

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
INDUSTRY CODE 8661		EMPLOYER FEIN		LOCATION #
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)	
BROTHERHOOD MUTUAL INSURANCE CO P.O. BOX 2228 FORT WAYNE, IN 46801 (800) 333-3371		TO		
		CHECK IF APPROPRIATE		
CARRIER FEIN		POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN	
		<input type="checkbox"/> SELF INSURANCE		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX	MARITAL STATUS		OCCUPATION / JOB TITLE
		<input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN	<input type="checkbox"/> U UNMARRIED SINGUE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN	EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS			NCCI CLASS CODE	
RATE PER:	DAY WEEK	MONTH OTHER:	DAYS WORKED/ WEEK	FULL PAY FOR DAY OF INJURY?	YES NO YES NO

OCCURENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	AM PM	DATE OF INJURY/IULNESS	TIME OF OCCURENCE	AM PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> 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 THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			

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

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	YES NO YES NO
		WERE THEY USED?	

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT
		1 MINOR: BY EMPLOYER
		2 MINOR CLINIC/HOSP
		3 EMERGENCY CARE
		4 HOSPITALIZED > 24 HRS
		5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESS (NAME & PHONE #)			
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DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER
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