

IA-1

**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#							
<b>CARRIER/CLAIMS ADMINISTRATOR</b>															
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															
<b>EMPLOYEE/WAGE</b>															
NAME (LAST, FIRST, MIDDLE)						DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE			
ADDRESS (INCL ZIP)						SEX		MARITAL STATUS		OCCUPATION/JOB TITLE					
						M MALE		U UNMARRIED SINGLE/DIVORCED							
						F FEMALE		M MARRIED		EMPLOYMENT STATUS					
						U UNKNOWN		S SEPARATED							
PHONE						# OF DEPENDENTS		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	
<b>OCCURRENCE/TREATMENT</b>															
TIME EMPLOYEE BEGAN WORK		<input type="checkbox"/> AM <input type="checkbox"/> PM		DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		<input type="checkbox"/> AM <input type="checkbox"/> 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?						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					
WITNESS (NAME & PHONE #)															
DATE ADMINISTRATOR NOTIFIED				DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER					

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**SEE BACK FOR IMPORTANT STATE INSTRUCTIONS/SIGNATURE**

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**Applicable in Alaska**

A person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception.

**Applicable in Arkansas**

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding worker's compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

**Applicable in California**

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

**Applicable in Connecticut**

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

**Applicable in Delaware and Oklahoma**

Any person who, knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. \*Delaware Statutes Regulation: Del #C Section 913(B)

**Applicable in Florida**

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

**Applicable in Idaho**

Any person who Knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company, Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

**Applicable in Indiana**

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Applicable in Kentucky and New York**

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim continuing 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. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Applicable in Michigan**

Any person who knowingly and with intent to injure or defraud any insurer submits claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to \$5,000.00

**Applicable in Minnesota**

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**Applicable in Nevada**

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

**Applicable in New Hampshire**

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**Applicable in New Jersey**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Applicable in Ohio**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Applicable in Pennsylvania**

Any person who knowingly and with intent to injure or defraud any insurer files a claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years or payment of a fine of up to \$50,000.

**Applicable in Utah**

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

**EMPLOYEE SIGNATURE:** \_\_\_\_\_