

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:	
	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	
	Name of Business: Cedar Falls Community Schools		Employer Contact Name and Business Phone Number: Denelle Gonnerman 319-553-2433		Employer Type Code: __ Employer (E) __ Lessor (L)	
POLICY	Insured Name		Insured FEIN:		Insured Postal Code:	
	Insured Postal Code:		Policy/Contact Number		Coverage Effective Date: 07/01/2009	
EMPLOYEE	Employee Name (First, Middle, Last, & Suffix):		Date of Birth:		Gender: __ Male (M) __ Female (F)	
	Mailing Address, City, State, & Postal Code:		Date of Hire:		Tax Filing Status __ Single (A) __ Married/ Filing Joint (C) __ Single/Head of Household (B) __ Married Filing Separate (D)	
	Phone Number (include area code): () -		Education Level (grade completed): (GED = 12)		Marital Status: (check one) __ Unmarried (U) __ Married (M) __ Separated (S)	
	Occupation Description:		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# _____ <input checked="" type="checkbox"/> Social Security Number __ Employment VISA Number __ Passport Number __ Green Card __ Employee ID Assigned by Jurisdiction	
	Manual Classification Code:		Employee's Authorization To Release the Following Medical Records: <input checked="" type="checkbox"/> Yes __ No		Social Security Number <input checked="" type="checkbox"/> Yes __ No	
	Department Where Regularly Worked:		Employee Number of Dependents:		Employee Number of Exemptions: ____ Entitled <input checked="" type="checkbox"/> Withholding	
	Average Wage \$ (check one): __ Hourly __ Bi-Weekly __ Daily __ Annual __ Semi-Monthly __ Weekly __ Monthly		Salary Continued In Lieu of Compensation: __ Yes <input checked="" type="checkbox"/> No		Full Wages Paid For Date Of Injury: <input checked="" type="checkbox"/> Yes __ No	
Number Of Days Regularly Worked Per Week:		Discontinued Fringe Benefits: \$		Employee Number of Exemptions: ____ Entitled <input checked="" type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Describe the events that caused the injury. (Ex. fall, operating machinery, chemical exposure):	
	Accident Premises Code: <input checked="" type="checkbox"/> Employer (E) <input type="checkbox"/> Lessee (L) <input type="checkbox"/> Other (X)		Name the object or substance that directly injured the employee (ex. knife, floor, acid, oil):	
	Accident Site Organization Name:		Specify activity the employee was engaged in when the event occurred.	
	Accident Site Street, City, State, & Postal Code:			
	Accident Location Narrative (if no street address):			
	Accident Site County/Parish:		Witness Name & Business Phone Number:	
MEDICAL	Initial Treatment Code <input type="checkbox"/> No medical treatment (0) <input type="checkbox"/> Minor/on-site treatment (1) <input type="checkbox"/> Clinic/hospital visit (2) <input type="checkbox"/> Emergency care Yes ___ No ___ <input type="checkbox"/> Hospital > 24 hours Yes ___ No ___ <input type="checkbox"/> Future medical treatment/lost time (5)		Initial Medical Provider Name: Wheaton Occupational Medicine at Arrowhead Medical Center	Managed Care Organization Name or ID Number:
			Initial Medical Provider Physical Address: 226 Bluebell Raod Cedar Falls, Iowa 50613 319-575-5600	ICD Primary Diagnostic Code (if known):
Preparer's Name & Title:		Preparer's Company Name:	Phone Number: () -	Date:
Building Supervisor's Signature			Phone Number: () -	Date: