



Please return to:

Downey Insurance, Inc.
 P. O. Box 690
 Kokomo, IN 46903-0690
 1-800-382-8837
 1-765-868-3310 FAX

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.

EMPLOYEE INFORMATION							
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	OCCUPATIONAL TITLE		NCCI CLASS CODE		
LAST NAME	FIRST	MIDDLE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED	DATE HIRED	STATE OF HIRE	EMPLOYEE STATUS	
ADDRESS (INCL ZIP)			# OF DEPENDENTS	HRS/DAY	DAYS/WK	AVG W/W	PAID DAY OF INJ <input type="checkbox"/> SALARY CONT'D <input type="checkbox"/>
PHONE				WAGE PER <input type="checkbox"/> HR <input type="checkbox"/> DAY <input type="checkbox"/> WK <input type="checkbox"/> MO <input type="checkbox"/> YR <input type="checkbox"/> OTHER			

EMPLOYER INFORMATION			
EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP)	EMPLOYER FEDERAL ID#	SIC CODE	INSURED REPORT NUMBER
	LOC #	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
	PHONE #		
CARRIER/ADMINSTRATOR CLAIM NUMBER		REPORT PURPOSE CODE	

Actual Location of Accident/Exposure (if not on employer's premises):

CARRIER/CLAIMS ADMINSTRATOR INFORMATION		
CLAIMS ADMINSTRATOR (NAME, ADDRESS, PHONE NO) Downey Insurance Inc. (IPEP) P. O. Box 690 Kokomo, IN 46903-0690 PHONE: 800-382-8837	CARRIER FEDERAL ID#	CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE
	<input type="checkbox"/> INSURANCE CARRIER	POLICY/SELF-INSUED NUMBER
	<input checked="" type="checkbox"/> THIRD PARTY ADMIN	POLICY PERIOD FROM _____ TO _____
AGENT NAME	CODE NUMBER	

OCCURRENCE/TREATMENT INFORMATION					
DATE OF INJ/EXP	TIME OF OCCURRENCE	DATE EMPLOYER NOTIFIED	TYPE OF INJURY/EXPOSURE		TYPE CODE
LAST WORK DATE	TIME WORKDAY BEGAN	DATE DISABILITY BEGAN	PART OF BODY		PART CODE
RTW DATE	DATE OF DEATH	INJURY/EXPOSURE OCCURRED ON EMPLOYER'S PREMISES?	<input type="checkbox"/> YES <input type="checkbox"/> NO	CONTACT NAME	PHONE 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 ACCIDENT/EXPOSURE		
HOW INJURY/EXPOSURE OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY RELEVANT OBJECTS OR SUBSTANCES					CAUSE OF INJURY CODE
NAME OF PHYSICIAN/HEALTH CARE PROVIDER					INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR, BY EMPLOYER <input type="checkbox"/> MINOR, CLINIC/HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > THAN 24HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ L/T
WITNESSES (NAME, PHONE#)			DATE ADMINSTRATOR NOTIFIED		
DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER		