WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

Employer (Name & Address Including Zip)						Carrier/Administration Claim Number			Report Purpose Code			
					Jurisdiction Jurisdiction Claim Number				mber			
					Insured Report Number KY							
					Employer's Location Address (if different)				Location #			
SIC Code	Employer FEIN								Phone #			
Carrier/Claims Adminis	trator											
Kentucky Employers' Muti						Poli	cy Period	Claims Ac	ministrator	(Name, A	Address, Phone No)	
Lexington Financial Center 250 W. Main Street, Suite 900						То						
Lexington, KY 40507						10						
Telephone: (859) 425-7800 Fax: (859) 425-7822						Check if Appropriate						
Carrier FEIN	earrier FEIN Policy/Self-Insured					☐Self Insurance		Administrator FEIN				
Agent Name & Code Number												
Employee												
Employee Name (Last, First, Middle)			Dat	Note of Dirth		Social Security No.		Date Hired			State of Hire	
Name (Last, First, Middle)	ast, First, Middle)			Date of Birth		Social Security No.		Date Tilled			State of fille	
Address (include ZIP)			Sex		Marital Status		Occupation	Occupation/Job Title		<u> </u>		
				☐ M – Male			U - Unmarried Single/Divorced					
				F - Female			☐ M - Married Em		Employment Status			
			╽╙	U - Unknown			S - Separated					
Phone			# o	# of Dependents			K - Unknown	NCCI Class Code				
Wage												
Rate		Day 🔲	Mont	h		# D	ays Worked/Week	Full Pa	ay for Day	of Injury?	☐ Yes ☐ No	
	Per 🗆	Week 🔲	Othe	r				Did Sa	alary Contir	nue?	☐ Yes ☐ No	
Occurrence/Treatment												
Time Employee ☐ AM Began Work ☐ PM	Date of In	jury/Illness	Tim	ne of Occuri	rence /		Last Work Date	Date Emp	loyer Notifi	ed Da	ate Disability Began	
Contact Name/Phone Number					Type of Injury/Illness			Part of Body Affected				
Did Injun/Illnoss exposure o	occur on omnlo	vor's promise	002	Type of Ir	oiur/Illnoo	o Coo	•	Dort of Po	dy Affected	l Codo		
Did Injury/Illness exposure occur on employer's premises? ☐ Yes ☐ No Type of Injury/Illness C							e	Part of Bo	dy Allected	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						Work process the employee was engaged in when accident or illness exposure occurred						
exposure occurred												
How injury or illness/abnorm	nal health condi	ition occurre	d. Des	cribe the se	equence of	f even	events and include any objects or substances that Cause of Injury Code				of Injury Code	
directly injured the employee	e or made the e	employee ill										
Date Returned to Work					Were Safeguards or Safety Equipment Provided? Were they Used?			d?	☐ Yes ☐ Yes	□ No □ No		
Physician/Health Care Provider (Name & Address) Hospital (N					(Name & Address)				Initial Tr	reatment		
											lo Medical Treatment	
										□ 2 N	Minor by Employer Minor Clinic/Hosp	
									☐ 3 Emergency Care ☐ 4 Hospitalized>24 Hrs			
										☐ 5 Future Major Medical/		
										L	ost Time Anticipated	
Witnesses (Name & Phone	#)											
		D	Prenare	r's Name &	Title			Г				
Date Admin/Carrier Date Prepared Preparer's Name & Title Notified									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."

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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:
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