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

Employer (Name & Address Including Zip)		Carrier/Administration Claim Number	Report Purpose Code
		Jurisdiction	Jurisdiction Claim Number
		Insured Report Number KY	
		Employer's Location Address (if different)	Location #
SIC Code	Employer FEIN		Phone #

Carrier/Claims Administrator

Kentucky Employers' Mutual Ins. Lexington Financial Center 250 W. Main Street, Suite 900 Lexington, KY 40507 Telephone: (859) 425-7800 Fax: (859) 425-7822		Policy Period To Check if Appropriate ☐ Self Insurance	Claims Administrator (Name, Address, Phone No)
Carrier FEIN	Policy/Self-Insured Number		Administrator FEIN
Agent Name & Code Number			

Employee

Name (Last, First, Middle)	Date of Birth	Social Security No.	Date Hired	State of Hire
Address (include ZIP)	Sex ☐ M – Male ☐ F - Female ☐ U - Unknown	Marital Status ☐ U - Unmarried Single/Divorced ☐ M - Married ☐ S - Separated ☐ K - Unknown	Occupation/Job Title Employment Status	
Phone	# of Dependents		NCCI Class Code	

Wage

Rate	Per ☐ Day ☐ Month ☐ Week ☐ Other	**# Days Worked/Week**	Full Pay for Day of Injury? ☐ Yes ☐ No Did Salary Continue? ☐ Yes ☐ No

Occurrence/Treatment

Time Employee Began Work ☐ AM ☐ PM	Date of Injury/Illness	Time of Occurrence ☐ AM ☐ PM	Last Work Date	Date Employer Notified	Date Disability Began
Contact Name/Phone Number		Type of Injury/Illness		Part of Body Affected	
Did Injury/Illness exposure occur on employer's premises? ☐ Yes ☐ No		Type of Injury/Illness 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			
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				Cause of Injury Code	
Date Returned to Work	If Fatal, Give Date of Death	Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No Were they Used? ☐ Yes ☐ No			
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 Hrs ☐ 5 Future Major Medical/ Lost Time Anticipated	
Witnesses (Name & Phone #)					
Date Admin/Carrier Notified	Date Prepared	Preparer's Name & Title		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 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."

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.

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Employee Signature: _____ DATE: _____

Form 113
Designation of Physician
Revised 03-12-03

Two-Sided Form

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
657 TO BE ANNOUNCED AVENUE
FRANKFORT, KY 40601
Claim No. _____

NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: _____
Name

_____
Street Address

_____
City, State, Zip

( ) _____
Telephone Number

_____
Date of Birth

_____
Social Security Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

_____
Name

_____
Street Address

_____
City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: _____

_____

DATE OF INJURY OR LAST EXPOSURE: _____

FIRST DESIGNATED PHYSICIAN:

_____
Name

_____
Street Address

_____
City, State, Zip

( ) _____
Telephone Number

Accepted by: _____

MEDICAL INFORMATION RELEASE: I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

_____
Date

_____
Employee Signature

MEDICAL PAYMENT OBLIGOR:

_____
Name Of Obligor

_____
Representative

_____
Street Address

_____
City, State, Zip

( ) _____
Telephone Number

Notice: The Workers' Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as "designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for medical services.