IA-1 WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)		Carrier/Administrator Claim Number	Report Purpose Code
		Jurisdiction	Jurisdiction Claim Number
		Insured Report Number	
		Employer's Location Address (if different)	Location No.
Sic Code	Employer FEIN		Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)		Policy Period	Claims Admin (Name, Address & Phone Number)
		To	
		☐ Check if self insured	
Carrier FEIN	Policy Number or Self-Insured Number		Administrator FEIN
Agent Name & Code Number			

Employee/Wage

Legal Name (Last, First, Middle)	Date of Birth	Social Security Number	Date Hired	State of Hire
Address (Incl. Zip)	Sex: ☐ Male ☐ Female ☐ Unknown	Marital Status: ☐ Unmarried/ Single/Div. ☐ Married ☐ Separated ☐ Unknown	Occupation/Job Title	
			Employment Status	
Phone	No. of Dependents		NCCI Class Code	
Wage Rate $	☐ Day ☐ Month	# Days Worked/WK	Full Pay for Date of Injury?	☐ Yes ☐ No
	☐ Week ☐ Other	# Hrs Worked per Day	Did Salary Continue?	☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM	Date of Injury or Illness	Time Occurred ☐ AM ☐ PM	Last Work Date	Date Employer Notified	Date Disability Began

Employer Contact Name/Phone Number	Type of Illness/Injury	Part of Body Affected
Did Injury/Illness Exposure Occur on Employer's Premises? Yes ☐ No ☐	Type of Illness/Injury Code	Part of Body Affected Code

Department or location where accident or illness exposure occurred	All Equipment, Materials, or Chemicals Employee was using when accident or illness exposure occurred.
Specific 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.	Cause of Injury Code

Date Returned to Work	If Fatal, Date of Death	Were Safeguards or Safety Equipment Provided?	☐ Yes ☐ No
		Were they used?	☐ Yes ☐ No

Treatment

Physician/Health Care Provider (Name & Address)	Hospital (Name & Address)	Initial Treatment
		0 ☐ No Medical Treatment 1 ☐ Minor: By Employer 2 ☐ Minor Clinic/Hosp 3 ☐ Emergency Care 4 ☐ Hospitalized > 24 hr. 5 ☐ Future Major Medical/Lost Time Anticipated

Other

Witness to Accident (Name & Phone Number)			
Date Administrator Notified	Date Prepared	Preparer's Name & Title	Preparer's Phone Number

IA-1 (2/95)	**SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE**

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