IA-1 WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

|  |  |  |  |
| --- | --- | --- | --- |
| **General** | Employer (Name & Address incl. zip)GRANT COUNTY BOARD OF EDUCATION820 ARNIE RISEN BLVD.WILLIAMSTOWN, KY 41097 | Carrier/Administrator Claim Number      | Report Purpose Code      |
| Jurisdiction      | Jurisdiction Claim Number      |
| Insured Report Number      |
| Employer’s Location Address (if different)      | Location No.      |
| Sic Code      | Employer FEIN61-6001380 | Phone No.      |
| **Carrier/Claims Admin** | Carrier (Name, Address & Phone Number)CHURCH MUTUALPO Box 2912Milwaukee, WI 53201-2912 | Policy Period | Claims Admin (Name, Address & Phone Number)Submit to Brian Linder at Grant County Board of Education. |
|       |
| To       |
| [ ]  | Check if self insured |
| Carrier FEIN      | Policy Number or Self-Insured Number07-033006 | Administrator FEIN      |
| Agent Name & Code NumberCURNEAL & HIGNITE INSURANCE, INC |
| **Employee/Wage** | Legal Name (Last, First, Middle)      | Date of Birth      | Social Security Number      | Date Hired      | State of Hire      |
| Address (Incl. Zip)      | Sex | Marital Status | Occupation/Job Title      |
| [ ]  | Male | [ ]  | Unmarried/Single/Div. |
| [ ]  | Female | [ ]  | Married | Employment Status      |
| [ ]  | Unknown | [ ]  | Separated |
| Phone      | No. of Dependents      | [ ]  | Unknown | NCCI Class Code      |
| Wage Rate$      | [ ]  | Day | [ ]  | Month | # Days Worked/WK     | Full Pay for Date of Injury? | [ ]  | Yes | [ ]  | No |
| [ ]  | Week | [x]  | Other | # Hrs Worked per Day      | Did Salary Continue? | [ ]  | Yes | [ ]  | No |
| **Occurrence** | Time Employee Began Work      | [ ]  | AM | Date of Injury or Illness      | Time Occurred      | [ ]  | AM | Last Work Date      | Date Employer Notified      | Date Disability Began      |
| [ ]  | PM | [ ]  | PM |
| Employer Contact Name/Phone Number859-824-3323 | Type of Illness/Injury      | Part of Body Affected      |
| Did Injury/Illness Exposure Occur on Employer’s Premises?      | Yes | [ ]  | Type of Illness/Injury Code      | Part of Body Affected Code      |
| 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 Returned to Work      | If Fatal, Date of Death      | Were Safeguards or Safety Equipment Provided? | [ ]  | Yes | [ ]  | No |
| Were they used? | [ ]  | Yes | [ ]  | No |
| **Treatment** | 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 hr. |
| **Other** | Witness to Accident (Name & Phone Number)      | 5 | [ ]  | Future Major Medical/Lost Time Anticipated |
|  |
| Date Administrator Notified      | Date Prepared      | Preparer’s Name & Title      | Preparer’s Phone Number      |
|  | **IA-1 (2/95)**  | **SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE** |

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