How to File a First Report of Injury

This guide is for members who do not use the FROI Administration application.

Start here: tasbrmf.org/claims

TASB RISK FUND

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Report a Claim

If you need immediate assistance, please call 800.482.7276. Calls are answered 24/7, including after hours and on the weekends. If you call outside of business hours, our answering service will contact an adjuster and you will receive a call within one hour.

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Workers' Compensation claims

First Report of Injury

- Program administrators who do not use the FROI Administration application, or
- Campuses and departments who need to report an employee injury to their organization's workers' compensation program administrator:

First Report of Injury WC Claim

Please type in your organization below to report a worker's compensation First Report of Injury

Organization

Type In Your Organization Here

Report a WC Claim

Type your organization into the search bar, and then click here.

First Report of Injury guides

- How to File a First Report of Injury (PDF)
- How to File a First Report of Injury for Campus or Department (PDF)
- FROI Administration Guide (PDF)

myTASB Access

myTASB You must have a myTASB user ID and password to access some resources. If you need access, speak with your program contact —the person in your organization responsible for granting user rights. For more information, visit our myTASB Access page.

Your Marketing Consultant

Want to know more about what the Fund can do for you?

Your marketing consultant can connect you to experts on training, loss prevention resources, and additional programs that can lower your exposure to risk.

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Reporting a Claim

Log Out and Exit

What you will need:

- Basic information about what happened, including date, location, etc.
- Additional details about the employee who was injured, such as name, address, and wage information

What you should know:

- The reporting form will timeout after 120 minutes of inactivity.
- You can find detailed instructions on how to report a workers' compensation claim in this guide.

When you are finished filling out the First Report of Injury (FROI) on the next page, be sure to click on the "Save Changes" button at the top of the page to submit to TASB.

Start a FROI

Click here to get started.

Chat now

Please note that all boxes marked with a red asterisk (*) are **mandatory**. As you work on the form, ensure all required boxes are completed and contain correct information.

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Employer General Information

Member	Education ISD		
Physical Address	123 1st Street	Mailing Address	PO Box 123
City	Your City	City	Your City
State	Texas	State	Texas
ZIP	00000	ZIP	00000
FEIN	12345678		
Phone	(123) 456 7890		

Is this a corrected copy? *

Select "Yes" if you have already submitted a claim for this incident and need to update any information or if you are submitting a FROI on an already-created claim.

Insured Report Number

Location *

Did injury or illness exposure occur on employer's premises?

If your organization uses employee numbers, you may enter the injured employee's number here. If not, leave this blank.

Click on the magnifying glass to select the applicable location from the list.

If the injury occurred off campus, select "No" and enter the address of the injury in a box that will appear to the right.

Insured Report Number

Location *

Did injury or illness exposure occur on employer's premises? No

Address where Injury/Illness Occurred

Since you selected Injury did not occur on employer's premises, please complete the accident address fields to the right.

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Employee Information

Field	Value
Claimant *	,
First Name *	
Middle Name	
Last Name *	
Street Address 1 *	
Street Address 2	
City *	
State *	Texas
ZIP *	#####-####
Phone *	(xxx) xxx-xxxx
Work Phone	(xxx) xxx-xxxx
Employee Email	
Does the employee speak English?	
Birth Date *	MM/DD/YYYY
Social Security ⓘ *	###-##-####
Other Employee ID	
Other Employee ID Qualifier	
Hire Date *	MM/DD/YYYY
Length of Service Years	0
Length of Service Months	
Hire State *	Texas
Gender *	
Marital Status *	
Occupation/Job Title *	
Payroll Class Code *	
Occupation Code *	
Department Code, if applicable	
Employment Status *	Regular/Full-time Employee
Number of Dependents	

Enter the employee's first and last names in these boxes. The names will populate the Claimant box above.

Enter complete employee contact information.

When you see this sign, you can hover over it for more information about its corresponding field.

Complete all required fields of employee information.

Enter employee's job title and select the employee's appropriate payroll and occupation categories from the dropdown lists.

Please select either regular/full-time or part-time.

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Wages

Wage Rate *

Wage Rate Type *

Days Worked Per Week * 5

Hours Worked per Week

Full Pay On Day Of Injury Yes

Did Salary Continue?

Gross Amount of Last Paycheck

Type of Pay

Has employee elected to use state, sick or vacation leave in lieu of temporary income benefits?

If so, how many leave hours have they elected to use?

Complete all mandatory wage information fields with accurate information.

Please make every effort to complete this information. Always alert the claim department **immediately** if the employee has elected to use paid leave for any absences.

Occurrence Information

Date of Injury/Illness * MM/DD/YYYY

Time Employee Began Work 12:00PM

Time of Injury or Illness Exposure * 12:00PM

Date Employer Notified * MM/DD/YYYY

Has the employee lost time or expected to lose time from work?

Was the injury or illness exposure fatal?

Employee's Supervisor

Supervisor Phone Number (xxx) xxx-xxxx

Type of Injury/Illness *

Part of Body Affected *

Cause of Injury *

Enter the time and date of injury.

This is the date the secretary, principal, nurse, or supervisor first knew of incident.

Click the magnifying glasses to select the employee's injury, affected body part, and cause of injury from the lists. You can also type the employee's injury/body part or its corresponding code number into the search bar and select from the dropdown lists.

