

NOTICE:INDIANA WORKERS COMPENSATION

This business operates under Indiana Workers Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, OR AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR OR FOREMAN OF THE EMPLOYER.

Workers Compensation insurance benefits are provided through:

BerkleyNet

To report a claim, contact us at:

Website: berkleynet.com

Email: claims@berkleynet.com

Address: 9301 Innovation Drive, Suite 200, Manassas, VA 20110

Phone: 877.497.2637 Fax: 866.275.6320

INSTRUCTIONS

General Instructions:

- 1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.
- 2. Enter all dates in MM/DD/YY format.
- 3. Please return completed form electronically by an approved EDI process.
- 4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME AND 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.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being e.g. Acetylene cutting torch, metal plate, etc.).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering

CONTACT NAME / TELEPHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor*, *HR Person*, *Nurse*, *etc*.)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised deigned by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (e.g. Maintenance, Client's Office, Cafeteria, etc.).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (e.g. Right forearm, Low Back, etc.)

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (Return to Work Date): Enter the date following the most recent disability period on which the employee returned to work.

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.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting).

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (e.g. Contusion, Laceration, Fracture, etc.)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (e.g. Building maintenance).



FOR WORKER'S COMPENSATION BOARD USE ONLY						
Jurisdiction	Jurisdiction claim number	Process date				

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

				MDLOV	EE INFORMA	A TION	M						
Social Security number	Date of birth	Sex		IVIFLO	EE INFORMA								
Social Security number	Date of biltin		ıle □ Fem	emale Unknown			Occupation / Job title					NCCI class code	
Name (last, first, middle)		N	Marital status		Date hired			State of hire		Employee status			
				☐ Un	married			I		I			
Address (number and street,	city, state, ZIP code)		☐ Ma	rried	Hrs / Day Days		Days / W	K	Avg Wg /	VVK	☐ Paid Day of Injury	
				☐ Separated								☐ Salary Continued	
			Unknown		Wasa B								
						Wage Per		_					
Telephone number (include area code)		N	Number of dependents		\$			☐ Hour ☐ Day ☐ ☐ Year ☐ Other		•	Month		
					ER INFORM	OITA	N						
Name of employer		E	Employer ID#		,		SIC	SIC code		Insured report number			
Address of employer (number and street, city, state, ZIP code)) L	Location number			Employer's loca			er's location	ation address (if different)			
			To	Telephone number				_					
												December 2011	
			Carrier / Administrator claim number						Report purpose code				
Actual location of accident / exposure (if not on employer's premises)													
		СА	RRIFR / CI	AIMS A	DMINISTRAT	OR II	NFORI	MATION					
Name of claims administrator				Carrier federal ID n									
				04.1161.1000141.12.1141.11261				☐ Self Insurance					
Address of claims administrator (number and street, city, state, ZIP code)			ZIP code)	☐ Insuran			Policy / Self-ins		Self-insure	red number			
Telephone number			☐ Third I		Party Admin.		. Pol	Policy period From To					
Name of agent		(Code number						10				
OCCURRENCE / TREATMENT INFORMATION													
Date of Inj./ Exp.	Time of occurrence		Date employ										
Date of Inj./ Exp.		м □ РМ	Date employ	er riotilie	u	Туре	Type of injury / exposure Type code			Type code			
Last work date	Time workday begar	١	Date disabilit	ability began			Part of body					Part code	
RTW date	Date of death		Injury / Exposure occurred on employer's premises?			,5						Telephone number	
Department or location where accident / exposure occurred All equipment, materials, or chemicals in					involve	olved in accident							
Specific activity engaged in during accident / exposure				Work process employee engage			gaged in du	d in during accident / exposure					
How injury / exposure occurr	ed Describe the sec	Hence of over	ants and inclu	de any ra	elevant objects o	or eubo	stancoc						
Tiow injury / exposure occurr	ed. Describe the seq	defice of eve	onto ana mola	de arry re	novani objecto c	or Subc	31011003	•				Cause of injur	y code
Name of physician / health care provider							II			INI	ITIAL TREATMENT ☐ No Medical Treatment		
						I		↓	☐ Minor: By Employer				
Name of witness Telephone		Telephone no	e number			Date administrator notified			☐ Minor: Clinic / Hospital ☐ Emergency Care				
Date prepared	Name of preparer			Title		Telephone number Hospitalized > 24 Hours Future Major Medical / Los Time Anticipated				> 24 Hours Medical / Lost			

WORKER'S COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Worker's Compensation Act of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

is:
(name of insurance carrier or administrator
of carrier/administrator)
(mailing address)
(city, state, zip)
(telephone number)

For more information about rights or procedures under the Indiana Worker's Compensation system, call or write:

Worker's Compensation Board of Indiana Ombudsman Division 402 W. Washington St., Rm W196 Indianapolis, IN 46204 (317) 232-3808 1-800-824-2667

NOTICIA DE COMPENSACION PARA TRABAJADORES

A su empleador le es requerido proveer pagos de beneficios bajo el Acta de Compensación para Trabajadores del Estado de Indiana.

Cualquier empleado que sea lesionado mientras esté trabajando debe reportar el accidente laboral inmediatamente a su supervisor, empleador o representante designado.

La compañía de seguro de compensación del trabajador o el administrador de la compañía
(nombre de la compaňía)
(nombre de la compañía de seguro/administrador)
(dirección)
(ciudad, estado, código postal)
(número de teléfono)
(persona de contacto)

Para más información acerca de sus derechos o los procedimientos bajo el sistema de compensación para trabajadores de Indiana, llame o escriba a:

Worker's Compensation Board of Indiana Ombudsman Division 402 W. Washington St., Rm W196 Indianapolis, IN 46204 (317) 232-3808 1-800-824-2667