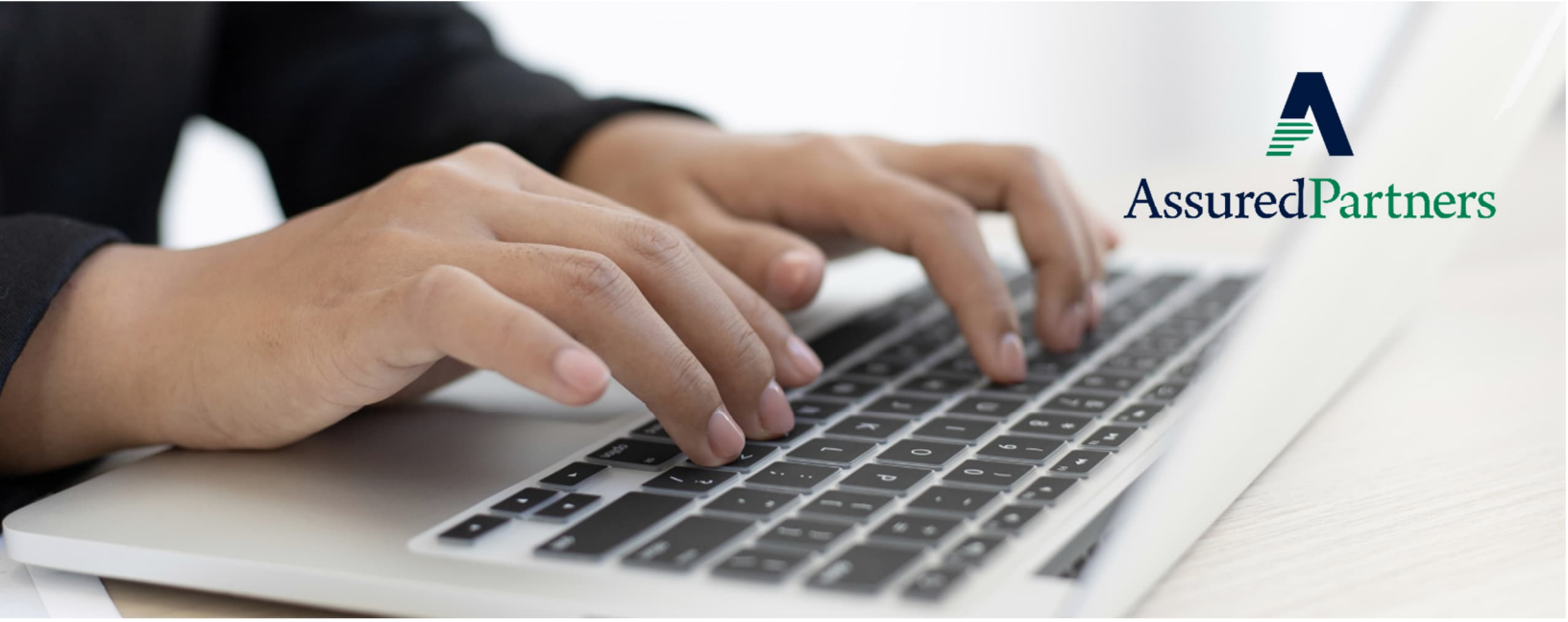


Diocese of Des Moines: Completing the First Report of Injury Form to Report an Employee Injury

To report an employee workplace injury or illness, you need to complete[1] the First Report of Injury (FROI) form, which is available online here: Workers' Compensation | Diocese of Des Moines.

Download the form by clicking the download icon or the save icon. You can then save your progress as you gather information.

Completed forms should be sent to Alison Miner at alison.miner@assuredpartners.com **within 24 hours** of notice of the injury or illness.

The different sections of the form are addressed below.

Fields outlined in red in the screenshots below ***MUST*** be completed before submitting the form. They include:

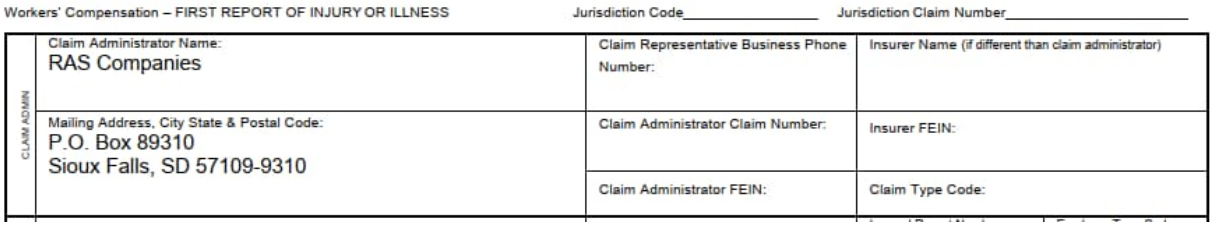
- Employer Name
- Employer Contact Name & Business Phone Number
- Employee Name and ID Number (typically a social security number)
- Date of Injury
- Something in any of the Injury section fields
- Treatment under the Medical section

[1] For convenience, a video walkthrough of these instructions can be found online here: Diocese of Des Moines FROI Demo.

