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 W/W	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 24HRS ☐ FUTURE MAJOR MEDICAL/ L/T

WITNESSES (NAME, PHONE#)	DATE ADMINSTRATOR NOTIFIED

DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER

DOWNEY PUBLIC RISK UNDERWRITERS

INDIANA PUBLIC EMPLOYERS' PLAN, INC.

SUPERVISOR'S INCIDENT INVESTIGATION REPORT

(Please Complete All Sections)

1. Company or Location
2. Department
3. Date of Incident/Day of Week
4. Exact Location of Incident
5. Time of Occurrence (am/pm)
6. Date Reported
7. Name of Injured
8. Occupation
9. Body Part Affected (See Back)
10. Nature of Injury or illness (See Back)
11. Item Inflicting Injury/Illness
12. Type of Accident (See Back)
13. Person With Most Control of Item 11.
14. Description of the Incident
15. Direct Causes of Incident
16. Why Each Cause Exists
17. Actions Taken or Needed to Prevent Recurrence
18. Date Completed
19. Investigated By
20. Date
21. Reviewed By
22. Date

Please mail form to: IPEP
P.O. Box 690
Kokomo, Indiana 46903-0690

Toll free: 1-800-245-1736
Claims Fax: 1-765-868-3310
Local: 1-765-457-9161

Type of Accident	Nature of Injury	Part of Body
Bite by Animal	Abrasion	Abdomen
Bite by Human	Amputation	Arm - Lower
Bite by Insect/Sting	Asphyxia	Arm - Upper
Body Reaction	Avulsion	Back/Spinal, Back/Non-spinal
Burn	Bruise, Contusion	Buttocks
Caught In/Between/On	Burn Caused by Chem.	Chest
Contacted Harmful Substance	Burn Caused by Heat	Ears, External
Contagious Disease Exposure	Carpal Tunnel Syndrome	Ears, Internal
Electrical Contact	Concussion	Elbow
Fall From	Cut, Laceration	Eyes
Fall Level	Crush	Face
Fell Through	Death	Fingers
Foreign Body	Dermatitis	Foot
Gunshot	Dislocation	Groin
Motor Vehicle	Electrical Shock	Hand
Other	Fracture	Head
Overexertion	Frostbite/Freezing	Hips
Pierced/Punctured By	Hearing Loss	Jaw
Public Transportation	Heart Attack	Knee
Repetitive Action/Motion	Heat Stroke	Leg - Lower
Slipped (Not Fall)	Hernia	Leg - Upper
Smoke Inhalation	Infection	Mouth
Stepped In/On	Inflammation/Swelling	Multiple Parts
Stress	Multiple Injuries	Neck/Spinal, Neck/Non-spinal
Struck Against	Other	Nervous System
Struck By	No Injuries	Nose
Struggle/Resistive Subject	Poisoning	Other
	Puncture	Respiratory System
	Radiation	Shoulder
	Soreness/Pain	Teeth
	Sprain/Strain	Thigh
	Stress	Thumb
	Tendonitis	Toes
		Trunk/Non-spinal
		Wrist

DOWNEY PUBLIC RISK UNDERWRITERS

Downey Public Risk Underwriters
P.O Box 1247
Kokomo, IN 46903-1247

Toll free: 1-800-382-8837
Local: 1-765-457-9161
Claims fax: 1-765-868-3310

Adjuster: _____ Claim No: _____

AUTHORIZATION FOR RELEASE OF MEDICAL, MILITARY, EDUCATION AND WAGE INFORMATION

To any physician, dentist, hospital, health care practioner, military authority, education authority, employer or insurance carrier:

The requested information is needed to accurately evaluate, adjust and pay the patient's insurance claim.

I hereby authorize any health care professional (including health care physicians, medical practioners or other health care providers, hospitals, medical attendants, nurses, x-ray technicians, or any other person), military authority, education authority, employer or insurance carrier, to furnish to the insurance company named above or its authorized vendors and representatives, wage loss and individually identifiable health information regarding my injuries, payment, treatment rendered, or health care received or provided. I understand that this authorization is voluntary.

I agree that a photocopy or fax of the original authorization shall have the same force and effect as the original.

I understand that my health care records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that I may revoke this authorization at any time by notifying the health care professional(s) in writing, but if I do it will not have any affect on any actions taken before receipt of the revocation.

I understand that once disclosed, the information and documentation released may be re-disclosed and may no longer be subject to the HIPAA Privacy Rule.

This disclosure is made at the request of the individual named below for the purposes of evaluation, adjusting and paying an insurance claim.

Unless otherwise required by law, this authorization shall expire upon the final resolution of the insurance claim.

By signing below, the patient acknowledges that he/she has read the fraud statement printed below.

_____ PATIENT OR REP SIGNATURE

_____ PATIENT ADDRESS

_____ PATIENT NAME OR REP (PLEASE PRINT)

_____ CITY, STATE, ZIP

_____ REPRESENTATIVE'S RELATIONSHIP TO PATIENT

_____ PATIENT PHONE NUMBER

_____ DATE

_____ SOCIAL SECURITY

_____ DATE OF BIRTH

ANY 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.

11/04