

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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN			OCCUPATIONAL TITLE		NCCI CLASS CODE						
LAST NAME		FIRST		MIDDLE		MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED # OF DEPENDENTS		DATE HIRED		STATE OF HIRE		EMPLOYEE STATUS			
ADDRESS (INCL ZIP)								HRS/DAY		DAYS/WK		AVG W/W		PAID DAY OF INJ <input type="checkbox"/>	
								WAGE PER		<input type="checkbox"/> HR <input type="checkbox"/> DAY <input type="checkbox"/> WK <input type="checkbox"/> MO		SALARY CONT'D <input type="checkbox"/>			
PHONE								<input type="checkbox"/> YR <input type="checkbox"/> 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#		CHECK IF APPROPRIATE	
		<input type="checkbox"/> INSURANCE CARRIER <input checked="" type="checkbox"/> THIRD PARTY ADMIN		<input type="checkbox"/> 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?		<input type="checkbox"/> YES <input type="checkbox"/> 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	
								INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR, BY EMPLOYER <input type="checkbox"/> MINOR, CLINIC/HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > THAN 24HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ L/T	
NAME OF PHYSICIAN/HEALTH CARE PROVIDER									
WITNESSES (NAME, PHONE#)						DATE ADMINSTRATOR NOTIFIED			
DATE PREPARED		PREPARER'S NAME			TITLE		PHONE NUMBER		