

Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS

Jurisdiction Code: _____ Jurisdiction Claim Number _____

CLAIM ADMIN	1. Claim Administrator Name: SEDGWICK CMS		3. Claim Representative Business Phone No.: (515) 327-4888 (866)-342-3920		6. Insurer Name (if different than claim administrator): IOWA -- STATE OF	
	2. Mailing Address, City, State, & Postal Code: P.O. Box 14628 Lexington, KY 40512 FAX (515) 327-4891		4. Claim Administrator Claim No.:		7. Insurer FEIN: 420932069	
EMPLOYER	9. Employer Name: IOWA -- STATE OF		12. Employer FEIN: 420932069		14. Insured Report No.:	
	10. Physical Address, City, State, & Postal Code 1305 E. WALNUT ST. DES MOINES, IA 50319-0150		13. Mailing Address, City, State & postal Code: SAME AS PHYSICAL ADDRESS		15. Industry Code:	
	11. Nature of Business: GOVERNMENT		19. Employer Contact Name and Business Phone Number: JEFF JOHNSON (515) 281-4513		17. Employer Type Code: <input checked="" type="checkbox"/> Employer (E) <input type="checkbox"/> Lessor (L)	
POLICY	20. Insured Name N/A		21. Insured FEIN: N/A		24. Coverage Effective Date: N/A	
			22. Insured Postal Code: N/A		25. Coverage Expiration Date: N/A	
EMPLOYEE	27. Employee Name (First, Middle, Last, & Suffix):		33. Date of Birth: / /		36. Gender <input type="checkbox"/> Male(M) <input type="checkbox"/> Female(F)	
	28. Residential Mailing Address: Street/PO Box: City: State: Postal Code:		34. Date of Hire: / /		37. Educational Level: N/A	
	29. Phone Number (include area code): ()		35. Employment Status (check one): <input type="checkbox"/> Piece Worker <input type="checkbox"/> Volunteer <input type="checkbox"/> Seasonal <input type="checkbox"/> Apprenticeship/FT <input type="checkbox"/> Apprenticeship/PT <input type="checkbox"/> Regular Employee/FT <input type="checkbox"/> Regular Employee/PT <input type="checkbox"/> Other		39. Employee ID No.: ID#: (check one) <input type="checkbox"/> Social Security No. <input type="checkbox"/> Employment VISA No. <input type="checkbox"/> Passport No. <input type="checkbox"/> Green Card <input type="checkbox"/> Employee ID Assigned by Jurisdiction	
	30. Occupation Description:				40. Marital Status (check one): <input type="checkbox"/> Unmarried (U) <input type="checkbox"/> Married (M) <input type="checkbox"/> Separated (S)	
	31. Manual Classification Code: N/A				41. Employee's Authorization to Release the Following: Medical Records <input type="checkbox"/> YES <input type="checkbox"/> NO Social Security Number <input type="checkbox"/> YES <input type="checkbox"/> NO	
	32. Department Where Regularly Worked:					
WAGE	42. Average Wage \$ _____ (check one): <input type="checkbox"/> hourly <input type="checkbox"/> daily <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> monthly <input type="checkbox"/> annual		44. Salary Continued in Lieu of Compensation: <input type="checkbox"/> YES <input type="checkbox"/> NO		47. Employee Number of Dependents:	
	43. Number of Days Regularly Worked Per Week:		45. Full Wages Paid for Date of Injury: <input type="checkbox"/> YES <input type="checkbox"/> NO		48. Employee Number of Exemptions: _____ (check one) <input checked="" type="checkbox"/> Entitled <input type="checkbox"/> Withholding	
			46. Discontinued Fringe Benefits: \$ N/A			
ACCIDENT v INJURY	49. / / Date of Injury		63. Describe the nature of the injury (ex. amputation, burn, cut, fracture):			
	50. / / Date Employer Had Knowledge of the Injury		64. Part(s) of body directly affected by the injury or illness (ex. hand, arm, circulatory system):			
	51. / / Date Claim Administrator Had Knowledge of the Injury					
	52. / / Last Day Worked		65. Describe the events that caused the injury (ex. fell, operating machinery, chemical exposure):			
	53. / / Initial Return to Work Date (if applicable)					
	54. / / Employee Date of Death (if applicable)					
	55. : Time of Injury					
56. : Time Employee Began Work						
57. Pre-existing Disability Code: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown						
58. Accident Premises Code: <input type="checkbox"/> Employer (E) <input type="checkbox"/> Lessee (L) <input type="checkbox"/> Other (X)		66. Name the object or substance that directly injured the employee (ex. knife, floor, acid, oil):				
59. Accident Site Organization Name:						
60. Accident Site: Street: City: State: Iowa Zip:		67. 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:				
61. Accident Location narrative (if no street address):						
62. Accident Site County/Parish:		68. Witness Name and Business Phone Number: ()				
MEDICAL	69. Initial Treatment Code (check one): <input type="checkbox"/> no medical treatment (0) <input type="checkbox"/> minor/on-site treatment (1) <input type="checkbox"/> clinic/hospital visit (2) <input type="checkbox"/> emergency care (3) <input type="checkbox"/> hospitalization > 24 hours (4) <input type="checkbox"/> future medical treatment/lost time anticipated (5)		70. Initial Medical Provider Name:		72. Managed Care Organization Name or ID No.: N/A	
			71. Initial Medical Provider Physical Location Address: City: State: Postal Code:		73. ICD Primary Diagnostic Code (if known): N/A	
74. Preparer's Name & Title (Supervisor)		75. Preparer's Department:		76. Preparer's Phone Number: ()		
				77. Date:		