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)
______ Lessor (L)
Physical Address, City, State & Postal Code
Mailing Address
Industry Code
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)
☐ Married/Filing Joint (C)
☐ Single/Head of Household(B)
☐ Married/Filing Separate (D)
Mailing Address
Date of Hire
Educational Level
Marital Status
☐ Unmarried (U)
☐ Married (M)
☐ Separated (S)
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
Occupation Description
Manual Classification Code
Department Where Regularly Worked
Employee's Authorization to Release the Following
Medical Records
☐ Yes ☐ No
Social Security Number
☐ Yes ☐ No

Average Wage $
☐ hourly ☐ Daily ☐ semi-mo ☐ monthly
☐ bi-weekly ☐ Annual ☐ weekly
Salary Continued in Lieu of Compensation
☐ Yes ☐ No
Full Wages Paid for Date of Injury ☐ Yes ☐ No
Employee Number of Dependants:
Employee Number of Exemptions:
☐ Entitled
☐ Withholding
Number of Days Regularly Worked Per Week:
Discontinued Fringe Benefits: $

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)
Time of Injury
Time Employee Began Work
Describe the nature of the injury. (ex. amputation, burn, cut, fracture):
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:
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: