

Worker Start Here (Select one)

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## SELF INSURER ACCIDENT REPORT (SIF-2)

UBI

**578,037,394**

Risk Class

CLAIM NUMBER

Business name of self insured employer

**KING COUNTY**

Name of injured employee (First, middle, last)

Employee's home phone

Employer's address

**500 - 4th Ave, Ste 500**

Mailing address

Employer's phone number

City

**SEATTLE**

State

**WA**

ZIP

**98104**

City

State

ZIP

Social security number

Dependent Children: Include unborn, estimate birthdate. Benefits will be based, in part, on number of legally dependent children. Please indicate custody status of each child.

Family Status  
(Select one)

Sex

Date of birth

Height

Weight

**DRAFT**

**DRAFT**

**INFORMATION ONLY**

**VOID**

**VOID**

**INFORMATION ONLY**

**INFORMATION ONLY**