

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL. ZIP)				CARRIER/ADMINISTRATOR CLAIM NUMBER				REPORT PURPOSE CODE			
				JURISDICTION				JURISDICTION CLAIM NUMBER			
				INSURED REPORT NUMBER							
				EMPLOYER LOCATION ADDRESS (IF DIFFERENT)						LOCATION #	
SIC CODE		EMPLOYER FEIN								PHONE #	
CARRIER/CLAIMS ADMINISTRATOR											
CARRIER (NAME, ADDRESS, & PHONE NO.)				POLICY PERIOD TO				CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO.)			
				CHECK IF APPROPRIATE							
				<input type="checkbox"/> SELF INSURANCE							
CARRIER FEIN		POLICY/SELF-INSURED NUMBER						ADMINISTRATOR FEIN			
AGENT NAME & CODE NUMBER											
EMPLOYEE/WAGE											
NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE	
ADDRESS (INCL. ZIP)				SEX		MARITAL STATUS		OCCUPATION/JOB TITLE			
				<input type="checkbox"/> MALE		<input type="checkbox"/> UNMARRIED		EMPLOYMENT STATUS			
				<input type="checkbox"/> FEMALE		<input type="checkbox"/> SINGLE/DIVORCE					
<input type="checkbox"/> UNKNOWN		<input type="checkbox"/> MARRIED		NCCI CLASS CODE							
<input type="checkbox"/> SEPARATED		<input type="checkbox"/> UNKNOWN									
PHONE		# OF DEPENDENTS									
RATE		PER:		DAY		MONTH		AVG WEEKLY WAGES		# DAYS WORKED/WEEK	
		WEEK		HOUR						FULL PAY FOR DAY OF INJURY?	
										<input type="checkbox"/> YES <input type="checkbox"/> NO	
										DID SALARY CONTINUE?	
										<input type="checkbox"/> YES <input type="checkbox"/> NO	
OCCURRENCE/TREATMENT											
TIME EMPLOYEE BEGAN WORK		AM		DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		AM		LAST WORK DATE	
		PM						PM			
CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED			
DID INJURY/ILLNESSEXPOSURE OCCUR ON EMPLOYER'S PREMISES?				TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE			
<input type="checkbox"/> YES <input type="checkbox"/> NO											
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 RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH				WERE SAFEGUARDS OR SAFTY EQUIPMENT PROVIDED?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
						WERE THEY USED?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
PHYSICIAN/HEALTH CARE PROVIDER(NAME & ADDRESS)						HOSPITAL (NAME & ADDRESS)				INITIAL TREATMENT	
										<input 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 #)											
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER			

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: _____