# Workers’ Compensation – FIRST REPORT OF INJURY OR ILLNESS Jurisdiction Code \_\_\_\_\_\_\_\_ Jurisdiction Claim Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| CLAIM ADMIN | Claim Administrator Name:RAS Companies | Claim Representative Business Phone Number:       | Insurer Name (if different than claim administrator)       |
| Mailing Address, City State & Postal Code:P.O. Box 89310Sioux Falls, SD 57109-9310 | Claim Administrator Claim Number:       | Insurer FEIN:       |
| Claim Administrator FEIN:       | Claim Type Code:       |
| EMPLOYER | Employer Name:       | Employer FEIN:       | Insured Report Number: | Employer Type Code X Employer (E)       Lessor (L) |
| Physical Address, City, State & Postal Code:      | Mailing Address, City, State& Postal Code       | Industry Code: 866101 |
| Insured Location Number:       | Employer UI Number:       |
| Nature of Business:       | Employer Contact Name & Business Phone Number:       |
| POLICY | Insured Name (parent company if different than employer):Roman Catholic Diocese of Des Moines | Insured FEIN: 420680255 | Insured Postal Code:       | Policy/Contract Number: WC020-0030434-2023A | Coverage Effective Date: 07/01/2023 | Self Insurance License/ Certificate Number:       |
| Coverage Expiration Date: 06/30/2024 |
| EMPLOYEE | Employee Name (First, Middle, Last & Suffix):        | Date of Birth:       | Gender:       Male (M)       Female (F) | Tax Filing Status (check one)      Single (A)       Married/Filing Joint (C)     Single/HedHousehold (B)       Married/FilinSeparate(D) |
| Mailing Address, City, State & Postal Code:       | Date of Hire:       |
| Employment Status (check one)      Piece Worker      Volunteer      Seasonal      Apprenticeship/Full –Time      Apprenticeship/Part-Time      Regular Employee/Full-Time      Part-time      Other | Employee ID Number (check one) ID #            Social Security Number      Employment VISA Number      Passport Number      Green Card      Employee ID Assigned by Jurisdiction | Marital Status:       Unmarried (U)       Married (M)       Separated (S) |
| Phone Number (include area code):       |
| Occupation Description:       | Employee’s Authorization to Release the Following:Medical Records \_\_ yes \_\_ noSocial Security # \_\_ yes \_\_ no |
| Manual Classification Code:       |
| Department Where Regularly Worked:       |
| WAGE | Average Wage $      (check one)      hourly       daily       semi-monthly      monthly      bi-weekly       annual      weekly | Salary Continued in Lieu of Compensation:       yes       no | Employee Number of Dependents:       |
|  Full Wages Paid for Date of Injury:       yes       no | Employee Number of Exemptions:       (check one)       Entitled       Withholding |
| Number of Days Regularly Worked Per Week:       |   Discontinued Fringe Benefits: $      |
| ACCIDENT / INJURY |       Date of Injury      Date Employer Had Knowledge of the Injury      Date Claim Administrator Had Knowledge of the Injury      Initial Date Last Worked      Initial Return to Work Date (if applicable)      Employee Date of Death (if applicable) | Describe the nature of the injury. (ex. amputation, burn, cut, fracture):       |
| Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):       |
|       Time of Injury      Time Employee Began Work | Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure): . |
| Pre-Existing Disability Code:       Yes       No       Unknown |
| Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):       |
| Accident Premises Code:       Employer (E)       Lessee (L)       Other (X) |
|
| Accident Site Organization Name:       | Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties:       |
| Accident Site Street, City, State & Postal Code:       |
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| Accident Location Narrative (if no street address):       |
| Accident Site County/Parish:       | Witness Name & Business Phone Number:       |
| MEDICAL | Initial Treatment Code check one):      no medical treatment (0)      minor/on-site treatment (1)      clinic/hospital visit (2)      emergency care (3)      hospitalization >24 hours (4)      future medical treatment/lost time anticipated (5) | Initial Medical Provider Name:       | Managed Care Organization Name or ID Number:       |
| Initial Medical Provider Physical Address, City, State, & Postal Code       | ICD Primary Diagnostic Code (if known):       |
|  | Preparer’s Name & Title       | Preparer’s Company Name:       | Phone Number:       | Date:       |

IAIABC FORM 1.2 (12/98)