

TO THE EMPLOYER: THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE UPON YOUR PREMISES.

NOTICE

REGARDING WORKERS' COMPENSATION INSURANCE

ALL WORKERS EMPLOYED BY THE UNDERSIGNED ARE HEREBY NOTIFIED THAT THE EMPLOYER HAS COMPLIED WITH THE LAW AS TO SECURING THE PAYMENT OF COMPENSATION TO EMPLOYEES AND THEIR DEPENDENTS, IN ACCORDANCE WITH THE PROVISIONS OF THE WORKERS' COMPENSATION LAW.

Employer

Date

By

Employer's Authorized Agent

An employee receiving an injury by accident must immediately notify his/her supervisor, superintendent, or the undersigned, who will provide medical attendance.

Claim for compensation must be made in writing and given to the employer. Forms for giving notice of injury and making claim for compensation will be furnished by the employer; by the surety,

or upon application, by the Industrial Commission in Boise, Idaho.

IDAHO WORK INJURY REPORTING PROCEDURES

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

First Report of Injury or Illness (IA-1)

This form must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, First Reports of Injury or Illness (FROI's) may be submitted to us online at: <https://berkindcomp.com>. Online Reporting Instructions are enclosed. Maintain a copy of the FROI for your records. Keep a separate file for each workers' compensation claim.

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the FROI. If the FROI is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

Wage Statement

Wage statements must be completed on claims involving lost time from work. The employee's gross wages for the 52 weeks prior to the date of injury are required. If the employee has not been employed for 52 weeks, then report the available wages. In addition to regular pay, computation of wages may include overtime, tips, and the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee. If there are weeks with no wages, please explain the reason by coding as follows:

V= Vacation I= Illness L= Lay off P= Personal leave O= Other

Please contact our claims department with questions.

Do not delay reporting the First Report of Injury or Illness for completion of the wage statement.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General	Employer (Name & Address incl. zip)				Carrier/Administrator Claim Number		Report Purpose Code									
					Jurisdiction		Jurisdiction Claim No.									
	Insured Report No.															
	Employer's Location Address (if different)						Location No.									
NAICS Code				Employer FEIN				Phone No.								
Carrier/Claims Admin	Carrier (Name, Address & Phone Number)				Policy Period		Claims Admin (Name, Address & Phone Number)									
					To											
	<input type="checkbox"/>		Check if self insured													
Carrier FEIN				Policy Number or Self-Insured Number				Administrator FEIN								
Agent Name & Code Number																
Employee	Legal Name (Last, First, Middle)			Birth Date		Social Security Number			Date Hired		State of Hire					
	Address (Incl. Zip)			Sex		Marital Status			Occupation/Job Title							
				<input type="checkbox"/> Male		<input type="checkbox"/> Unmarried/Single/Div.										
				<input type="checkbox"/> Female		<input type="checkbox"/> Married										
	Phone			<input type="checkbox"/> Unknown		<input type="checkbox"/> Separated			Employment Status							
				No. of Dependents		<input type="checkbox"/> Unknown			NCCI Class Code							
Wage Rate		<input type="checkbox"/> Day		<input type="checkbox"/> Month		# Days Worked/WK		Full Pay for Date of Injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No						
\$		<input type="checkbox"/> Week		<input type="checkbox"/> Other		# Hrs Worked per Day		Did Salary Continue?		<input type="checkbox"/> Yes <input type="checkbox"/> No						
Occurrence	Time Employee Began Work		<input type="checkbox"/> AM <input type="checkbox"/> PM		Date of Injury or Illness		Time Occurred		<input type="checkbox"/> AM <input type="checkbox"/> PM		Last Work Date		Date Employer Notified		Date Disability Began	
	Employer Contact Name/Phone Number						Type of Illness/Injury				Part of Body Affected					
	Did Injury/Illness Exposure Occur on Employer's Premises?						Yes <input type="checkbox"/> No <input type="checkbox"/>		Type of Illness/Injury Code				Part of Body Affected Code			
	Department or location where accident or illness exposure occurred						All Equipment, Materials, or Chemicals Employee Using upon Occurrence									
	Specific Activity Employee Engaged in at Time of Occurrence						Work Process the Employee Was Engaged in at Time of Occurrence									
	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 Returned to Work				If Fatal, 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			
Treatment	Physician/Health Care Provider (Name & Address)				Hospital (Name & Address)				Initial Treatment							
									0 <input type="checkbox"/> No Medical Treatment 1 <input type="checkbox"/> Minor: By Employer 2 <input type="checkbox"/> Minor Clinic/Hosp 3 <input type="checkbox"/> Emergency Care 4 <input type="checkbox"/> Hospitalized – 24 hr. 5 <input type="checkbox"/> Anticipated Major Med/Lost Time							
Other	Signature of Injured Employee, or Signature on File, Date				Witness to Accident (Name & Phone Number)											
	Date Administrator Notified		Date Prepared		Preparer's Name & Title				Preparer's Phone Number							

Filing this report is not an admission of liability. This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made. Idaho Industrial Commission, P.O. Box 83720, Boise, ID 83720-0041 IC Form IA-1 (08/2013)

WAGE STATEMENT

In order to determine with accuracy, the average weekly wages in accordance with the provisions of the Workmen's Compensation Law, please fill out and return.

This is to certify that I _____ am the _____
(Name of Person Certifying) (Name of Office or Position Held)

of _____ of _____
(Name of Employer) (Number, Street, City, Town)

employer of _____ injured on or about _____,
(Name of Injured Person) (Month, Day, Year)

"A" I have examined the payroll of said employer and the following table shows the days worked and the wages earned by said _____ employed as a _____ during the period stated therein.

"B" I have examined the payroll of said employer and find that _____ the injured employee, did not work for said employer a substantial portion of the year before the accident.

The following table shows the days worked and the wages earned by _____ another employee of the same class employed by the same employer who did work a substantial part of such year in the same or similar employment.

Official Position _____ Signed By _____

	WEEK ENDING			Days Worked	Amount Paid Including Overtime		WEEK ENDING			Days Worked	Amount Paid Including Overtime
	Month	Day	Year				Month	Day	Year		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					
TOTAL PAID							TOTAL PAID				
							TOTAL GROSS				