

IA-1 WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

| | | | | | | | | | | | | | |
|--|--|--------------------------|---------------------------|---|------------------------------------|---|---|------------------------------|---|----------------------------|---------------|--------------------------|--------------|
| General | Employer (Name & Address incl. zip) Kentucky Community & Technical College System 300 N. Main Street Versailles, KY 40383 | | | | Carrier/Administrator Claim Number | | Report Purpose Code | | | | | | |
| | | | | | Jurisdiction | Jurisdiction Claim Number | | | | | | | |
| | Sic Code | | | | Employer FEIN | | | | Insured Report Number | | | | |
| | | | | | | | | | Employer's Location Address (if different) | | | | Location No. |
| | | | | | | | | Phone No. | | | | | |
| Carrier/Claims Admin | Carrier (Name, Address & Phone Number) | | | | Policy Period | | Claims Admin (Name, Address & Phone Number) | | | | | | |
| | | | | | To | | | | | | | | |
| | <input type="checkbox"/> | | Check if self insured | | | | | | | | | | |
| Carrier FEIN | | | | Policy Number or Self-Insured Number | | | | Administrator FEIN | | | | | |
| Agent Name & Code Number | | | | | | | | | | | | | |
| Employee/Wage | Legal Name (Last, First, Middle) | | | Date of Birth | | Social Security Number | | | Date Hired | | State of Hire | | |
| | Address (Incl. Zip) | | | Sex | | Marital Status | | Occupation/Job Title | | | | | |
| | | | | <input type="checkbox"/> | Male | <input type="checkbox"/> | Unmarried/Single/Div. | | | | | | |
| | | | | <input type="checkbox"/> | Female | <input type="checkbox"/> | Married | | Employment Status | | | | |
| | <input type="checkbox"/> | Unknown | <input type="checkbox"/> | Separated | | | | | | | | | |
| Phone | | | No. of Dependents | | <input type="checkbox"/> | Unknown | | NCCI Class Code | | | | | |
| Wage Rate | | <input type="checkbox"/> | Day | <input type="checkbox"/> | Month | # Days Worked/WK | | Full Pay for Date of Injury? | | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| \$ | | <input type="checkbox"/> | Week | <input type="checkbox"/> | Other | # Hrs Worked per Day | | Did Salary Continue? | | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Time Employee Began Work | <input type="checkbox"/> | AM | Date of Injury or Illness | | Time Occurred | <input type="checkbox"/> | AM | Last Work Date | | Date Employer Notified | | Date Disability Began | |
| | <input type="checkbox"/> | PM | | | <input type="checkbox"/> | PM | | | | | | | |
| Employer Contact Name/Phone Number | | | | | Type of Illness/Injury | | | | Part of Body Affected | | | | |
| Did Injury/Illness Exposure Occur on Employer's Premises? | | | | Yes | <input type="checkbox"/> | Type of Illness/Injury Code | | | | Part of Body Affected Code | | | |
| No | | | | <input type="checkbox"/> | | | | | | | | | |
| Department or location where accident or illness exposure occurred | | | | | | All Equipment, Materials, or Chemicals Employee was using when accident or illness exposure occurred. | | | | | | | |
| Specific Activity the Employee was engaged in when the accident or illness exposure occurred. | | | | | | Work Process the Employee Was Engaged in when accident or illness exposure occurred. | | | | | | | |
| How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill. | | | | | | | | | | Cause of Injury Code | | | |
| Date Returned to Work | | | If Fatal, Date of Death | | | Were Safeguards or Safety Equipment Provided? | | | | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| | | | | | | Were they used? | | | | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Treatment | Physician/Health Care Provider (Name & Address) | | | | Hospital (Name & Address) | | | | Initial Treatment 0 <input type="checkbox"/> No Medical Treatment 1 <input type="checkbox"/> Minor: By Employer 2 <input type="checkbox"/> Minor Clinic/Hosp 3 <input type="checkbox"/> Emergency Care 4 <input type="checkbox"/> Hospitalized > 24 hr. 5 <input type="checkbox"/> Future Major Medical/Lost Time Anticipated | | | | |
| | | | | | | | | | | | | | |
| Other | Witness to Accident (Name & Phone Number) | | | | | | | | | | | | |
| | Date Administrator Notified | | | Date Prepared | | Preparer's Name & Title | | | | Preparer's Phone Number | | | |
| IA-1 (2/95) | | | | SEE NEXT PAGE FOR IMPORTANT STATE INFORMATION/SIGNATURE | | | | | | | | | |

Applicable in Alaska

A person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception.

Applicable in Arkansas

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding worker's compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

Applicable in California

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Applicable in Connecticut

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Applicable in Delaware and Oklahoma

Any person who, knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. *Delaware Statutes Regulation: Del #C Section 913(B)

Applicable in Florida

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Applicable in Idaho

Any person who Knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company, Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kentucky and New York

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Michigan

Any person who knowingly and with intent to injure or defraud any insurer submits a claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to \$5,000.00.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Pennsylvania

Any person who knowingly and with intent to injure or defraud any insurer files a claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years or payment of a fine of up to \$50,000.

Applicable in Utah

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

EMPLOYEE SIGNATURE:

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