Worker's Compensation – FIRST REPORT OF INJURY OR ILLNESS **Jurisdiction Code _____** **Jurisdiction Claim Number _____**

Claim Administrator Name			Claim Rep Phone No	Insurer Name (if different from claim administrator)	
Mailing Address, City, State & Postal Code			Claim Admin. Claim No.	Insurer FEIN:	
			Claim Admin. FEIN	Claim Type Code	
Employer Name			Employer FEIN	Insured Report Number	Employer Type Code: _____ Employer (E)
Physical Address, City, State & Postal Code			Mailing Address	Industry Code	_____ Lessor (L)
				Insured Location No.	Employer UI No.
Nature of Business			Employer Contact Name and Business Phone Number:		
Insured Name (parent co)	Insured FEIN:	Insured Postal Code	Policy/Contract No.	Coverage Effective Date Coverage Expiration Date	Self Insurance License/ Certificate Number:
Employee Name		Date of Birth	Gender: ☐ Male ☐ Female	Tax Filing Status ☐ Single (A) ☐ Single/Head of Household(B)	☐ Married/Filing Joint (C) ☐ Married/Filing Separate (D)
Mailing Address		Date of Hire	Educational Level		Marital Status
Phone Number		Employment Status ☐ Piece Worker ☐ Volunteer ☐ Seasonal ☐ Apprenticeship/F-T ☐ Apprenticeship/P-T ☐ Regular Employee F-T ☐ Part-time ☐ Other	Employee ID Number ID #: ☐ Social Security Number ☐ Employment VISA Number ☐ Passport Number ☐ Green Card ☐ Employee ID Assigned by Jurisdiction		☐ Unmarried (U) ☐ Married (M) ☐ Separated (S)
Occupation Description					Employee's Authorization to Release the Following Medical Records ☐ Yes ☐ No
Manual Classification Code					Social Security Number ☐ Yes ☐ No
Department Where Regularly Worked					
Average Wage $ ☐ hourly ☐ Daily ☐ semi-mo ☐ monthly ☐ bi-weekly ☐ Annual ☐ weekly		Salary Continued in Lieu of Compensation ☐ Yes ☐ No		Employee Number of Dependants: Employee Number of Exemptions:	
Number of Days Regularly Worked Per Week:		Full Wages Paid for Date of Injury ☐ Yes ☐ No Discontinued Fringe Benefits: $		☐ Entitled ☐ Withholding	
	Date of Injury Date Employer Had Knowledge of Injury Date Claim Admin Had Knowledge of Injury Initial Date Last Day Worked Initial Return to Work Date (if applicable) Employee Date of Death (if applicable)	Describe the nature of the injury. (ex. amputation, burn, cut, fracture):			
	Time of Injury Time Employee Began Work	Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):			
Pre-Existing Disability Code: ☐ Yes ☐ No ☐ Unknown		Describe the events that caused the injury. (ex fell, operating machinery, chemical exposure):			
Accident Premises Code ☐ Employer (E) ☐ Lessee (L) ☐ Other (X)		Name the object or substance that directly injured the employee (ex. knife, floor, acid, oil):			
Accident Site Organization Name					
Accident Site Street, City, State & Postal Code		Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring)			
Accident Location Narrative (if no street address)					
Accident Site County/Parish:		Witness Name & Business Phone Number:			
Initial Treatment Code ☐ no medical treatment (0) ☐ minor/on-site treatment (1) ☐ clinic/hospital visit (2) ☐ emergency care (3) ☐ hospitalization > 24 hours (4) ☐ future medical treatment/lost time antic. (5)		Initial Medical Provider Name: Initial Medical Provider Physical Address, City, State, & Postal Code			Managed Care Organization ICD Primary Diagnostic Code
Preparer's Name & Title:		Preparer's Company Name: HORAK INSURANCE, INC.		Phone No. 319-653-2116	Date: