Please return to:

IPEP
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	OCCUPATIONAL TITLE	NCCI CLASS CODE
		☐ MALE ☐ FEMALE ☐ UNKNOWN		

LAST NAME	FIRST	MIDDLE	DATE HIRED	STATE OF HIRE	EMPLOYEE STATUS

ADDRESS (INCL ZIP)

MARITAL STATUS
☐ SINGLE
☐ MARRIED
☐ SEPARATED

OF DEPENDENTS

PHONE

HRS/DAY	DAYS/WK	AVG W/W	PAID DAY OF INJ ☐
			SALARY CONT'D ☐

WAGE PER ☐ HR ☐ DAY ☐ WK ☐ MO ☐ YR ☐ 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)

IPEP
P. O. Box 690
Kokomo, IN 46903-0690
PHONE: 800-382-8837

CARRIER FEDERAL ID#

☐ INSURANCE CARRIER
☐ THIRD PARTY ADMIN

CHECK IF APPROPRIATE
☐ SELF INSURANCE

POLICY/SELF-INSUED NUMBER

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? ☐ YES ☐ 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

WITNESSES (NAME, PHONE#)

DATE ADMINSTRATOR NOTIFIED

DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER

INITIAL TREATMENT
☐ NO MEDICAL TREATMENT
☐ MINOR, BY EMPLOYER
☐ MINOR, CLINIC/HOSP
☐ EMERGENCY CARE
☐ HOSPITALIZED > THAN 24HRS
☐ FUTURE MAJOR MEDICAL/ L/T