

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
Employee Name	Date of Birth	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Tax Filing Status	
Mailing Address	Date of Hire		<input type="checkbox"/> Single (A)	<input type="checkbox"/> Married/Filing Joint (C)
Phone Number	Employment Status <input type="checkbox"/> Piece Worker <input type="checkbox"/> Volunteer <input type="checkbox"/> Seasonal <input type="checkbox"/> Apprenticeship/F-T <input type="checkbox"/> Apprenticeship/P-T <input type="checkbox"/> Regular Employee F-T <input type="checkbox"/> Part-time <input type="checkbox"/> Other	Employee ID Number ID #:	Marital Status	
Occupation Description			Educational Level	<input type="checkbox"/> Single/Head of Household(B)
Manual Classification Code		<input type="checkbox"/> Social Security Number <input type="checkbox"/> Employment VISA Number <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/> Employee ID Assigned by Jurisdiction	Employee's Authorization to Release the Following Medical Records <input type="checkbox"/> Yes <input type="checkbox"/> No Social Security Number <input type="checkbox"/> Yes <input type="checkbox"/> No	
Department Where Regularly Worked				
Average Wage \$ <input type="checkbox"/> hourly <input type="checkbox"/> Daily <input type="checkbox"/> semi-mo <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> Annual <input type="checkbox"/> weekly		Salary Continued in Lieu of Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No		Employee Number of Dependents:
Number of Days Regularly Worked Per Week:		Full Wages Paid for Date of Injury <input type="checkbox"/> Yes <input type="checkbox"/> No		Employee Number of Exemptions:
		Discontinued Fringe Benefits: \$		<input type="checkbox"/> Entitled <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Describe the events that caused the injury. (ex fell, operating machinery, chemical exposure):		
Accident Premises Code <input type="checkbox"/> Employer (E) <input type="checkbox"/> Lessee (L) <input type="checkbox"/> 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 <input type="checkbox"/> no medical treatment (0) <input type="checkbox"/> minor/on-site treatment (1) <input type="checkbox"/> clinic/hospital visit (2) <input type="checkbox"/> emergency care (3) <input type="checkbox"/> hospitalization > 24 hours (4) <input type="checkbox"/> future medical treatment/lost time antic. (5)		Initial Medical Provider Name:		Managed Care Organization
		Initial Medical Provider Physical Address, City, State, & Postal Code		ICD Primary Diagnostic Code
Preparer's Name & Title:		Preparer's Company Name: HORAK INSURANCE, INC.		Phone No. 319-653-2116
				Date: