Complete all forms included and return to the address listed below:

Eastern Kentucky University
Environmental Health & Safety
Mattox Building, Suite A-2
Office Phone: (859) 622-5523 or (859) 622-8169
Fax Number: (859) 622-1258
Attention: Connie Howe – University Claims Specialist
Bryan Makinen - Director
(859) 622-2421 or (859) 893-6503

INSTRUCTIONS – PLEASE READ CAREFULLY

Supervisors

Please notify this office immediately if:

- Your employee has a work related injury/illness "arising out of and in the course and scope of their employment."
- Off work or Return to work status.

1. COMPLETE THE IA-1 FORM – (First Report of Injury, page 1)
    - Please submit this completed form within 24 hours of the incident **(Very Important)**
    - Form must be TYPEWRITTEN.
    - **Supervisors, Deans, or Chairs must sign the form at the bottom of page. (Preparer's Name and Title). Employee must sign this form as well.**

2. Signature Page – Employee injured must sign this form. (page 2)

3. Request to doctor – If the employee is seeking medical attention for their injury/illness, please ask them to contact this office immediately to ensure they are taking the proper paperwork to the medical provider with them for billing purposes. (page 3)

ALL FORMS MUST BE SIGNED BY A SUPERVISOR, DEAN OR CHAIR. If these forms are not signed by the employee and supervisor they will be returned for signatures.

If you have any questions, please contact the Workers' Compensation Office.

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

General

- 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 No.
- Phone No.
- Sic Code
- Employer FEIN

Carrier/Claims Admin

- Carrier (Name, Address & Phone Number)
- Policy Period
- To
- ☐ Check if self insured
- Claims Admin (Name, Address & Phone Number)
- Carrier FEIN
- Policy Number or Self-Insured Number
- Administrator FEIN
- Agent Name & Code Number

Employee/Wage

- Legal Name (Last, First, Middle)
- Date of Birth
- Social Security Number
- Date Hired
- State of Hire
- Address (Incl. Zip)
- Sex: ☐ Male ☐ Female ☐ Unknown
- Marital Status: ☐ Unmarried/Single/Div. ☐ Married ☐ Separated ☐ Unknown
- Occupation/Job Title
- Employment Status
- Phone
- No. of Dependents
- NCCI Class Code
- Wage Rate $ ☐ Day ☐ Week ☐ Month ☐ Other
- # Days Worked/WK
- # Hrs Worked per Day
- Full Pay for Date of Injury? ☐ Yes ☐ No
- Did Salary Continue? ☐ Yes ☐ No

Occurrence

- Time Employee Began Work ☐ AM ☐ PM
- Date of Injury or Illness
- Time Occurred ☐ AM ☐ PM
- Last Work Date
- Date Employer Notified
- Date Disability Began
- Employer Contact Name/Phone Number
- Type of Illness/Injury
- Part of Body Affected
- Did Injury/Illness Exposure Occur on Employer's Premises? Yes ☐ No ☐
- Type of Illness/Injury 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.
- 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.
  - 5 ☐ Future Major Medical/Lost Time Anticipated

Other

- Witness to Accident (Name & Phone Number)
- 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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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 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. 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 a 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: ______________________________

IA-1 (2-95)

PLEASE TAKE THIS FORM TO YOUR DOCTOR AND LEAVE IT WITH THEM

(For billing purposes only)

DOCTOR ____

ADDRESS ____

EMPLOYEE ____

- Claims that (he/she) ____ was injured on (date) ____ while in our employ. Please render necessary treatment and report (his/her) ____ condition to the Claim Department of Liberty Mutual Insurance Companies on "Surgeon's or Physician's First Report" Form, or on the required form.
- If the injury is not covered under the Workers' Compensation Law, liability is limited to payment for your first examination and report.

EMPLOYER __EASTERN KENTUCKY UNIVERSITY__

ADDRESS __521 Lancaster Ave, Richmond, KY 40475__

SIGNED ______________________________ **Date** ______________

NOTICE TO DOCTOR

- Please send your first report to Liberty Mutual Insurance Companies immediately. This Request to Doctor Form should be attached to the report.
- Send supplementary reports at two week intervals until the employee is able to resume work.
- At termination of the disability please send your final report. If the employee is discharged from treatment, include your itemized bill.
- Report forms can be obtained from the nearest office listed below.

Send all bills to:
Liberty Mutual Middle
P.O. Box 7205
London, KY 40742

Employer Contact : Connie Howe
Office: (859) 622-5523
Fax: (859) 622-1258

Telephone Number: 1-866-568-1119

EMPLOYEE CLAIM #: ____