INSTRUCTIONS

General Instructions:

- 1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.
- 2. Enter all dates in MM/DD/YY format.
- 3. Please return completed form electronically by an approved EDI process.
- 4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME AND CODE NUMBER: Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (e.g. Acetylene cutting torch, metal plate, etc.).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (including overtime, tips, etc.) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME / TELEPHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (i.e. Supervisor, HR Person, Nurse, etc.)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised deigned by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (e.g. Maintenance, Client's Office, Cafeteria, etc.).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: (FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (e.g. Right forearm, Low Back, etc.)

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

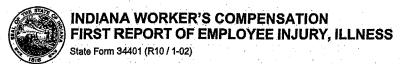
RTW DATE (Return to Work Date): Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is 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.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting).

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (e.g. Contusion, Laceration, Fracture, etc.)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (e.g. Building maintenance).



FOR WORKER'S COMPENSATION BOARD USE ONLY									
Jurisdiction	Jurisdiction claim number	Process date							

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

	<u> </u>		EMPLOYEE INFO			
Social Security numb	er Date of birth	Sex		Occupation /	Job title	NCCI class code
		│	Female Unknown			
Name (last, first, mide	dle)		Marital status	Date hired	State of hire	Employee status
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Address (number and street, city, state, ZIP code)		☐ Married	Hrs / Day	oays/Wk AvgWg/Wk	Paid Day of Injury	
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Telephone number (in	clude area		Number of dependents	- s	☐ Hour ☐	Day ☐ Week ☐ Mont
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lame of employer			Employer ID#		SIC code	Insured report number
ddress of employer (number and street, city, sta	ate, ZIP code)	Location number		Employer's location address (if different)	
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			Telephone number		-	
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			Camer / Administrator c	am number	OSHA log number	Report purpose code
ctual location of accid	ent / exposure (if not on er	mplover's premises)	<u> </u>	 		
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		CARRIER	CLAIMS ADMINISTRA	TOR INFORMA	TION	La service and the service of the se
ame of claims adminis	strator	SARGERY		al ID number	Check if appropriate	
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ddress of claims admir	nistrator (number and stree	t city state 7/D code			Policy / Self-insured num	
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ame of agent			Code number			
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		OCCUR	RENCE / TREATMENT	INFORMATION		
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	□Ca	nnot be determined		Assaulte a.		
st work date	Time workday began		bility began	Part of body		Part code
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ΓW date	Date of death	Injury / Ex	posure occurred \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Name of cont	act	Telephone number
Tr date			posure occurred $\square Y_{\epsilon}$ /er's premises? $\square N_{\epsilon}$		au.	Telephone flumber
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ecific activity engaged	I in during accident / expos	ure		Work process emp	oloyee engaged in during ac	cident / exposure
		<u> </u>				
w injury / exposure oc	curred. Describe the sequi	ence of events and in	clude any relevant objects o	r substances.		
						Cause of injury code
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spital or offsite treatme	ent (name and address)				IMIT	IAL TREATMENT
•						No Medical Treatment
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		12::-			П	Minor: Clinic / Hospital
me of witness		Telephone	umber Date administr			Emergency Care
	17.77			<u> </u>		Hospitalized > 24 Hours
le prepared	Name of preparer		Title	Telephone num	ber	Future Major Medical / Lost
			1			Time Anticipated