IA-1

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 #

Carrier/Claims Administrator

Carrier/Claims Administrator	Policy Period	Claims Administrator (Name, Address, Phone No)
Kentucky Employers' Mutual Ins. Lexington Financial Center 250 W. Main Street, Suite 900 Lexington, KY 40507 Telephone: (859) 425-7800 Fax: (859) 425-7822	To Check if Appropriate ☐ Self Insurance	
Carrier FEIN	Policy/Self-Insured Number	Administrator FEIN
Agent Name & Code Number		

Employee

Name (Last, First, Middle)	Date of Birth	Social Security No.	Date Hired	State of Hire
Address (include 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	# of Dependents		NCCI Class Code	

Wage

Rate	Per ☐ Day ☐ Month ☐ Week ☐ Other	**# Days Worked/Week**	Full Pay for Day of Injury? ☐ Yes ☐ No Did Salary Continue? ☐ Yes ☐ No

Occurrence/Treatment

Time Employee Began Work ☐ AM ☐ PM	Date of Injury/Illness	Time of Occurrence ☐ 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? ☐ 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
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? ☐ 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 Clinic/Hosp ☐ 3 Emergency Care ☐ 4 Hospitalized>24 Hrs ☐ 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 IAIABC (as modified by and for KEMI).

REPRINTED WITH PERMISSION OF THE IAIABC (AS MODIFIED BY AND FOR KEMI)