#### **WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS**

	Employer (Name & Address Including Zip)					Carrier/Administration Claim Number			Repor	Report Purpose Code			
Employer's Location Address (if different)							Juris	ediction	Jurisdiction Claim Number				
Since   Employer FEIN   Priors #   Policy Period   Clams Administrator (Name, Address, Priore No)   Priors #   Policy Period   Clams Administrator (Name, Address, Priore No)   Priors #   Policy Period   Priors #   Pri							Insured Report Number KY						
Policy Period   Claims Administrator   Name						Employer's Location Address (if different)				Location #			
Policy Period Congress Mutual Inc. Longing Frace (Paris Certific Social Security No.   Claim Administrator (Name, Address, Prione No)   Claim Administrator FEIN   Claim Administrator FEIN   Claim Administrator FEIN   Administrator FEIN   Administrator FEIN   Administrator FEIN   Claim Administrator FEIN   Claim Administrator FEIN   Administrator FEIN   Administrator FEIN   Administrator FEIN   Administrator FEIN   Claim Administrator FEIN   Administrator FEIN   Administrator FEIN   Claim Administrator FEIN   Administrator FEIN   Administrator FEIN   Administrator FEIN   Claim Administrator FEIN   Administrator FEIN   Claim Administrator FEIN   Administrator FE	SIC Code	Employer FEIN								Phone #			
Leangach Financial Center 2007. Main stress: Sales 90 0  Chack If Appropriate   Sales (389) 425-782   Carrier FEIN	Carrier/Claims Adminis	trator									1		
To Control (Asia) Solor (Asia)		ual Ins.					Poli	cy Period	Claims	Administrato	(Name,	Address, Phone No)	
Losington (KY 40507   Telephone (Sp.) 425-7802   Chock if Appropriate   Self Insurance		00						<b>-</b>					
Tolephone: (869) 425-7802  Carrier FEIN  Policy/Self-Insured Number    Carrier FEIN   Policy/Self-Insured Number   Policy/Self-Insur		00						10					
See   Insurance   See   Insurance   Administrator FEIN									_				
Agent Name & Code Number  Agent Name & Code Number  Name (Last, First, Middle)  Date of Birth  Social Security No.  Date of Birth  Address (include ZIP)  Date of Birth  Social Security No.  Date of Birth  Address (include ZIP)  Date of Birth  Dat	Fax: (859) 425-7822												
Date of Birth   Social Security No.   Date Hired   State of Hire	Carrier FEIN	arrier FEIN Policy/Self			elf-Insured Number					Administrator FEIN			
Date of Birth   Social Security No.   Date Hired   State of Hire	Agent Name & Code Number	er											
Date of Birth   Social Security No.   Date Hired   State of Hire	Employee												
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P. Fernale	Address (include ZIP)									Occupation/Job Title			
Du - Unknown				-	□ IVI – IVIAIE		-						
Phone ### of Dependents   # of Dependents   # of Dependents   K - Unknown   NCCI Class Code      Wage					☐ F - Female		_	l		Employment Status			
Rate					☐ U - Unknown			ivi - iviamed	Linploy	mem otatus			
Wage   Per				-				S - Separated					
Wage   Per	Phone			# 01	f Denenden	ite	┨┌	K - Unknown	NCCLC	lass Code			
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Week   Other   Other   Other   Trime Employee   AM Began Work   PM Date of Injury/Illness   Time of Occurrence   AM Began Work   PM Date of Injury/Illness   Time of Occurrence   AM Began Work   PM Date of Injury/Illness   Time of Occurrence   AM Began Work   PM Date of Injury/Illness   Time of Occurrence   AM Date Employer Notified   Date Disability Began   Date Injury/Illness   Part of Body Affected	Rate		ay 🗆	Mont	h		# D	ays Worked/Week	Full	Pay for Day	of Injury?	Yes No	
Time Employee AM Date of Injury/Illness Time of Occurrence AM Date Employer Notified Date Disability Began    Date Employer Notified Date Disability Began			Veek	Othe	r				Did	Salary Conti	nue?	☐ Yes ☐ No	
Did Injury/Illness exposure occur on employer's premises? Type of Injury/Illness Code Part of Body Affected  Did Injury/Illness exposure occur on employer's premises? Type of Injury/Illness Code Part of Body Affected Code    Yes											_		
Contact Name/Phone Number		Date of Inju	ury/Illness	Tim	ne of Occuri			Last Work Date	Date Er	nployer Notifi	ied Da	ate Disability Began	
Did Injury/Illness exposure occur on employer's premises?    Type of Injury/Illness Code	Began Work ☐ PIVI					ш	PIVI						
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Department or location where accident or illness exposure occurred  All equipment, materials, or chemicals employee was using when accident or illness exposure occurred  Specify activity the employee was engaged in when the accident or illness exposure occurred  Work process the employee was engaged in when accident or illness exposure occurred  How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill  Date Returned to Work If Fatal, Give Date of Death Were Safeguards or Safety Equipment Provided? Yes No Were they Used? Initial Treatment Initial Treatment No Medical Treatment Initial Treatment	Contact Name/Phone Numb	per					Type of Injury/Illness Pa			'art of Body Affected			
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Date Returned to Work	exposure occurred												
Date Returned to Work	How injury or illness/abnorm	nal health conditi	on occurre	ed. Des	cribe the se	equence of	f even	ts and include any objects or s	ubstances	that	Cause	of Injury Code	
Were they Used?  Physician/Health Care Provider (Name & Address)  Hospital (Name & Address)  Hospital (Name & Address)  Initial Treatment  O No Medical  Treatment  I Minor by Employer  2 Minor Clinic/Hosp  3 Emergency Care  4 Hospitalized>24 Hrs  5 Future Major Medical/  Lost Time Anticipated  Witnesses (Name & Phone #)  Date Admin/Carrier  Date Prepared  Preparer's Name & Title	directly injured the employee	e or made the en	nployee ill	I									
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O No Medical Treatment   1 Minor by Employer   2 Minor Clinic/Hosp   3 Emergency Care   4 Hospitalized>24 Hrs   5 Future Major Medical/ Lost Time Anticipated      Witnesses (Name & Phone #)   Date Admin/Carrier   Date Prepared   Preparer's Name & Title   Phone Number   Phon							Wer	e they Used?			☐ Yes	s 🔲 No	
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Phone Number	williesses (Name & Phone									1			
		Date Prepared	'   '	Prepare	rs Name &	Phone Number							

