Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS

Email completed form as an attachment to: workcomp@uni.edu

Jurisdiction Code: _____ Jurisdiction Claim Number _____

CLAIM ADMN

1. Claim Administrator Name:
SEDGWICK CMS

2. Mailing Address, City, State, & Postal Code:
P.O. Box 61564
King of Prussia, PA 19406
FAX (515) 327-4899

3. Claim Representative Business Phone No.:
(515) 327-4888

4. Claim Administrator Claim No.:

5. Claim Administrator FEIN:
362685608

6. Insurer Name (if different than claim administrator):
IOWA - - STATE OF

7. Insurer FEIN:
420932069

8. Claim Type Code:

EMPLOYER

9. Employer Name:
UNIVERSITY O F NORTHERN IOWA

10. Physical Address, City, State, & Postal Code
1227 W. 27TH ST.
CEDAR FALLS, IA 50614-0034

11. Nature of Business:
HIGHER EDUCATION

12. Employer FEIN:

13. Mailing Address, City, State & postal Code:
HUMAN RESOURCE SERVICES
027 GILCHRIST
CEDAR FALLS , IA 50613

14. Insured Report No.:

15. Industry Code:

16. Insured Location No.:

17. Employer Type Code:
☒ Employer (E)
☐ Lessor (L)

18. Employer UI No.:

19. Employer Contact Name and Business Phone Number:
Melissa Ward (319) 273-6164

POLICY

20. Insured Name
N/A

21. Insured FEIN:
N/A

22. Insured Postal Code:
N/A

23. Policy/Contract No. :
N/A

24. Coverage Effective Date:
N/A

25. Coverage Expiration Date:
N/A

26. Self Insurance License/Certificate No.:
N/A

EMPLOYEE

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

28. Residential Mailing Address:
Street/PO Box:
City:
State: Postal Code:

29. Phone Number (include area code):
( )

30. Occupation Description:

31. Manual Classification Code: N/A

32. Department Where Regularly Worked:

33. Date of Birth:
/ /
Age:

34. Date of Hire:
/ /

35. Employment Status (check one):
☐ Piece Worker
☐ Volunteer
☐ Seasonal
☐ Apprenticeship/FT
☐ Apprenticeship/PT
☐ Regular Employee/FT
☐ Regular Employee/PT
☐ Other

36. Gender
☐ Male(M) ☐ Female(F)

37. Educational Level:
N/A

39. Employee ID No.:
ID#:
(check one)
☐ Social Security No.
☐ Employment VISA No.
☐ Passport No.
☐ Green Card
☐ Employee ID Assigned by Jurisdiction

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

40. Marital Status (check one):
☐ Unmarried (U)
☐ Married (M)
☐ Separated (S)

41. Employee's Authorization to Release the Following:
Medical Records ☐ YES ☐ NO
Social Security Number ☐ YES ☐ NO

WAGE

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

43. Number of Days Regularly Worked Per Week:

44. Salary Continued in Lieu of Compensation:
☐ YES ☐ NO

45. Full Wages Paid for Date of Injury:
☐ YES ☐ NO

46. Discontinued Fringe Benefits:
$ N/A

47. Employee Number of Dependents:

48. Employee Number of Exemptions: ____
(check one)
☒ Entitled
☐ Withholding

ACCIDENT v INJURY

49. / / Date of Injury
50. / / Date Employer Had Knowledge of the Injury
51. / / Date Claim Administrator Had Knowledge of the Injury
52. / / Last Day Worked
53. / / Initial Return to Work Date (if applicable)
54. / / Employee Date of Death (if applicable)

55. : Time of Injury
56. : Time Employee Began Work

57. Pre-existing Disability Code:
☐ YES ☐ NO ☐ Unknown

58. Accident Premises Code:
☐ Employer (E) ☐ Lessee (L) ☐ Other (X)

59. Accident Site Organization Name:

60. Accident Site:
Street:
City: State: Iowa Zip:

61. Accident Location narrative (if no street address):

62. Accident Site County/Parish:

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

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

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

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

67. 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:

68. Witness Name and Business Phone Number:
( )

MEDICAL

69. 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)

70. Initial Medical Provider Name:

71. Initial Medical Provider Physical Location
Address:
City: State:
Postal Code:

72. Managed Care Organization Name or ID No.:
N/A

73. ICD Primary Diagnostic Code (if known):
N/A

74. Preparer's Name & Title (Supervisor)

75. Preparer's Department:

76. Preparer's Phone Number:
( )

77. Date:

University of Northern Iowa
First Report of Injury Form

All accidents and injuries occurring at work or in the course of employment must be reported to the employee's supervisor, even if no medical attention is required. The supervisor is responsible for completing a First Report of Injury form and submitting it to the Human Resources Office, workcomp@uni.edu within 24 hours of the incident.

