

**IA-1**

**WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS**

EMPLOYER (NAME & ADDRESS INCLUDING 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 NUMBER) KY AGC/SIF P.O. BOX 436949 LOUISVILLE, KY 40253-6949 (502) 245-2007		POLICY PERIOD  TO  CHECK IF APPROPRIATE <input checked="" type="checkbox"/> SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NUMBER) LADEGAST & HEFFNER CLAIMS SERVICE, INC. P.O. BOX 436949 LOUISVILLE, KY 40253-6949 (502) 245-8395
CARRIER FEIN <b>61-6117673</b>	POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN <b>61-1294537</b>

AGENT NAME

**EMPLOYEE/WAGE**

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCLUDING ZIP)		SEX M MALE F FEMALE U UNKNOWN	MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	OCCUPATION/JOB TITLE	
PHONE		# OF DEPENDENTS	EMPLOYMENT STATUS (FULL TIME, PART TIME, ETC.)		NCCI JOB CLASS CODE
RATE PER:	DAY WEEK	MONTH OTHER	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY DID SALARY CONTINUE?	YES NO 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? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE		
LOCATION OF ACCIDENT OR ILLNESS EXPOSURE INCLUDING POSTAL ZIP CODE				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN 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? WERE THEY USED?	YES NO 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

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER
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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 workers' 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 Regulations: \*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:** \_\_\_\_\_