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	

ICPN 10/11 Printed by the authority of the State of Illinois.

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

ILLINOIS FORM 85: EMPLOYER'S SUPPLEMENTARY REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	This report is Supplementary / Final
Employer's name		Doing business as	
Employer's full 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
Insurer's mailing address		City	State / Zip code
Employee's full name			Birthdate
Employee's full mailing address		Employee's email address	

Date of injury/diagnosis	Date of first payment	Employee's average weekly wage	# Dependents
Period of disability		If the employee died as a result of the accident, give the date of death.	

BENEFIT INFORMATION

Please provide a comprehensive history of payments.

Payment Type (TTD, medical, etc.)	Weekly Payment	Number of Weeks	Benefit Paid From	Benefit Paid Through	Total Payments
			Grand total		$

Was this case closed by the Industrial Commission? Yes / No	If so, how was the case resolved? Settlement contract / Arbitration decision / Commission decision

Report prepared by	Signature	Title, telephone #, and email address

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE ROAD SPRINGFIELD, IL 62703-5118**

In addition to the *Employer's First Report of Injury* (IC45), employers shall file this report when 1) benefits begin or are stopped; 2) there is a change in the employee's status; 3) final compensation is made. This information is confidential. IC85 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

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

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

M MALE
F FEMALE
U UNKNOWN

MARITAL STATUS

U UNMARRIED SINGLE/DIVORCED
M MARRIED
S SEPARATED
K UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER: | DAYS WORKED/WEEK | FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO | DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED ☐ AM ☐ 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? ☐ YES ☐ 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? ☐ YES ☐ NO | WERE THEY USED? ☐ YES ☐ 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 DISABLITY? ☐ YES ☐ NO	DATE OF REPRESENTATION	DATE OF DEATH	REPORT PURPOSE

RELEASED/RETURNED TO WORK (RTW) DATE	RELEASED/ RTW QUALIFIER			JURISDICTION CLAIM NUMBER
		RTW WITHOUT RESTRICTIONS	☐ RELEASED RTW WITHOUT RESTRICTIONS	
		RTW WITH RESTRICTIONS	☐ RELEASED RTW WITH RESTRICITONS	

# OF DEPENDENTS	DEATH DEPENDENT PAYEE RELATIONSHIP INSERT #	☐ WIDOW	☐ WIDOWER	☐ CHILDREN	☐ SIBLINGS	☐ PARENTS	☐ HANDICAPPED CHILDREN	☐ JURISDICTION FUND	☐ OTHER	DATE OF MAXIMUM MED. IMPRVMNT.

PERMANENT IMPAIRMENT	BODY PART	PERCENT	BODY PART	PERCENT	BODY PART	PERCENT

EMPLOYER NAME	FEIN	INSURED REPORT NUMBER

WAGE

WAGE PERIOD ☐ WEEKLY ☐ 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? ☐ YES ☐ 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_____

Please mail to IWCC, 4500 S. Sixth Street Frontage Road, Springfield, IL 62703.