Please return to:

DOWNEY PUBLIC RISK UNDERWRITERS

Downey Public Risk Underwriters
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 ☐ MALE ☐ FEMALE ☐ UNKNOWN	OCCUPATIONAL TITLE	NCCI CLASS CODE

LAST NAME	FIRST	MIDDLE	MARITAL STATUS	DATE HIRED	STATE OF HIRE	EMPLOYEE STATUS
			☐ SINGLE ☐ MARRIED ☐ SEPARATED			

ADDRESS (INCL ZIP)	# OF DEPENDENTS	HRS/DAY	DAYS/WK	AVG WW	PAID DAY OF INJ ☐ SALARY CONT'D ☐

PHONE

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 premisis)

CARRIER/CLAIMS ADMINSTRATOR INFORMATION

CLAIMS ADMINSTRATOR (NAME, ADDRESS, PHONE NO)	CARRIER FEDERAL ID#	CHECK IF APPROPRIATE ☐ SELF INSURANCE
Downey Public Risk Underwriters (IPEP) P. O. Box 690 Kokomo, IN 46903-0690 PHONE: 800-382-8837	☐ INSURANCE CARRIER ☑ THIRD PARTY ADMIN	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

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

WITNESSES (NAME, PHONE#) — DATE ADMINISTRATOR NOTIFIED

DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER