IOWA WORK INJURY REPORTING PROCEDURES

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

First Report of Injury or Illness (IAIABC Form 1.2)

This form must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, First Reports of Injury or Illness (FROI's) may be submitted to us online at: www.berkindcomp.com. Online Reporting Instructions are enclosed. Maintain a copy of the FROI for your records. Keep a separate file for each workers' compensation claim.

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the FROI. If the FROI is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

Wage Statement

Wage statements must be completed on claims involving lost time from work. The employee's gross wages for the 52 weeks prior to the date of injury are required. If the employee has not been employed for 52 weeks, then report the available wages. In addition to regular pay, computation of wages may include overtime, tips, and the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee. If there are weeks with no wages, please explain the reason by coding as follows:

V= Vacation I= Illness L= Lay off P= Personal leave O= Other

Please contact our claims department with questions.

Do not delay reporting the First Report of Injury or Illness for completion of the wage statement.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

Iowa Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS **Jurisdiction Code_____** **Jurisdiction Claim Number_____**

CLAIM ADMIN

Claim Administrator Name:

Claim Representative Business Phone Number:

Insurer Name (if different than claim administrator):

Mailing Address, City, State, & Postal Code:

Claim Administrator Claim Number:

Insurer FEIN:

Claim Administrator FEIN:

Claim Type Code:

EMPLOYER

Employer Name:

Employer FEIN:

Insured Report Number:

Employer Type Code:
__ Employer (E)
__ Lessor (L)

Physical Address, City, State, & Postal Code:

Mailing Address, City, State, & Postal Code:

Industry Code:

Insured Location Number:

Employer UI Number:

Nature of Business:

Employer Contact Name and Business Phone Number:

POLICY

Insured Name (parent company if different than employer):

Insured FEIN:

Insured Postal Code:

Policy/Contract Number:

Coverage Effective Date:

Coverage Expiration Date:

Self Insurance License/ Certificate Number:

EMPLOYEE

Employee Name (First, Middle, Last, & Suffix):

Date of Birth:

Gender:
__ Male (M)
__ Female (F)

Tax Filing Status (check one):
____ Single (A)
____ Married/Filing Joint (C)
____ Single/Head of Household (B)
____ Married/Filing Separate(D)

Mailing Address, City, State, & Postal Code:

Date of Hire:

Educational Level (grade completed): _____ [GED = 12]

Marital Status: (check one)
___ Unmarried (U)
___ Married (M)
___ Separated (S)

Phone Number (include area code):

Employment Status (check one):
____ Piece Worker
____ Volunteer
____ Seasonal
____ Apprenticeship/Full-Time
____ Apprenticeship/Part-Time
____ Regular Employee/Full-Time
____ Part-Time
____ Other

Employee ID Number (check one):
ID # _____
____ Social Security Number
____ Employment VISA Number
____ Passport Number
____ Green Card
____ Employee ID Assigned by Jurisdiction

Occupation Description:

Manual Classification Code:

Department Where Regularly Worked:

Employee's Authorization to Release the Following:
Medical Records __ yes __ no
Social Security Number __ yes __ no

WAGE

Average Wage $ _____ (check one):
___ hourly ___ daily ___ semi-monthly ___ monthly
___ bi-weekly ___ annual ___ weekly

Salary Continued In Lieu of Compensation: ___ yes ___ no

Employee Number of Dependents: _____

Full Wages Paid for Date of Injury: ___ yes ___ no

Employee Number of Exemptions: _____ (check one)
___ Entitled
___ Withholding

Number of Days Regularly Worked Per Week: _____

Discontinued Fringe Benefits: $_____

ACCIDENT/INJURY

_____ Date of Injury
_____ Date Employer Had Knowledge of the Injury
_____ Date Claim Administrator Had Knowledge of the Injury
_____ Initial Date Last Day Worked
_____ Initial Return to Work Date (if applicable)
_____ Employee Date of Death (if applicable)

_____ Time of Injury
_____ Time Employee Began Work

Pre-Existing Disability Code:
___ Yes
___ No
___ Unknown

Accident Premises Code:
___ Employer (E)
___ Lessee (L)
___ Other (X)

Accident Site Organization Name:

Accident Site Street, City, State, & Postal Code:

Accident Location Narrative (if no street address):

Accident Site County/Parish:

Describe the nature of the injury. (ex. amputation, burn, cut, fracture):

Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):

Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):

Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):

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:

Witness Name & Business Phone Number:

