



ASSOCIATED
CLAIMS
ADMINISTRATORS

Dear Employer:

Associated Claims Administrators (ACA) will be administering your Worker's Compensation claims on behalf of National Liability & Fire Insurance Company and in partnership with North American Risk Services (NARS).

ACA and NARS professionals are experienced in Worker's Compensation Law. Please feel free to call our office with any questions you may have regarding your Worker's Compensation concerns.

Early involvement in a claim is important. It is not only cost effective for you, but it also can help the injured employee get proper medical care and return to work as soon as possible. We look forward to working with to accomplish these goals.

You, the employer, are a vital part of making this happen. Listed below are some things you can do:

1. Report all work-related injuries as soon as you are aware of them.
2. You may report all work-related injuries by email at claims@acaworkcomp.com, fax to **1-800-988-4722**, or call **1-800-388-6268** for assistance reporting a claim.

After reporting your claim, you can contact NARS at **1-800-315-6090** for further assistance with your claim including:

1. Refer all medical authorization requests to NARS.
2. Communicate with your employee and NARS throughout the claim.
3. Have some light duty work available for restricted duty.
4. Advise NARS when the employee returns to work.

Please keep copies of the attached forms to have on hand if needed. Fillable forms can also be downloaded at <https://aiamga.com/workers-compensation/states-covered/>.

We look forward to a long and pleasant working relationship with you and your employees.

Please call anytime between 8:00am and 5:00pm Central Time, Monday through Friday if you have any questions regarding Worker's Compensation claims procedures.

Best regards,

Associated Claims Administrators

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.
2. Enter all dates in MM/DD/YY format.
3. Please return completed form electronically by an approved EDI process.
4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME AND 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.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (e.g. *Acetylene cutting torch, metal plate, etc.*).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

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

CONTACT NAME / TELEPHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (i.e. *Supervisor, HR Person, Nurse, etc.*)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwise deemed by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (e.g. *Maintenance, Client's Office, Cafeteria, etc.*).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: *FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK*).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (e.g. *Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall.*)

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (e.g. *Right forearm, Low Back, etc.*)

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (Return to Work Date): Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (e.g. *Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting.*)

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (e.g. *Contusion, Laceration, Fracture, etc.*)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (e.g. *Building maintenance*).



INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

FOR WORKER'S COMPENSATION BOARD USE ONLY

Jurisdiction

Jurisdiction claim number

Process date

Please return completed form electronically by an approved EDI process.

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 / Job title			NCCI class code	
Name (last, first, middle)			Marital status ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown		Date hired		State of hire		Employee status
Address (number and street, city, state, ZIP code)					Hrs / Day	Days / Wk	Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued	
Telephone number (include area)			Number of dependents		Wage Per \$ ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other				
EMPLOYER INFORMATION									
Name of employer			Employer ID#			SIC code		Insured report number	
Address of employer (number and street, city, state, ZIP code)			Location number			Employer's location address (if different)			
			Telephone number						
			Carrier / Administrator claim number			OSHA log number		Report purpose code	
Actual location of accident / exposure (if not on employer's premises)									
CARRIER / CLAIMS ADMINISTRATOR INFORMATION									
Name of claims administrator			Carrier federal ID number			Check if appropriate ☐ Self Insurance			
Address of claims administrator (number and street, city, state, ZIP code)			☐ Insurance Carrier ☐ Third Party Admin.			Policy / Self-insured number			
Telephone number						Policy period From To			
Name of agent			Code number						
OCCURRENCE / TREATMENT INFORMATION									
Date of Inj./ Exp.	Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined			Date employer notified		Type of injury / exposure			Type code
Last work date	Time workday began		Date disability began			Part of body			Part code
RTW date	Date of death		Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No		Name of contact			Telephone number	
Department or location where accident / exposure occurred					All equipment, materials, or chemicals involved in accident				
Specific activity engaged in during accident / exposure					Work process employee engaged in during accident / exposure				
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.									Cause of injury code
Name of physician / health care provider									
Hospital or offsite treatment (name and address)								INITIAL TREATMENT ☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor: Clinic / Hospital ☐ Emergency Care ☐ Hospitalized > 24 Hours ☐ Future Major Medical / Lost Time Anticipated	
Name of witness			Telephone number		Date administrator notified				
Date prepared		Name of preparer		Title		Telephone number			

An employer's failure to report an occupational injury or illness may result in a \$50 fine (IC 22-3-4-13).