Workers Compensation Fund

Description of Fields on the Employer's First Report of Injury Form

General Section

Employer (name and address, including ZIP code) : The name and address of the business entity employing the claimant.

Carrier/Administrator Claim Number: Identifies a specific claim within a claims administrator's claims processing system.

Report Purpose Code: Code identifying purpose of the filing (codes will be distributed at a later date). (Examples: original filing, delete, change, etc.)

Jurisdiction (state): The governing body who will administer the claim and whose statutes will apply to the claim adjustment process. Used to identify the jurisdiction administering the claim.

Jurisdiction Claim Number: The number assigned by the Commission to identify a specific claim.

Insured Report Number: A number used by the insured to identify a specific claim.

Employer's Location Address (if different): The address of the employer's facility where the clamant was employed at the time of injury if not listed above.

Location Number: A code defined by the employer which is used to identify the employer's location of the accident (for insured loss prevention program management).

Phone Number: Employer's telephone number.

SIC Code: This code represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

Employer FEIN: The employer's Federal Employer's Identification Number.

Carrier Claims Administration Section

Carrier (name, address and phone number): The employer's worker's compensation insurance carrier.

Policy Period: The effective date and expiration date of the workers' compensation policy under which the claim occurred.

Claims Administrator (name, address and phone number): Carrier or self-insured financially responsible for the claim.

Carrier FEIN: The FEIN of the carrier or self-insured assuming the employer's financial responsibility for worker's compensation claims.

Policy/Self-Insured Number: The number assigned to the workers' compensation policy for the employer (self-insureds currently are not assigned a number).

Administrator FEIN: The FEIN of the claims administrator.

Agent Name and Code Number: Name of the insurance agent (broker) who wrote the policy and the number assigned to the agent.

Employee Section

Name (last, first, middle): Claimant's name in the above order.

Date of Birth: Claimant's date of birth.

Social Security Number: Claimant's Social Security Number.

Date Hired: The date the claimant was hired by this employer.

State of Hire: The state where the claimant was hired.

Address (include zip code): Claimant's address.

Sex: Claimant's sex (m = male, f = female, u = unknown)

Marital Status: Claimant's marital status

Occupation/Job Title: Identifies the primary occupation of the claimant at the time of the accident or injurious exposure.

Employment Status: Full-time, part time, seasonal, etc.

Phone: Claimant's telephone number.

Number of Dependents: Dependent spouse plus the number of dependent children under the age of 18 years.

NCCI Class Code: A code which corresponds to the primary occupation which the claimant was engaged at the time of accident or injurious exposure. The code is according to the Basic Manual for Workers Compensation and Employers Liability Insurance, and can be found on the policy Information Page.

Wage Section

Rate: Claimant's rate of pay - check one of the following: day, week, month, other. If other is checked, specify.

Number of Days Workers/Week: Number of days per week claimant worked.

Full Pay for Day of Injury: If claimant was paid full wages for the date of the accident/illness by the employer check YES, if not check NO.

Did Salary Continue: If claimant's salary continued, check YES, if not check NO.

Occurrence Section

Time Employee Began Work: The time claimant began work — check either AM or PM.

Date of Injury/Illness: For injuries, the date on which the accident occurred. For occupational illnesses or cumulative injuries, the date of injury is the date of last injurious exposure to the cause or substance creating the condition as determined by the date when the illness or cumulative injury was diagnosed. As a last resort, use the date reported to the employer.

Occurrence: Time of occurrence. Check either AM or PM.

Occurrence Section (cont'd)

Last Work Date: The date the employee last worked.

Date Employer Notified: The date that the claimant reported the injury/illness to a representative of the employer.

Date Disability Began: The first day on which the claimant originally lost time from work due to the occupational injury or illness.

Contact Name/Phone Number: Employer's contact person's name and telephone number.

Type of Injury/Illness: The type of accident or exposure classification identifies the event which directly resulted in the injury or illness. (Examples: fall, overexertion, struck by, etc.)

Part of Body Affected: The part of body the claimant sustained the injury.

Did Injury/Illness Exposure Occur on Employer's Premises? An indicator to denote whether the accident at the employer's address. Check YES or NO.

Type of Injury Illness Code: Detailed claims information (DCI) codes will be provided at a later date to carriers and self-insureds.

Part of Body Affected Code: Detailed claims information (DCI) codes will be provided at a later date to carriers and self-insureds.

Department or Location where Accident or Illness Exposure Occurred: If occurrence was on employer's premises, note department. If occurrence was off site, note location along with city and state.

All Equipment, Materials or Chemicals Employee Was Using When Accident or Illness Exposure Occurred: Free form — self-explanatory.

Specific Activity the Employee was Engaged in When the Accident or Illness Exposure Occurred: Free form — self-explanatory.

Work Process the Employee was Engaged in When the Accident or Illness Exposure Occurred: Free form — self-explanatory.

How Injury or Illness/Abnormal Health Condition Occurred: Describe the Sequence of Events and Include Objects or Substances That Directly Injured the Employee or Made the Employee Ill: Free form — self-explanatory.

Cause of Injury Code: Detailed claims information (DCI) codes will be provided at a later date to carriers and self-insureds.

Date Return(ed) to Work: Date employee returned to work after the injury or illness.

If fatal, give date of death: Self-explanatory.

Were safeguards or safety equipment provided? Check YES or NO.

Were they used? Check YES or NO.

Treatment Section

Physical/Health Care Provider (name and address): Self-explanatory

Hospital (name and address): Self-explanatory

Initial Treatment: Self-explanatory

Other Section

Witnesses (name and phone number): Give witness' names and telephone numbers.

Date Administrator Notified: The date notification of the occurrence is received by the carrier, third party administrator or self-insured that is financially responsible for the claim.

Date Prepared: Self-explanatory

Preparer's Name and Title: Self-explanatory

Phone Number: Self-explanatory

Workers Compensation Fund Section

Office/Partner? An indicator to denote whether the injured workers is a corporate officer or a partner in the company. Check YES or NO. If yes, give the title of the officer/partner. (Examples: president, owner, etc.)

Did Injury happen during performance or regular duties? An indicator to denote whether the injured worker was engaged in the performance of his/her usual duties at the time that the injury/illness occurred. Check YES, NO, or UNKNOWN.

Has Employee injured this part of the body before? If so, give details. Free form — self-explanatory

Policy Department Code: This field is for employers who are reporting their injuries at the department level. If this applies to your company, enter the policy department code corresponding to the department in which the injury occurred.

Accident Cause Code: The field is for employers who are reporting an extra level of details about how the accident occurred. If this applies to your company, enter the accident cause code corresponding to what caused the injury. (Examples: ice, liquid on the floor, power hand tool, etc.)

Was accident caused by failure of a machine or product? If yes, explain. An indicator to denote whether the accident may have been caused by the malfunction of a machine or product. Check YES or NO. If yes, briefly describe the machine and how it may have malfunctioned.

If the accident was caused by any person or company besides the employee, a co-employees, or the employer, please identify: Free form — self-explanatory

Do you doubt the validity of this claim? If so, attach a separate written explanation. Free form — self-explanatory

For Lost Time Claim Only: List name of spouse, minor dependents and their birthdays. Free form — self-explanatory