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

EMPLOYER NAME & MAILING ADDRESS (INCLUDING ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT FROM MAILING ADDRESS)

LOCATION NO.

PHONE NO.

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER NAME, ADDRESS & PHONE NO.

POLICY PERIOD

TO

CHECK IF APPROPRIATE

❑ SELF-INSURANCE

CLAIMS ADMINISTRATOR NAME, ADDRESS & PHONE NO.

SUMMIT CLAIMS CENTER
P.O. Box 2928 • Lakeland, FL 33806-2928
1-800-282-7644

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NO.

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NO.

DATE HIRED

STATE OF HIRE

ADDRESS (INCLUDING 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

NO. OF DEPENDENTS

NCCI CLASS CODE

RATE

PER: ❑ DAY ❑ MONTH ❑ WEEK ❑ OTHER_____

NO. DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ❑ YES ❑ NO

DID SALARY CONTINUE? ❑ YES ❑ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK
ADFADF
____ AM ____ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE
____ AM ____ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME & PHONE NO.

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

SPECIFIC ACTIVITY EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED EMPLOYEE OR MADE EMPLOYEE ILL.

CAUSE OF INJURY CODE

DATE RETURN(ED) 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 BY CLINIC/HOSPITAL
3 — EMERGENCY CARE
4 — HOSPITALIZED > 24 HOURS
5 — FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESSES (NAME & PHONE NO.)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

SEE BACK FOR IMPORTANT STATE INFORMATION, INSTRUCTIONS & SIGNATURE

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES: Enter all dates in MM/DD/YY format.

SIC CODE: This is the code which 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.

CARRIER: The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of 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 the following:

Full-Time	Unknown
Part-Time	Apprenticeship Full-Time
Not Employed	Apprenticeship Part-Time
On Strike	Volunteer
Disabled	Seasonal
Retired	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 deigned by 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 address or location. Be specific.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (e.g., acetylene cutting torch, metal plate)

List all of the 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 for 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: (e.g.: 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.

Any person who, knowingly and with intent to defraud any insurance company or other person, files a statement of claim 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.

EMPLOYEE SIGNATURE _____