## FORM IA-1 SEE BACK FOR IMPORTANT INFORMATION & SIGNATURE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. Reprinted with permission of the IAIABC (as modified by and for KEMI).

# EMPLOYER'S INSTRUCTIONS DO NOT ENTER DATA IN SHADED FIELDS

#### DATES:

Enter all dates in MM/DD/YY.

#### SIC CODE:

This is the code that represents the nature of the employer's business that is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

#### **CARRIER:**

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer or the claimant.

#### **CLAIMS ADMINISTRATOR:**

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

### **AGENT NAME & CODE NUMBER:**

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

#### **OCCUPATION/JOB TITLE:**

This is the primary occupation of the claimant at the time of the accident or exposure.

#### **EMPLOYMENT STATUS:**

Indicate the employee's work status. The valid choices are: Full-Time, Not Employed, Disabled, Unknown, Apprenticeship Part-Time, Seasonal, Part-Time, On Strike, Retired, Apprenticeship Full-Time, Volunteer, and Piece Worker.

#### DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwise designated by the statute.

#### CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

## **TYPE OF INJURY/ILLNESS:**

Briefly describe the nature of the injury or illness, (e.g. Lacerations to the forearm).

#### PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (e.g. Right forearm, lower back).

#### DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210) If the accident or illness exposure did not occur on the employer's premises, enter the address or location. Be specific.

## ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSRE OCCURRED:

(e.g., Acetylene cutting torch, metal plate)

List all equipment, materials and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

## SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g., Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation of painting.

## WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g., walking along a hallway).

## HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK: Enter the date following the most recent disability period on which the employee returned to work.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. Reprinted with permission of the IAIABC (as modified by and for KEMI).

Employee Signature:		DATE:
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