Fields outlined in blue also should be completed if the information is readily available.

- Please include as much of this information as you can – if this information is not readily available, please include the information available and submit the form.
- Submitting the information as soon as possible is more important than completing every field.

CARRIER ADMIN

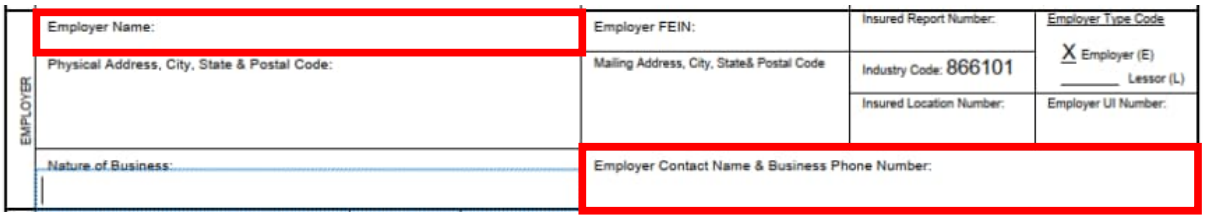

Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS Jurisdiction Code_____ Jurisdiction Claim Number_____

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 89310 Sioux Falls, SD 57109-9310	Claim Administrator Claim Number:	Insurer FEIN:
	Claim Administrator FEIN:	Claim Type Code:

You do not need to complete any information in the top section of the form (Jurisdiction Codes/Numbers or the **CARRIER ADMIN** section). These fields are for the insurance carrier, so you can disregard them.

EMPLOYER

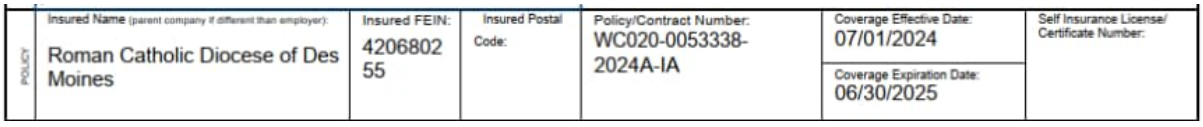


EMPLOYER

Employer Name:	Employer FEIN:	Insured Report Number:	Employer Type Code
Physical Address, City, State & Postal Code:	Mailing Address, City, State& Postal Code	Industry Code: 866101	X Employer (E) _____ Lessor (L)
		Insured Location Number:	Employer UI Number:
Nature of Business:	Employer Contact Name & Business Phone Number:		

Employer Name should be the specific location (ex: parish or school) name, not just "Diocese of Des Moines."

