Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS Jurisdiction Code_____ Jurisdiction Claim Number_____

CLAIM ADMIN

Claim Administrator Name: Church Mutual Insurance Company

Mailing Address, City, State, & Postal Code:

Claim Representative Business Phone Number:

Claim Administrator Claim Number:

Claim Administrator FEIN:

Insurer Name (if different than claim administrator):

Insurer FEIN:

Claim Type Code:

EMPLOYER

Employer Name: DIOCESE OF SIOUX CITY

Physical Address, City, State, & Postal Code: 1821 JACKSON STREET SIOUX CITY IA 51105

Nature of Business: RELIGIOUS/NON-PROFIT

Employer FEIN: 42-0680296

Mailing Address, City, State, & Postal Code:

Insured Report Number:

Industry Code:

Insured Location Number:

Employer Type Code:
__ Employer (E)
__ Lessor (L)

Employer UI Number:

Employer Contact Name and Business Phone Number: MARK WETZ 712-233-7559

POLICY

Insured Name (parent company if different than employer):

Insured FEIN:

Insured Postal Code:

Policy/Contract Number:

Coverage Effective Date:

Coverage Expiration Date:

Self Insurance License/ Certificate Number:

EMPLOYEE

Employee Name (First, Middle, Last, & Suffix):

Mailing Address, City, State, & Postal Code:

Phone Number (include area code):

Occupation Description:

Manual Classification Code:

Department Where Regularly Worked:

Date of Birth:

Date of Hire:

Gender:
__ Male (M)
__ Female (F)

Tax Filing Status (check one):
____ Single (A)
____ Married/Filing Joint (C)
____ Single/Head of Household (B)
____ Married/Filing Separate(D)

Educational Level (grade completed): _____ [GED = 12]

Employment Status (check one):
____ Piece Worker
____ Volunteer
____ Seasonal
____ Apprenticeship/Full-Time
____ Apprenticeship/Part-Time
____ Regular Employee/Full-Time
____ Part-Time
____ Other

Employee ID Number (check one):
ID # _____
____ Social Security Number
____ Employment VISA Number
____ Passport Number
____ Green Card
____ Employee ID Assigned by Jurisdiction

Marital Status: (check one)
___ Unmarried (U)
___ Married (M)
___ Separated (S)

Employee's Authorization to Release the Following:
Medical Records ___yes ___no
Social Security Number ___yes ___no

WAGE

Average Wage $ _____ (check one):
___ hourly ___ daily ___ semi-monthly ___ monthly
___ bi-weekly ___ annual ___ weekly

Number of Days Regularly Worked Per Week: _____

Salary Continued In Lieu of Compensation: ___yes ___no

Full Wages Paid for Date of Injury: ___yes ___no

Discontinued Fringe Benefits: $_____

Employee Number of Dependents: _____

Employee Number of Exemptions: _____ (check one)
___ Entitled
___ Withholding

ACCIDENT/INJURY

_____ Date of Injury
_____ Date Employer Had Knowledge of the Injury
_____ Date Claim Administrator Had Knowledge of the Injury
_____ Initial Date Last Day Worked
_____ Initial Return to Work Date (if applicable)
_____ Employee Date of Death (if applicable)

_____ Time of Injury
_____ Time Employee Began Work

Pre-Existing Disability Code:
___ Yes
___ No
___ Unknown

Accident Premises Code:
___ Employer (E)
___ Lessee (L)
___ Other (X)

Accident Site Organization Name:

Accident Site Street, City, State, & Postal Code:

Accident Location Narrative (if no street address):

Accident Site County/Parish:

Describe the nature of the injury. (ex. amputation, burn, cut, fracture):

Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):

Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):

Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):

Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties:

Witness Name & Business Phone Number:

MEDICAL

Initial Treatment Code (check one):
___ no medical treatment (0)
___ minor/on-site treatment (1)
___ clinic/hospital visit (2)
___ emergency care (3)
___ hospitalization > 24 hours (4)
___ future medical treatment/lost time anticipated (5)

Initial Medical Provider Name:

Initial Medical Provider Physical Address, City, State, & Postal Code:

Managed Care Organization Name or ID Number:

ICD Primary Diagnostic Code (if known):

Preparer's Name & Title:

Preparer's Company Name:

Phone Number:

Date:

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