FORT HAYS STATE UNIVERSITY
Forward thinking. World ready.

State Self Insurance Fund
Work-Related Injuries
(Employee Claim Form)

Employees must report the work-related injury to their supervisor as soon as possible. A delay in reporting may cause the claim to be denied. The injured employee's supervisor is responsible filing the claim through the SSIF portal: https://kansas.systemasoft.com/Sims/PortalNew.aspx?insurancelineid=1. (Supervisors – after submitting this information in the portal, please send this form to the Human Resource Office.)

GENERAL

Date of Injury/Illness _____ Agency Number: S-246

EMPLOYEE

Employee Name _____
(First) (MI) (Last)

DOB _____ Gender ☐ Male ☐ Female

SSN (Verbally provide this information to your supervisor) Employee ID# _____

Physical Address _____
(Address) (City) (State) (Zip)

Mailing Address _____
(Address) (City) (State) (Zip)

Separate Mailing Address? ☐ Yes ☐ No Employee E-mail _____

Employee Work Phone _____ Employee Mobile Phone _____

Employee Home Phone _____

EMPLOYMENT

Date of Hire _____ Hours per Day _____ Days per Week _____

Supervisor's Name _____

Supervisor's Work Phone _____ Supervisor's E-mail _____

(Continue to page 2)

LOSS OF LIFE

Death Result of Injury? ☐ Yes ☐ No Date of Death _____

Marital Status _____ Number of Dependents _____

OCCURRENCE

Time Employee Began Work _____ Time Injury/Illness Occurred _____

Date Supervisor/Employer Notified _____ Body Part (primary if multiple) _____

Accident Premises _____ Cause of Injury _____

Nature of Injury _____

Description of How Injury/Illness Occurred _____

_____

_____

Injury Address _____
(Address) (City) (State) (Zip)

Witness Name (if applicable) _____ Witness Phone # _____

TREATMENT

Medical Treatment Sought? _____
(No Treatment; Minor Clinic; Emergency Room; Hospitalization; Minor On-Site; Future Major Medical)

SSIF Prior Medical Approval ☐ Yes ☐ No

Physician Name _____
(First) (MI) (Last)

Physician Address _____
(Address) (City) (State) (Zip)

Hospital Name _____