POLICY

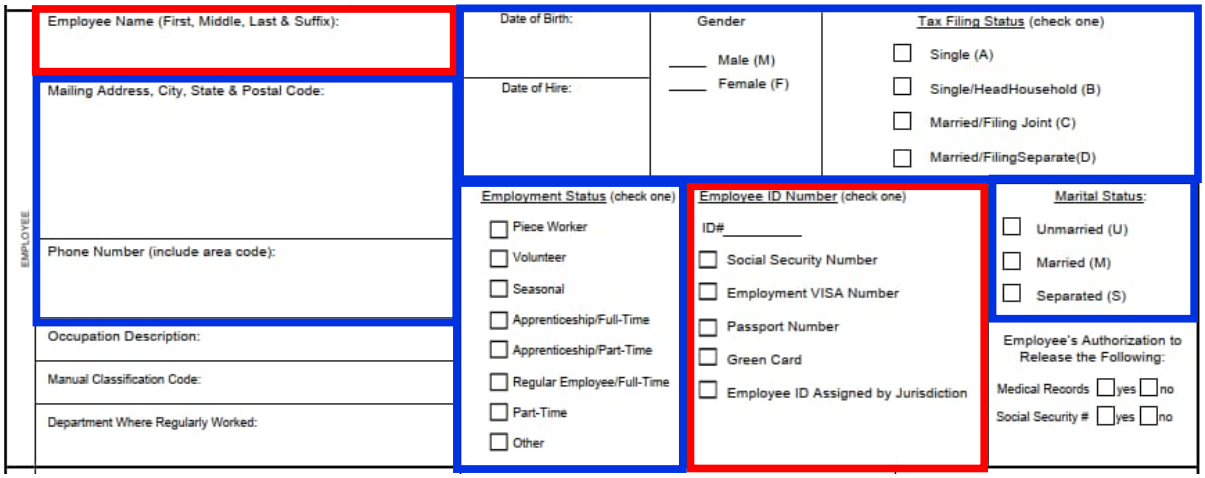


POLICY

Insured Name (parent company if different than employer):	Insured FEIN:	Insured Postal Code:	Policy/Contract Number:	Coverage Effective Date:	Self Insurance License/ Certificate Number:
Roman Catholic Diocese of Des Moines	420680255		WC020-0053338-2024A-IA	07/01/2024	
				Coverage Expiration Date: 06/30/2025	

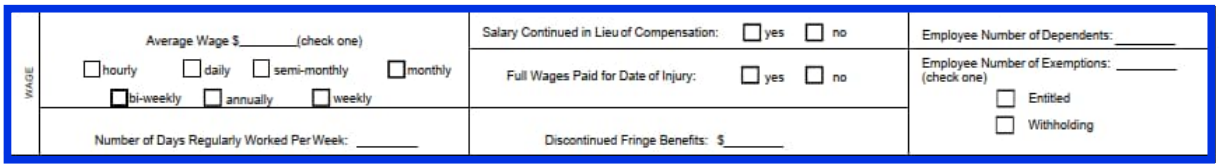
This section is already completed by the Diocese. If you are reusing a form and the date of injury is after the Coverage Expiration Date listed in this section, then please download the current form from the Diocese website (Workers' Compensation | Diocese of Des Moines).

EMPLOYEE



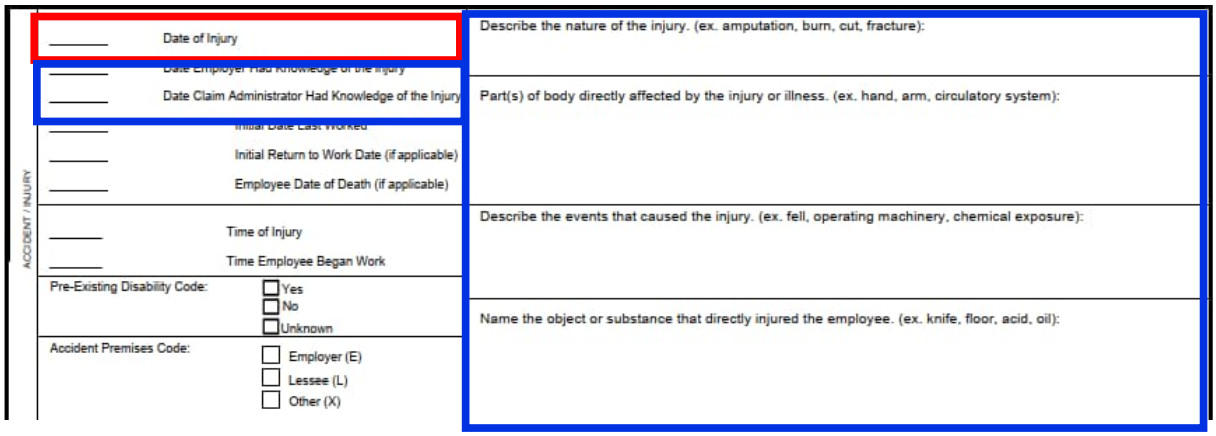
Employee ID Number is typically the injured employee's social security number.

WAGE



This entire section is especially important if you expect the injured worker is likely to miss more than three (3) days of work.

ACCIDENT/INJURY



Note: This section continues onto the second page of the form.

ACCIDENT/INJURY – continued

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:	
Accident Location Narrative (if no street address):	
Accident Site County/Parish:	Witness Name & Business Phone Number:

Accident Site and subsequent details also are important if the injury occurred somewhere other than the location already described in the “Employer” section.

MEDICAL

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):

If you know that treatment was provided, but you do not have any details about the treatment, please indicate that treatment was provided. If you do not know, please list “Unknown.”

PREPARER

Preparer's Name & Title	Preparer's Company Name:	Phone Number:	Date:

IAIABC FORM 1.2 (12/98)

This form should be completed by the employer, NOT the injured worker.