NOTICE:
INDIANA WORKERS COMPENSATION

This business operates under Indiana Workers Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, OR AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR OR FOREMAN OF THE EMPLOYER.

Workers Compensation insurance benefits are provided through:

BerkleyNet

To report a claim, contact us at:

Website: berkleynet.com
Email: claims@berkleynet.com
Address: 9301 Innovation Drive, Suite 200, Manassas, VA 20110
Phone: 877.497.2637
Fax: 866.275.6320

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 *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

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 *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*).

INDIANA WORKER'S COMPENSATION
FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R9 / 3-01)

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.

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex ☐ Male ☐ Female ☐ Unknown	Occupation / Job title	NCCI class code

Name (*last, first, middle*)	Marital status	Date hired	State of hire	Employee status
	☐ Unmarried ☐ Married ☐ Separated ☐ Unknown			

Address (*number and street, city, state, ZIP code)*	Hrs / Day	Days / Wk	Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued

Telephone number (include area code)	Number of dependents	Wage $	Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number

Address of employer (*number and street, city, state, ZIP code*)	Location number	Employer's location address (*if different)*
	Telephone number	

	Carrier / Administrator claim number	Report purpose code

Actual location of accident / exposure (*if not on employer's premises*)

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate ☐ Self Insurance

Address of claims administrator (*number and street, city, state, ZIP code*)	☐ Insurance Carrier ☐ Third Party Admin.	Policy / Self-insured number

Telephone number		Policy period From To

Name of agent	Code number

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp.	Time of occurrence ☐ AM ☐ PM	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? ☐ Yes ☐ No	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 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
- ☐ No Medical Treatment
- ☐ Minor: By Employer
- ☐ Minor: Clinic / Hospital
- ☐ Emergency Care
- ☐ Hospitalized > 24 Hours
- ☐ Future Major Medical / Lost Time Anticipated

Name of witness	Telephone number	Date administrator notified

Date prepared	Name of preparer	Title	Telephone number

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).

WORKER'S COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Worker's Compensation Act of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The worker's compensation insurance carrier or the administrator for

_____ is: _____
(name of company) (name of insurance carrier or administrator)

_____
(name of carrier/administrator)

_____
(mailing address)

_____
(city, state, zip)

_____
(telephone number)

_____
(contact person)

For more information about rights or procedures under the Indiana Worker's Compensation system, call or write:

Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

NOTICIA DE COMPENSACION PARA TRABAJADORES

A su empleador le es requerido proveer pagos de beneficios bajo el Acta de Compensación para Trabajadores del Estado de Indiana.

Cualquier empleado que sea lesionado mientras esté trabajando debe reportar el accidente laboral inmediatamente a su supervisor, empleador o representante designado.

La compañía de seguro de compensación del trabajador o el administrador de la compañía _____ es:
(nombre de la compañía)

_____
(nombre de la compañía de seguro/administrador)

_____
(dirección)

_____
(ciudad, estado, código postal)

_____
(número de teléfono)

_____
(persona de contacto)

Para más información acerca de sus derechos o los procedimientos bajo el sistema de compensación para trabajadores de Indiana, llame o escriba a:

Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
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