Note: These are national, standardized codes. Choose the option that best matches your incident.

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Worksite location of injury ⓘ

Was employee doing their regular job?

Examples include walking, cleaning, or cooking.

Specify activity the employee was engaged in when the injury or illness exposure occurred *

How did the injury or illness exposure occur? ⓘ *

For example, employee slipped on wet floor in hallway while walking and fell on both knees

Briefly explain how the injury occurred. Be concise and to the point. **Specify body part(s) and exact location and side of body.** If you need more space to complete injury description, use the "All Other Information" box at the end of this form.

Is the employee seeking or expected to seek medical treatment? *

Type of Claim ⓘ *

Record Only is for no medical treatment, no lost time, and no questions or concerns.
Medical Only is for initial medical and/or no more than 5 days of lost time.
Lost Time/Indemnity is for ongoing medical treatment and/or lost time and all other.

Treatment Information

Medical Provider

Physician/Hospital Name

Address

City

State

ZIP: #####-####

Phone: (xxx) xxx-xxxx

Fax: (xxx) xxx-xxxx

Enter doctor/hospital information if known. This is not a mandatory field. Don't worry about inputting addresses.

Initial Treatment *

This field is mandatory. Select the appropriate option from the dropdown list.

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Other Information

Date Administrator Notified MM/DD/YYYY

Date Prepared * MM/DD/YYYY

Preparer's Name *

Preparer's Title *

Preparer's Phone * (xxx) xxx-xxxx

E-mail address to receive confirmation ⓘ

Witness

Witness Phone # (xxx) xxx-xxxx

All Other Information

This is the date that the location notifies administration.

Don't forget to enter your email address so you can get confirmation of claim submission.

Please list any known witnesses and their contact information. Do not include student names.

You can use this space to enter additional information about this incident if necessary.

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New First Report of Injury — Complete Incident or Cancel

Employer General Information

Member	Abbott ISD		
Physical Address	219 S First St	Mailing Address	PO Box 226
City	Abbott	City	Abbott
State	Texas	State	Texas
ZIP	76621	ZIP	76621-0226
FEIN	746000001		
Phone	(254) 582-3011		
Is this a corrected copy? *	No		
Insured Report Number			
Location *	ADMINISTRATION (Main Memb		
Did injury or illness exposure occur on employer's premises?			

Employee Information

After you've filled out all the required fields, click here to submit the FROI to the TASB Risk Management Fund.

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New First Report of Injury

live.origamirisk.com says

Are you ready to complete this incident?

OK Cancel

Complete Incident or Cancel

Employer General Information

Member	Education ISD		
Physical Address	123 1st Street	Mailing Address	PO Box 123
City	Your City	City	Your City
State	Texas	State	Texas
ZIP	00000	ZIP	00000
FEIN	12345678		
Phone	(123) 456 7890		

Is this a corrected copy

Insured Report Number

Location * ADMINISTRATION (Main Memb

Did injury or illness exposure occur on employer's premises?

Click Ok

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Upload Claim File Documentation

Save Successful

Please upload any relevant documentation such as videos, photos, passenger lists, police reports, damage estimates, medical, or legal notices. Otherwise, you've provided enough information for us to begin processing. Click I'm done below to finish reporting your claim. If submitting a First Report of Injury (FROI), it has been sent to your TASB FROI Administrator for review. To download a copy of the FROI, use your browser's refresh button to display a link.

#1 Doe, John (EV2020004582-1) Upload File

No files uploaded.

I'm done or Click here to exit

Congratulations! You have successfully completed your FROI. If you want a PDF copy of your report, refresh your browser and a link will appear.

TASB RISK FUND

Upload Claim File Documentation

Please upload any relevant documentation such as videos, photos, passenger lists, police reports, damage estimates, medical, or legal notices. Otherwise, you've provided enough information for us to begin processing. Click I'm done below to finish reporting your claim. If submitting a First Report of Injury (FROI), it has been sent to your TASB FROI Administrator for review. To download a copy of the FROI, use your browser's refresh button to display a link.

#1 Doe, Jane (20200005506) Upload File

Filename	Description	Folder	Entry Date
EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS CLAIM.pdf	FROI DWC-01	Claims	12/07/2020 12:06 PM

Click here to download a copy of the FROI to give to the employee.

I'm done or Click here to exit

When you're ready, click here to exit the application.

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You will receive a confirmation email upon submitting your claim. Once it is processed, you will receive an email with your adjuster information that looks like this:

From: tasbriskfundnotices@tasb.org <tasbriskfundnotices@tasb.org>
Sent: Monday, December 7, 2020 1:09 PM
To: member@isd.org
Subject: Claim Assignment

The First Report of Injury or Illness (FROI) for Stephanie Howard with date of injury of 12/1/2020 has been processed. The claim number and adjuster assigned to the claim are:

Claim #: 20200005510
Claimant: Jane Doe
Employer: Education ISD
Date of injury: 12/1/2020

Adjuster name: John Smith
Adjuster phone: 123.456.7890
Adjuster email: john.smith@educationisd.org

If you have any questions or concerns, please contact the assigned adjuster at 800.482.7276 x2982 for assistance.

For any questions about reporting a workers' compensation claim, please contact **Laura Romaine** at 800.482.7276, x2845.

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