*If medical care is required, treatment must be received at:
Occupational Medicine & Wellness
Arrowhead Medical Center
226 Bluebell Road (corner of South Main Street and Greenhill Road)
Cedar Falls, IA 50613
319-575-5600

* Treatment not received at Occupational Medicine & Wellness will be considered unauthorized, and will not be paid by Workers' Compensation.

Employer Contact:
Melissa Ward
Human Resource Services
319-273-6164
Melissa.Ward@uni.edu

Instructions for Completing the Iowa First Report of Injury

Employee Section

Box 27 Employee Name: Please fill in the first name, middle initial, last name and suffix of the employee.
Box 28 Residential Mailing Address: Please fill in the Street/PO Box, City, State, and Postal Code of the employee.
Box 29 Phone Number: Please fill in the phone number with area code of the employee.
Box 30 Occupation Description: Indicate the primary occupation of the employee at the time of the accident or exposure.
Box 31 Manual Classification Code: Leave blank.
Box 32 Department Where Regularly Worked: Indicate the department where the employee normally works.
Box 33 Date of Birth: Enter Month/Day/ Year of birth of employee.
Box 34 Date of Hire: Date the employee began work at UNI.
Box 35 Employment Status: Check appropriate box.
Box 36 Gender: Select male or female.
Box 37 Education Level: example, GED = 12
Box 38 Tax filing status: Check appropriate box.
Box 39 Employee ID No: Enter the employee's social security number and select the "Social Security No." box.
Box 40 Marital Status: Check appropriate box.
Box 41 Employee's Authorization to Release the Following: Check appropriate box.

Wage Section

Box 42 Average wage: Use annual salary for regular staff and hourly salary for all others.
Box 43 Number of Days Regularly Worked per Week: Enter number.
Box 44 Salary Continued in Lieu of Compensation: If the employee anticipates not asking for workers compensation missed time benefits, check yes, otherwise check no.
Box 45 Full Wages Paid for Date of Injury: Check appropriate box.
Box 46 Discontinued Fringe Benefits: N/A
Box 47 Employee Number of Dependents: Total number of children under 18 years of age living in household.
Box 48 Employee Number of Exemptions: Put the number of exemptions claimed on last income tax filing, not the number claimed on tax withholding statements.

Accident/Injury

Box 49-54 Fill in appropriate dates
Initial Date Last Day Worked – enter the last day the employee was able to work prior to the original lost time from work due to the occupational injury or disease. This date may be the date of injury or the first day prior to the initial lost time.
Initial Return to Work Date – enter the date following the first disability on which the employee returned to work.
Box 55- 56 Fill in appropriate times (indicate the time in military format 00:00 through 23:59)
Box 57 Pre-existing Disability Code: Did the injury occur because of an existing disability?
Box 58 Accident Premises Code: Check the code that indicates the premises on which the accident occurred.

Accident/Injury Continued

Box 59 Accident Site Organization Name: University of Northern Iowa
Box 60 Accident Site: Enter building name or address of accident site.
Box 61 Accident Location Narrative: Explain where the accident took place (i.e. loading dock, chemistry lab, etc.)
Box 62 Accident Site County/Parish: Enter County name
Box 63. Describe the nature or the injury (ex. Amputation, burn, cut, fracture): List the injury or illness IN DETAI.
Box 64 Part(s) of body directly affected by the injury or illness (ex. Hand, arm, circulatory system): Indicate the exact part(s) of the body affected. Include words like right/left/index/upper/lower. Incompleteness will delay processing.
Box 65 Describe the events that caused the injury (ex. Fell, operating machinery, chemical exposure): Be as specific as possible. Use words like tripped/slipped/fell/lifted/cut/burned/ data entry, etc.
Box 66 Name the object or substance that directly injured the employee (ex. Knife, floor, acid, oil): Be as specific as possible.
Box 67 Specify activity the employee was engaged in when the event occurred (ex. Cutting metal plate, typing, filing, lifting). Indicate if activity was part of normal duties. Be as specific as possible.
Box 68 Witness Name and Business Phone Number: List name and phone number of witness, if any.

Medical

Box 69 Initial Treatment Code: Check appropriate box.
Box 70 Initial Medical Provider Name: Occupational Medicine & Wellness
Box 71 Initial Medical Provider Physical Location: Arrowhead Medical Center, 226 Bluebell Rd. Cedar Falls
Box 72 Managed Care Organization Name or ID No: N/A
Box 73 ICD Primary Diagnostic Code (if known): N/A

Preparer Information

Box 74 Preparer's Name and Title: First Report of Injury should be completed by the employee's supervisor or departmental representative, not the employee.
Box 75 Preparer's Company Name: Should be University of Northern Iowa
Box 76 Preparer's Phone Number: Supervisor's phone number should be listed here.
Box 77 Date: Should be the date that the report was completed.