

**WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS**

Employer (Name & Address Including Zip)		Carrier/Administration Claim Number		Report Purpose Code			
		Jurisdiction		Jurisdiction Claim Number			
		Insured Report Number KY					
		Employer's Location Address (if different)				Location #	
SIC Code	Employer FEIN					Phone #	
<b>Carrier/Claims Administrator</b>							
<b>Kentucky Employers' Mutual Ins.</b> Lexington Financial Center 250 W. Main Street, Suite 900 Lexington, KY 40507 Telephone: (859) 425-7800 Fax: (859) 425-7822		Policy Period		Claims Administrator (Name, Address, Phone No)			
		To					
Carrier FEIN		Policy/Self-Insured Number		Administrator FEIN			
Agent Name & Code Number							
<b>Employee</b>							
Name (Last, First, Middle)		Date of Birth	Social Security No.	Date Hired	State of Hire		
Address (include ZIP)		Sex <input type="checkbox"/> M - Male <input type="checkbox"/> F - Female <input type="checkbox"/> U - Unknown	Marital Status <input type="checkbox"/> U - Unmarried Single/Divorced <input type="checkbox"/> M - Married <input type="checkbox"/> S - Separated <input type="checkbox"/> K - Unknown	Occupation/Job Title			
				Employment Status			
Phone		# of Dependents		NCCI Class Code			
<b>Wage</b>							
Rate	Per	<input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Other	# Days Worked/Week	Full Pay for Day of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did Salary Continue? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Occurrence/Treatment</b>							
Time Employee Began Work <input type="checkbox"/> AM <input type="checkbox"/> PM	Date of Injury/Illness	Time of Occurrence <input type="checkbox"/> AM <input type="checkbox"/> 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				
Specify 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 Returned to Work	If Fatal, Give Date of Death	Were Safeguards or Safety Equipment Provided? Were they Used?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Physician/Health Care Provider (Name & Address)		Hospital (Name & Address)		Initial Treatment <input type="checkbox"/> 0 No Medical Treatment <input type="checkbox"/> 1 Minor by Employer <input type="checkbox"/> 2 Minor Clinic/Hosp <input type="checkbox"/> 3 Emergency Care <input type="checkbox"/> 4 Hospitalized>24 Hrs <input type="checkbox"/> 5 Future Major Medical/ Lost Time Anticipated			
Witnesses (Name & Phone #)							
Date Admin/Carrier Notified	Date Prepared	Preparer's Name & Title		Phone Number			

FORM IA-1

**SEE BACK FOR IMPORTANT INFORMATION & SIGNATURE**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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. Reprinted with permission of the IAABC (as modified by and for KEMI).**

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**EMPLOYER'S INSTRUCTIONS  
DO NOT ENTER DATA IN SHADED FIELDS**

**DATES:**

Enter all dates in MM/DD/YY.

**SIC CODE:**

This is the code that represents the nature of the employer's business that 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 or 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: Full-Time, Not Employed, Disabled, Unknown, Apprenticeship Part-Time, Seasonal, Part-Time, On Strike, Retired, Apprenticeship Full-Time, Volunteer, and 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 designated by the 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 the address or location. Be specific.

**ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:**

(e.g., Acetylene cutting torch, metal plate)

List all 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 of 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:**

(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.

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Employee Signature: \_\_\_\_\_  
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DATE: \_\_\_\_\_