Indiana Worker's Compensation
First Report of Employee Injury/Illness

Please Return Completed Form to: 402 W. Washington St, Room W1 96
Indianapolis, IN 46204-2753
(317) 232-3808

FOR WORKER'S COMPENSATION BOARD USE ONLY		
JURISDICTION	JURISDICTION CLAIM NUMBER	PROCESS DATE

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	OCCUPATION/JOBTITLE	NCCI CLASS CODE

LAST NAME	FIRST	MIDDLE

ADDRESS (INCL ZIP)

PHONE

MARITAL STATUS
○ UNMARRIED
○ MARRIED
○ SEPARATED
○ UNKNOWN

OF DEPENDENTS

DATE HIRED	STATE OF HIRE	EMPLOYEE STATUS

HRS/DAY	DAYS/WK	AVG WG/WK	PAID DAY OF INJ ☐ SALARY CONT'D ☐

WAGE PER ○HR ○DA ○WK ○MO
$ ○YR ○OTHER

EMPLOYER INFORMATION

EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP)
Wabash College
301 W Wabash Ave
Crawfordsville, IN 47933

EMPLOYER FEDERAL ID# 35-0868202

SIC CODE

INSURED REPORT NUMBER

LOCATION #

PHONE# 765-361-6100

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

Actual Location of Accident/Exposure (if not on employers premises):

CARRIER/CLAIMS ADMINISTRATOR INFORMATION

CLAIMS ADMINISTRATOR (NAME, ADDRESS, PHONE NO)
Accident Fund
232 S Capitol Ave
Lansing, MI 48901

CARRIER FEDERAL ID#

CHECK IF APPROPRIATE
☐ SELF INSURANCE

☒ INSURANCE CARRIER

POLICY/SELF-INSURED NUMBER
WCV6029720

POLICY PERIOD

[redacted]