

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								
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #:				
SIC CODE	EMPLOYER FEIN					PHONE #:				
CARRIER/CLAIMS ADMINISTRATOR										
CARRIER (NAME, ADDRESS & PHONE NO.)		POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)						
		TO								
		CHECK IF APPROPRIATE								
		<input type="checkbox"/> SELF-INSURANCE								
CARRIER FEIN		POLICY/SELF-INSURED NUMBER				ADMINISTRATOR FEIN				
AGENT NAME & CODE NUMBER										
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"/> U UNMARRIED SINGLE/DIVORCED		EMPLOYMENT STATUS				
			<input type="checkbox"/> F FEMALE	<input type="checkbox"/> M MARRIED						
			<input type="checkbox"/> U UNKNOWN	<input type="checkbox"/> S SEPARATED						
PHONE					<input type="checkbox"/> K UNKNOWN		NCCI CLASS CODE			
RATE	PER:		DAY	MONTH	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	YES	NO		
			WEEK	OTHER:		DID SALARY CONTINUE?	YES	NO		
OCCURRENCE/TREATMENT										
TIME EMPLOYEE BEGAN WORK		AM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		AM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
		PM					PM			
CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED			
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?				TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE			
<input type="checkbox"/> YES <input type="checkbox"/> NO										
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		
				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 ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER		
IAIABC IA-1 (4/96)		SEE BACK FOR INSTRUCTIONS								

WORKERS' COMPENSATION - FIRST REPORT OF INJURY EMPLOYER'S INSTRUCTIONS

GENERAL INFORMATION

EMPLOYER (NAME & ADDRESS INCL ZIP) - The name and address of the entity employing or statutorily responsible for the employee.

SIC CODE - 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.

EMPLOYER FEIN - Employer's Federal Employer Identification Number.

CARRIER/ADMINISTRATOR CLAIM NUMBER - Carrier's claim or file number.

REPORT PURPOSE CODE - A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

JURISDICTION - State in which you are filing the claim (Mississippi).

JURISDICTION CLAIM NUMBER - Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

INSURED REPORT NUMBER - The number, if any, used by the employer to identify the claim.

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) - The name and address of the employer's facility where the employee was employed at the time of injury, if different from above.

LOCATION #/PHONE # - The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

CARRIER (NAME, ADDRESS & PHONE NO) - The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

POLICY PERIOD - The date that the contract/policy under which the claim occurred began and expired.

CHECK IF APPROPRIATE (SELF-INSURANCE) - An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

CLAIMS ADMINISTRATOR - The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

CARRIER FEIN - Carrier's Federal Employer Identification Number.

POLICY/SELF-INSURED NUMBER - The number assigned by the carrier to the insurance contract/policy for the employer; or any similar number assigned to a self-insured employer.

ADMINISTRATOR FEIN - Federal Employer Identification Number of Administrator.

AGENT NAME & CODE NUMBER - The name of the insurance agent and the agent's code number if known. This information should be found in the insurance policy.

EMPLOYEE/WAGE INFORMATION

NAME (LAST, FIRST, MIDDLE) - Employee's legally recognized name.

ADDRESS - The mailing address used by the employee.

PHONE - A telephone number where the employee can be reached.

DATE OF BIRTH - The date the employee was born.

SOCIAL SECURITY NUMBER - A number assigned by the Social Security Administration used to identify the employee.

DATE HIRED - The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

STATE OF HIRE - State where employee was hired.

SEX - The code which indicates the sex of the employee.

MARITAL STATUS - The code which indicates the marital status of the employee.

OCCUPATION/JOB TITLE - This is the primary occupation of the employee at the time of the accident or exposure.

EMPLOYMENT STATUS - Indicate the employee's work status. The valid choices are: Full-Time, Part-Time, Not Employed, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-Time, Apprenticeship Part-Time, Volunteer, Seasonal, or Piece Worker.

NCCI CLASS CODE - A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY INSURANCE.

RATE - The reported employee's wage rate at the time of injury.

DAYS WORKED/WEEK - The number of days worked by the employee in a week.

FULL PAY FOR DAY OF INJURY - State whether employee was paid his full wages on the injury date.

DID SALARY CONTINUE - State whether employee's salary was continued by the employer in lieu of compensation benefits.

OCCURRENCE/TREATMENT INFORMATION

TIME EMPLOYEE BEGAN WORK - The time employee began work on date of injury.

DATE OF INJURY/ILLNESS - The date employee was injured.

TIME OF OCCURRENCE - The time employee was injured.

LAST WORK DATE - The date employee last worked following the injury.

DATE EMPLOYER NOTIFIED - The date on which employer was notified of the injury.

DATE DISABILITY BEGAN - The date on which employee began losing time.

CONTACT NAME/PHONE NUMBER - Name and phone number of employer representative to be contacted for further 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 the body affected by the injury/illness, (e.g., Right Forearm, lower back).

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES - Mark yes or no as applicable.

TYPE OF INJURY/ILLNESS CODE - The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

PART OF BODY AFFECTED CODE - The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - Be specific (e.g., Maintenance Department of Client's office at 452 Monroe Street, Washington, D.C. 26210). If the accident or illness exposure did not occur on the employer's premises, enter address or location.

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED - List all of the 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.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - Describe the specific activity the employee was engaged in when the accident of illness exposure occurred, such as sanding ceiling woodwork in preparation for 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 - 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.

CAUSE OF INJURY CODE - The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

DATE RETURN(ED) TO WORK - Enter the date following the most recent disability period on which the employee returned to work.

IF FATAL, GIVE DATE OF DEATH - Date of death of employee.

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED/WERE THEY USED - Check if applicable "yes" or "no" box.

PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS) - The name and address of the physician or health care professional providing initial treatment.

HOSPITAL (NAME AND ADDRESS) - The name and address of the hospital where employee was treated (if applicable).

INITIAL TREATMENT - Check applicable choices.

WITNESSES (NAME & PHONE #) - The name(s) and phone number(s) of any one who witnessed the accident.

DATE ADMINISTRATOR NOTIFIED - The date the carrier or claims administrator processing the claim received notice of the injury.

DATE PREPARED - The date this report was prepared.

PREPARER'S NAME & TITLE - The name and title of the person who prepared this report.

PHONE NUMBER - The phone number of the person who prepared this report.