Reset Form

INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

Please return completed form electronically by an approved EDI process.

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 ☐ Male ☐ Female ☐ Unknown | Occupation / Job title | NCCI class code

Name (*last, first, middle*) | Marital status ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown | Date hired | State of hire | Employee status

Address (*number and street, city, state, ZIP code*) | Hrs / Day | Days / Wk | Avg Wg / Wk | ☐ Paid Day of Injury ☐ Salary Continued

Telephone number (include area | Number of dependents | Wage $ | Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other

EMPLOYER INFORMATION

Name of employer: City of Mishawaka | Employer ID# | SIC code | Insured report number

Address of employer (*number and street, city, state, ZIP code*): 600 E Third St, Mishawaka, IN 46544 | Location number | Employer's location address (*if different*)

Telephone number: 574-258-1615

Carrier / Administrator claim number | OSHA log number | Report purpose code

Actual location of accident / exposure (*if not on employer's premises*)

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator: Bituminous Insurance Co. | Carrier federal ID number | Check if appropriate ☐ Self Insurance

Address of claims administrator (*number and street, city, state, ZIP code*): 17197 N. Laurel Park Dr., Ste. 254 Livonia, MI 48152 | ☐ Insurance Carrier ☐ Third Party Admin. | Policy / Self-insured number

Telephone number: 800-356-8727 | Policy period From To

Name of agent: McCarthy Smessaert Insurance Group, Inc., Phone: 259-5622 | Code number

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp. | Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined | 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 | Name of contact | Telephone 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

Hospital or offsite treatment (*name and address*)

Name of witness | Telephone number | Date administrator notified

Date prepared | Name of preparer | Title | Telephone number

INITIAL TREATMENT
- ☐ No Medical Treatment
- ☐ Minor: By Employer
- ☐ Minor: Clinic / Hospital
- ☐ Emergency Care
- ☐ Hospitalized > 24 Hours
- ☐ Future Major Medical / Lost Time Anticipated

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).