

WORKERS' COMPENSATION



is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

1. GET MEDICAL ASSISTANCE. By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation, the PPP counts as one of your two choices of providers.

2. NOTIFY YOUR EMPLOYER. You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.

3. LEARN YOUR RIGHTS. Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.

4. KEEP WITHIN THE TIME LIMITS. Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033 Chicago: 312/814-6611 Peoria: 309/671-3019 Springfield: 217/785-7087
 Web site: www.iwcc.il.gov Collinsville: 618/346-3450 Rockford: 815/987-7292 TDD (Deaf): 312/814-2959

**BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE
IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.**

Party handling workers' compensation claims			
Business address			
Business phone			
Effective date		Termination date	
Policy number		Employer's FEIN	

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? Yes No
Employer's name		Doing business as	
Employer's mailing address			Employer's email address
Nature of business or service			SIC code
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? Yes No
Employee's full name			Birthdate
Employee's mailing address			Employee's e-mail address
Gender Male Female	Marital status Married Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? Yes No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? Yes No		Was the employee hospitalized overnight as an inpatient? Yes No	
Report prepared by	Signature	Title and telephone #	Email address

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD SPRINGFIELD, IL 62703**
 By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any way. This information is confidential. IC45 8/12

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		OSHA LOG NUMBER		REPORT PURPOSE CODE			
		JURISDICTION		JURISDICTION CLAIM NUMBER					
		INSURED REPORT NUMBER							
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #			
INDUSTRY CODE		EMPLOYER FEIN						PHONE #	
CARRIER/CLAIMS ADMINISTRATOR									
CARRIER (NAME, ADDRESS, & PHONE #)			POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)				
			TO						
			CHECK IF APPROPRIATE						
			<input type="checkbox"/> SELF INSURANCE						
CARRIER FEIN		POLICY/SELF-INSURED NUMBER			ADMINISTRATOR FEIN				
EMPLOYEE/WAGE									
NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH		DATE HIRED		STATE OF HIRE		
ADDRESS (INCL ZIP)			SEX		MARITAL STATUS		OCCUPATION/JOB TITLE		
			<input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN		<input type="checkbox"/> U UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN		EMPLOYMENT STATUS		
PHONE			# OF DEPENDENTS				NCCI CLASS CODE		
RATE PER:		<input type="checkbox"/> DAY WEEK	<input type="checkbox"/> MONTH OTHER:	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
OCCURRENCE/TREATMENT									
TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE () CANNOT BE DETERMINED		<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED			
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE			
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL									
							CAUSE OF INJURY CODE		
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
				WERE THEY USED?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)			INITIAL TREATMENT			
						0 NO MEDICAL TREATMENT			
						1 MINOR: BY EMPLOYER			
						2 MINOR CLINIC/HOSP			
						3 EMERGENCY CARE			
						4 HOSPITALIZED > 24 HOURS			
			5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED						
OTHER									
WITNESSES (NAME & PHONE #)									
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED	PREPARER'S NAME & TITLE				PHONE NUMBER		

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

IA-2 WORKERS COMPENSATION - SUBSEQUENT REPORT

EMPLOYEE NAME (LAST, FIRST, MIDDLE)				DATE OF INJURY	REPORT EFFECTIVE DATE	JURISDICTION
DATE DISABILITY BEGAN	PRE-EXISTING DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF REPRESENTATION	DATE OF DEATH	REPORT PURPOSE		
RELEASED/RETURNED TO WORK (RTW) DATE	RELEASED/RTW QUALIFIER	RTW WITHOUT RESTRICTIONS	RELEASED RTW WITHOUT RESTRICTIONS	JURISDICTION CLAIM NUMBER		
# OF DEPENDENTS	DEATH DEPENDENT PAYEE RELATIONSHIP INSERT #	WIDOW WIDOWER	CHILDREN SIBLINGS	PARENTS HANDICAPPED CHILDREN	JURISDICTION FUND OTHER	DATE OF MAXIMUM MED. IMPRVMT.
PERMANENT IMPAIRMENT	BODY PART	PERCENT	BODY PART	PERCENT	BODY PART	PERCENT
EMPLOYER NAME				FEIN	INSURED REPORT NUMBER	

WAGE						
WAGE PERIOD <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY	AVERAGE WAGE	EFFECTIVE DATE OF AVERAGE WAGE CHANGE	COMP. RATE	EFFECTIVE DATE OF COMP. RATE CHANGE	# DAYS WORKED PER WEEK	SALARY CONTINUED IN LIEU OF COMP? <input type="checkbox"/> YES <input type="checkbox"/> NO

PAYMENTS							
PAYMENT TYPE	WEEKLY PYMT AMOUNT	AMOUNT PAID TO DATE	PAID FROM (MM/DD/YYYY)	PAID THROUGH (MM/DD/YYYY)	# WEEKS PAID	# DAYS PAID	

BENEFIT ADJUSTMENTS					
BENEFIT ADJUSTMENT TYPE	WEEKLY AMOUNT (+ OR -)	START DATE	BENEFIT ADJUSTMENT TYPE	WEEKLY AMOUNT (+ OR -)	START DATE

PAID-TO-DATE							
PAID-TO-DATE (PTD) TYPE	PTD AMOUNT	ACTUAL/ DEEMED	WK #	WEEKLY EARNINGS	ACTUAL/ DEEMED	WEEKLY EARNINGS	

PAID-TO-DATE							
RECOVERY TYPE	RECOVERY AMOUNT						

CLAIM ADMINISTRATION							
INSURER NAME	FEIN	CLAIM STATUS	OPEN	REOPENED			
			CLOSED	REOPENED/CLOSED			
THIRD PARTY ADMINISTRATOR NAME	FEIN	CLAIM TYPE	MEDICAL ONLY	NOTIFICATION ONLY	BECAME LOST TIME		
			INDEMNITY	BECAME MED ONLY	TRANSFER		
CLAIM ADMINISTRATOR CLAIM NUMBER				AGREEMENT TO COMPENSATE	WITHOUT LIABILITY		
					WITH LIABILITY		
CLAIM ADMINISTRATOR ADDRESS (Include city, state, postal code, and phone number)				LATE REASON			
				DATE PREPARED		PAGE	
						OF	