

***APPENDIX “E”***  
***RICHLAND COUNTY***  
***Worker’s Compensation Accident***  
***Identification Card***

Claimant Name:		Employer Name:	
Accident Date:	Time:	Accident Number:	
Adjuster Name:			
Adjuster Address:		City/State:	Zip Code:
Adjuster Contact Number(s):			

**Possession of this card does not suggest the claim has been accepted by the above Worker's Compensation insurer. However, all bills and reports relating to the accident should be submitted to the adjuster listed above.**

**For Worker's Compensation Claims, Contact:**

MACO Claims Dept.  
P.O. BOX 7059  
Helena, MT 59604