Workers' Compensation - FIRST REPORT OF INJURY OR ILLNESS
Jurisdiction Code _____ Jurisdiction Claim Number _____

CLAIM ADMIN

Claim Administrator Name: **United Wisconsin Ins Co DBA United Heartland**	Claim Representative Business Phone Number:**1-800-258-2667**	Insurer Name (if different than claim administrator): __United Wisconsin Insurance Co. Fein No. 39-0941450 __Greenwich Insurance Co. Fein No. 95-1479095
Mailing Address, City, State, & Postal Code: **P.O. Box 3026** **Milwaukee, WI. 53201-3026**	Claim Administrator Claim Number: Claim Administrator FEIN: **39-0941450**	Insurer FEIN: Claim Type Code:

EMPLOYER

Employer Name: **Cedar Falls Community Schools**	Employer FEIN: **40-2862684**	Insured Report Number:	Employer Type Code: __ Employer (E) __ Lessor (L)
Physical Address, City, State, & Postal Code: **1002 West First Street** **Cedar Falls, Iowa 50613**	Mailing Address, City, State, & Postal Code: **1002 West First Street** **Cedar Falls, Iowa 50613**	Industry Code: **8211** Insured Location Number:	Employer UI Number: **101172 5**
Name of Business: **Cedar Falls Community Schools**	Employer Contact Name and Business Phone Number: **Douglas Nefzger 319-553-2433**		

POLICY

Insured Name	Insured FEIN:	Insured Postal Code:	Policy/Contact Number	Coverage Effective Date: **07/01/2009** 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 ___Single (A) ___Married/ Filing Joint (C) ___Single/Head of Household (B) ___Married Filing Separate (D)	
Mailing Address, City, State, & Postal Code:	Date of Hire:	Education 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 SS# _____ **X** Social Security Number __Employment VISA Number __Passport Number __Green Card __Employee ID Assigned by Jurisdiction		Employee's Authorization To Release the Following: Medical Records: __√__ Yes ___ No Social Security Number __√__ Yes ____ No
Occupation Description:				
Manual Classification Code:				
Department Where Regularly Worked:				

WAGE

Average Wage $ (check one): _____Hourly _____Bi-Weekly _____Daily _____Annual _____Semi-Monthly _____ Weekly _____Monthly	Salary Continued In Lieu of Compensation: _____ Yes __√__ No Full Wages Paid For Date Of Injury: __√__ Yes ____ No	Employee Number of Dependants:
Number Of Days Regularly Worked Per Week:	Discontinued Fringe Benefits: $	Employee Number of Exemptions: _____ _____ Entitled __√__Withholding

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)	Describe the nature of the injury. (Ex. amputation, burn, cut, fracture):
Time of Injury Time Employee Began Work	Part(s) of body directly affected by the injury or illness. (Ex. hand, arm, circulatory system):
Pre-Existing Disability Code: _____ Yes _____ No _____ Unknown	Describe the events that caused the injury. (Ex. fall, operating machinery, chemical exposure):
Accident Premises Code: __√__ Employer (E) _____ Lessee (L) _____ Other (X)	Name the object or substance that directly injured the employee (ex. knife, floor, acid, oil):
Accident Site Organization Name:	
Accident Site Street, City, State, & Postal Code:	Specify activity the employee was engaged in when the event occurred.
Accident Location Narrative (if no street address):	
Accident Site County/Parish:	Witness Name & Business Phone Number:

MEDICAL

Initial Treatment Code _____ No medical treatment (0) _____ Minor/on-site treatment (1) _____ Clinic/hospital visit (2) _____ Emergency care Yes __ No __ _____ Hospital > 24 hours Yes___ No_____ ____ Future medical treatment/lost time (5)	Initial Medical Provider Name: **Wheaton Occupational Medicine at Arrowhead Medical Center** Initial Medical Provider Physical Address. **226 Bluebell Raod** **Cedar Falls, Iowa 50613** **319-575-5600**	Managed Care Organization Name or ID Number: ICD Primary Diagnostic Code (if known):

Preparer's Name & Title:	Preparer's Company Name:	Phone Number: ( ) -	Date:
Building Supervisor's Signature		Phone Number: ( ) -	Date:

IAIABC FORM 1.2 (2/02)