Please return to:

IPEP

ipepclaims@ipep.com

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 | DATE HIRED | STATE OF HIRE | EMPLOYEE STATUS

ADDRESS (INCL ZIP) | MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED | HRS/DAY | DAYS/WK | AVG W/W | PAID DAY OF INJ ☐ | SALARY CONT'D ☐

PHONE | # OF DEPENDENTS | 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 premises):

CARRIER/CLAIMS ADMINSTRATOR INFORMATION

CLAIMS ADMINSTRATOR (NAME, ADDRESS, PHONE NO)

IPEP
P. O. Box 1247
Kokomo, IN 46903-1247
PHONE: 800-382-8837

CARRIER FEDERAL ID#

☐ INSURANCE CARRIER

☐ THIRD PARTY ADMIN

CHECK IF APPROPRIATE

☐ SELF INSURANCE

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

WITNESSES (NAME, PHONE#) | DATE ADMINSTRATOR NOTIFIED

DATE PREPARED | PREPARER'S NAME | TITLE | PHONE NUMBER

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