

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL. ZIP) <p style="text-align: center;">UNIVERSITY OF LOUISVILLE</p>				CARRIER/ADMINISTRATOR CLAIM NUMBER				REPORT PURPOSE CODE									
SIC CODE				EMPLOYER FEIN				INSURED REPORT NUMBER									
JURISDICTION				JURISDICTION CLAIM NUMBER				EMPLOYER LOCATION ADDRESS (IF DIFFERENT) <p style="text-align: center;">SCHOOL OF EDUCATION</p>									
LOCATION #				PHONE # 852-XXXX													
CARRIER/CLAIMS ADMINISTRATOR																	
CARRIER (NAME, ADDRESS, & PHONE NO.)						POLICY PERIOD <p style="text-align: center;">TO</p>			CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO.)								
CHECK IF APPROPRIATE						SELF INSURANCE											
CARRIER FEIN				POLICY/SELF-INSURED NUMBER				ADMINISTRATOR FEIN									
AGENT NAME & CODE NUMBER																	
EMPLOYEE/WAGE																	
NAME (LAST, FIRST, MIDDLE) JONES, JAN J				DATE OF BIRTH 1/1/71		SOCIAL SECURITY NUMBER XXX-XX-XXXX		DATE HIRED 1/1/81		STATE OF HIRE KENTUCKY							
ADDRESS (INCL. ZIP) XXX STREET NAME CITY, STATE ZIP				SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		MARITAL STATUS <input type="checkbox"/> UNMARRIED <input checked="" type="checkbox"/> SINGLE/DIVORCE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		OCCUPATION/JOB TITLE UNIT BUSINESS MANAGER									
PHONE 502-XXX-XXXX				# OF DEPENDENTS 2		EMPLOYMENT STATUS FULL TIME		NCCI CLASS CODE									
RATE 12.00		PER: WEEK		DAY WEEK		MONTH X HOUR		AVG WEEKLY WAGES 450.00		# DAYS WORKED/WEEK 5/37.5		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
OCCURRENCE/TREATMENT																	
TIME EMPLOYEE BEGAN WORK 8:00		<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		DATE OF INJURY/ILLNESS 1/1/2006		TIME OF OCCURRENCE 8:25		<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		LAST WORK DATE 1/1/2006		DATE EMPLOYER NOTIFIED 1/1/2006		DATE DISABILITY BEGAN			
CONTACT NAME/PHONE NUMBER SALLY SUE SUPERVISOR/852-XXXX				TYPE OF INJURY/ILLNESS FALL				PART OF BODY AFFECTED RIGHT LEG									
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE									
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED SCHOOL OF EDUCATION 1ST FLOOR HALLWAY						ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED N/A											
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED WALKING TO FILE ROOM						WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED FILING											
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 TRIPPED OVER FILES IN FLOOR																	
CAUSE OF INJURY CODE																	
DATE RETURN(ED) TO WORK			IF FATAL, GIVE DATE OF DEATH			WERE SAFEGUARDS OR SAFTY EQUIPMENT PROVIDED? WERE THEY USED?			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO						
PHYSICIAN/HEALTH CARE PROVIDER(NAME & ADDRESS) DOCTOR WHO				HOSPITAL (NAME & ADDRESS) U OF L HOSPITAL				INITIAL TREATMENT <input checked="" type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC/HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED >24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED									
WITNESS (NAME & PHONE #) N/A																	
DATE ADMINISTRATOR NOTIFIED 1/1/2006			DATE PREPARED 1/1/2006			PREPARER'S NAME & TITLE SALLY SUE (SIGNATURE), SUPERVISOR			PHONE NUMBER 852-XXXX								

Applicable in Alaska

A person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception.

Applicable in Arkansas

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding worker's compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

Applicable in California

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying worker's compensation benefits or payments is guilty of a felony.

Applicable in Connecticut

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Applicable in Delaware and Oklahoma

Any person who, knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. * Delaware Statutes Regulation: Del #C Section 913(B)

Applicable in Florida

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company of self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Applicable in Idaho

Any person who, knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company, Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

Applicable in Indiana

A person who, knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kentucky and New York

Any person who, knowingly and with intent to defraud any insurance company or other person files a 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. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Michigan

Any person who, knowingly and with intent to injure or defraud any insurer submits a claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to \$5,000.00.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a

fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in New Jersey

Any person who, knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Pennsylvania

Any person who, knowingly and with intent to injure or defraud any insurer files a claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years or payment of a fine of up to \$50,000.00.

Applicable in Utah

Any person who, knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

EMPLOYEE

SIGNATURE: _____