## 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 Pull-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).



State Form 34401 (R10 / 1-02)

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## 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.

				EMPL	OYEE INFORM	ΑТ	ION					
Social Security number	·						Occupation / Job title				NCCI class code	
		Male F			Unknown							
Name (last, first, middle)			Marital status Unmarried			Date hired			State of hire	Employee sta	tus	
Address (number and street, city, state, ZIP code)				Married	Ī	Hrs / Day	Days / Wk	!_	Avg Wg / Wk	Doid	Doy of Injury	
				Separated							Day of Injury ry Continued	
					Unknown	L					Salai	y Continued
					Onknown	٧	Vage	Per				
Telephone number (include area)				Number of dependents			3		Hour Day			Week Mont
				EMPL	OYER INFORM	ΑT	ION					
Name of employer				Employer ID#				SIC	SIC code		Insured report number	
Address of employer (number and street, city, state, ZIP code)				Location number				Empl	Employer's location address		(if different)	
				Teleph	none number							
			Carrier / Administrator clair			number	OSH	OSHA log number		Report purpose code		
Actual location of accident /	exposure (if not on en	nployer's pr	emises)									
		CA	ARRIER /	CLAII	MS ADMINISTRA	ΑT	OR INFOR					
Name of Claims Administra					Carrier fede	eral	ID number	Chec	k if	appropriate		
Indiana Public Employers Plan (IPEP)									D " (0 ":		Self Insurance	
Email of Claims Administrator: ipepclaims@ipep.com				Insur			ance Carrier		ı/S	Self-insured number		
Telephone number							F		у р	period		
800-382-8837 765-868-3310 FAX									From		То	
Name of agent				Code	number							
			OCCUR	RENC	E / TREATMENT	T IN	NFORMAT	ION				
					employer notified		Type of injur		osure			Type code
Cannot be determined												
Last work date	Time workday began Date disab			ility began			Part of body					Part code
RTW date	Date of death		Injury / Ex	•			Name of contact				Telephone number	
Department or location where accident / exposure occurred							All equipment, materials, or chemicals involved in accident					
Specific activity engaged in during accident / exposure							Work process employee engaged in during accide				/ exposure	
How injury / exposure occur	red. Describe the sequ	uence of ev	ents and inc	clude a	ny relevant objects	or	substances				Course of indicate	
											Cause of injur	y code
Name of physician / health of	care provider											
Hospital or offsite treatment	(name and address)										INITIAL TR	
											No Medical Minor: By E	mployer
Name of witness Teleph			Telephone	ne number			Date administrator notified				Emergency	
Date prepared	Name of preparer			Title			Telephone number				Hospitalized > 24 Hours Future Major Medical / Lost Time Anticipated	