, what date did you return: _____

TREATMENT

27. Did you treat at a hospital emergency room? Yes ☐ No ☐

    If yes, which hospital? _____
28. Are you still receiving treatment? Yes ☐ No ☐
29. What is the name of your current doctor or clinic? _____
30. Did you or your employer select your current doctor? _____
31. Date of first doctor's visit with current doctor: _____ Date of last doctor's visit: _____
32. What is the name and phone number of your current pharmacy? _____

    _____

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MISCELLANEOUS

33. Name(s) and phone number(s) of witness(es) to this injury/accident:

_____ _____

_____ _____

_____ _____

34. Did someone other than yourself cause your injury or accident? Yes ☐ No ☐
(Example: car accident, machine malfunction)

35. Have you ever received medical care for the above injured body part(s)? Yes ☐ No ☐

If yes, when and with whom: _____

36. Have you ever filed any previous workers' compensation claims? Yes ☐ No ☐

If yes, please provide employer's name and body part(s) injured: _____

_____

37. Do you currently take any of the following medications that were not prescribed for this injury? If yes, please list and provide the prescribing doctor's name:

Yes ☐ No ☐

☐ Pain Medications: _____

☐ Muscle Relaxers: _____

☐ Anti-Inflammatories: _____

Please sign and date below if you have understood all questions on this questionnaire and if your answers have been true to the best of your knowledge.

_____ _____

Signature Date

Return completed forms: Email to claims@alabamaretail.org
Fax to (334) 263-1976
Mail to Alabama Retail Comp
PO Box 240549
Montgomery, AL 36124-0549