MEDICAL

Initial Treatment Code (check one):
___ no medical treatment (0)
___ minor/on-site treatment (1)
___ clinic/hospital visit (2)
___ emergency care (3)
___ hospitalization > 24 hours (4)
___ future medical treatment/lost time anticipated (5)

Initial Medical Provider Name:

Initial Medical Provider Physical Address, City, State, & Postal Code:

Managed Care Organization Name or ID Number:

ICD Primary Diagnostic Code (if known):

Preparer's Name & Title:

Preparer's Company Name:

Phone Number:

Date:

First Report of Injury or Illness Requirement

A First Report of Injury or Illness (First Report) must be filed by an employer or the employer's insurance carrier in case of occupational
- fatality,
- permanent disability; or,
- temporary disability lasing more than three days.

A First Report must be electronically filed within four days of the incident. An employer or insurance carrier must file a First Report if the employee says the disability is caused by work even if the employer disagrees.

For more information on these and other requirements, please call 515-281-5387 or visit http://www.iowaworkforce.org/wc/.

The Iowa Workers' Compensation Act RECORDS AND REPORTS

Every employer shall keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day. An employer with notice or knowledge of an injury which temporarily disables an employee for more than three days or results in permanent total disability, permanent partial disability or death is required to electronically file a report with the Workers' Compensation Commissioner within four days from such event when such injury is alleged by the employee to have been sustained in the course of employment.

All books, records, and payrolls of an employer are required to be open for inspection by the Workers' Compensation Commissioner for purposes of administration of the Iowa Workers' Compensation Act.

The Workers' Compensation Commissioner may require an employer to appear and show why the employer should not be subject to a civil penalty of $1,000.00 per occurrence for failure to comply with the reporting or inspection requirements. Upon hearing, if the facts indicate, the commissioner may enter an order requiring payment of such penalty. Unless voluntarily paid, the commissioner may petition the district court for entry of judgment on the order. The employer's insurance carrier shall be responsible in the same manner and to the same extent as the employer when a report of injury has been submitted to the employer's insurance carrier and not filed by them with the Workers' Compensation Commissioner.

The employer is required to furnish to an employee, on request, one statement of earnings, wages, or salary for the year preceding the injury. An employer may be subject to a civil penalty of $1000.00 per offense for refusal to furnish such wage statement.

Additional Iowa OSHA Reporting Requirements

Additional reporting and recordkeeping requirements may apply to the incident described on the First Report. An employer must:

- Report a workplace fatality to Iowa OSHA within 8 hours. You may report by calling 877-242-6742 or visit www.iowaosha.gov for a form and instructions.
- Report a hospitalization, the loss of any eye, or an amputation to Iowa OSHA within 24 hours. You may report by calling 877-242-6742 or visit www.iowaosha.gov for a form and instructions.
- Complete an OSHA Form 301 or equivalent for recordable, work-related incidents within seven days and retain the completed form on site. The First Report is equivalent to the OSHA Form 301 if the case number from the OSHA 300 log is added. Visit www.osha.gov/recordkeeping for more information.
- Make an entry in your Log of Work-Related Injuries and Illnesses, OSHA Form 300, for recordable cases within seven days and retain the completed form on site. Some industries are exempt from this requirement. Visit www.osha.gov/recordkeeping for more information.

For more information on these and other OSHA requirements, please visit www.Iowaosha.gov or call 515-242-5870.

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WAGE STATEMENT

In order to determine with accuracy, the average weekly wages in accordance with the provisions of the Workmen's Compensation Law, please fill out and return.

This is to certify that I _____ am the _____
(Name of Person Certifying) (Name of Office or Position Held)

of _____ of _____
(Name of Employer) (Number, Street, City, Town)

employer of _____ injured on or about _____, _____
(Name of Injured Person) (Month, Day, Year)

"A" I have examined the payroll of said employer and the following table shows the days worked and the wages earned by said _____ employed as a _____ during the period stated therein.

"B" I have examined the payroll of said employer and find that _____ the injured employee, did not work for said employer a substantial portion of the year before the accident.

The following table shows the days worked and the wages earned by _____ another employee of the same class employed by the same employer who did work a substantial part of such year in the same or similar employment.

Official Position _____ Signed By _____

	WEEK ENDING			Days Worked	Amount Paid Including Overtime		WEEK ENDING			Days Worked	Amount Paid Including Overtime
	Month	Day	Year				Month	Day	Year		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					
			TOTAL PAID						TOTAL PAID		
									TOTAL GROSS		