IPEP
INDIANA PUBLIC EMPLOYERS PLAN, INC.

P.O. Box 1247
1010 E. Markland Ave.
Kokomo, Indiana
46903-1247

317-457-9161
800-382-8837

FAX 317-459-4528

Document Transmittal Form

To: IPEP
P.O. Box 690
Kokomo, IN 46903-0690

Attn: Claim Department

From: _____
_____
_____

Employee: _____
Date of Loss: _____

Attached:

___ Employers Report of Injury/Illness of Employee

This Claim is
____ Clearly Compensable
____ Compensability Questionable

Claim involves
____ No Lost Time
____ Lost Time
____ Record only, No medical treatment anticipated

Date anticipated to return to work: _____

___ Wage Statement attached (required on all losses where lost time is anticipated to be more than 7 days).

___ Medical Authorization

DOWNEY INSURANCE
Protecting Those Who Serve℠

302 S. Reed Rd.
P.O. Box 690
Kokomo, IN 46903-0690
1-800-382-8837

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
LAST NAME	FIRST	MIDDLE
ADDRESS (INCL ZIP)		
PHONE		

MARITAL STATUS
◯UNMARRIED
◯MARRIED
◯SEPARATED
◯UNKNOWN

OF DEPENDENTS

OCCUPATION/JOB TITLE		NCCI CLASS CODE
DATE HIRED	STATE OF HIRE	EMPLOYEE STATUS
HRS/DAY	DAYS/WK	AVG WG/WK

PAID DAY OF INJ ☐
SALARY CONT'D ☐

WAGE PER ◯HR ◯DAY ◯WK ◯MO
$ ◯YR ◯OTHER:

EMPLOYER INFORMATION

EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP)	EMPLOYER FEDERAL ID#	SIC CODE	INSURED REPORT NUMBER
	LOCATION #	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
	PHONE #		
	CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE

Actual Location of Accident/Exposure (if not on employer's premises):

CARRIER/CLAIMS ADMINISTRATOR INFORMATION

CLAIMS ADMINISTRATOR (NAME, ADDRESS, PHONE NO)	CARRIER FEDERAL ID#	CHECK IF APPROPRIATE ☐ SELF INSURANCE
	☐ INSURANCE CARRIER	POLICY/SELF-INSURED NUMBER
PHONE:	☐ THIRD PARTY ADMIN	POLICY PERIOD FROM TO
AGENT NAME	CODE NUMBER	

OCCURRENCE/TREATMENT INFORMATION

DATE OF INJ/EXP	TIME OF OCCURRENCE ___M	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	CONTACT NAME	PHONE 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

WITNESSES (NAME, PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER

INITIAL TREATMENT
☐ NO MEDICAL TREATMENT
☐ MINOR: BY EMPLOYER
☐ MINOR: CLINIC/HOSP
☐ EMERGENCY CARE
☐ HOSPITALIZED >24 HRS
☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

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

STATE FORM 34401 (R8 2/96)

DOWNEY
INSURANCE
Protecting Those Who Serve™

INDIANA PUBLIC EMPLOYERS' PLAN, INC.

SUPERVISOR'S INCIDENT INVESTIGATION REPORT

(Please Complete All Sections)

1. Company or Location | 2. Department | 3. Date of Incident/Day of Week

4. Exact Location of Incident | 5. Time of Occurrence (am/pm) | 6. Date Reported

7. Name of Injured | 8. Occupation | 9. Body Part Affected (See Back)

10. Nature of Injury or illness (See Back) | 11. Item Inflicting Injury/Illness | 12. Type of Accident (See Back)

13. Person With Most Control of Item 11.

14. Description of the Incident

15. Direct Causes of Incident | 16. Why Each Cause Exists

17. Actions Taken or Needed to Prevent Recurrence | 18. Date Completed

19. Investigated By | 20. Date | 21. Reviewed By | 22. Date

Please mail form to: IPEP
P.O. Box 690
Kokomo, Indiana 46903-0690

Toll free: 1-800-382-8837
Claims Fax: 1-765-868-3310
Local: 1-765-457-9161

DOWNEY PUBLIC RISK UNDERWRITERS

Downey Public Risk Underwriters
P.O Box 1247
Kokomo, IN 46903-1247

Toll free: 1-800-382-8837
Local: 1-765-457-9161
Claims fax: 1-765-868-3310

Adjuster: _____ Claim No: _____

AUTHORIZATION FOR RELEASE OF MEDICAL, MILITARY, EDUCATION AND WAGE INFORMATION

To any physician, dentist, hospital, health care practioner, military authority, education authority, employer or insurance carrier:

The requested information is needed to accurately evaluate, adjust and pay the patient's insurance claim.

I hereby authorize any health care professional (including health care physicians, medical practioners or other health care providers, hospitals, medical attendants, nurses, x-ray technicians, or any other person), military authority, education authority, employer or insurance carrier, to furnish to the insurance company named above or its authorized vendors and representatives, wage loss and individually identifiable health information regarding my injuries, payment, treatment rendered, or health care received or provided. I understand that this authorization is voluntary.

I agree that a photocopy or fax of the original authorization shall have the same force and effect as the original.

I understand that my health care records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that I may revoke this authorization at any time by notifying the health care professional(s) in writing, but if I do it will not have any affect on any actions taken before receipt of the revocation.

I understand that once disclosed, the information and documentation released may be re-disclosed and may no longer be subject to the HIPAA Privacy Rule.

This disclosure is made at the request of the individual named below for the purposes of evaluation, adjusting and paying an insurance claim.

Unless otherwise required by law, this authorization shall expire upon the final resolution of the insurance claim.

By signing below, the patient acknowledges that he/she has read the fraud statement printed below.

_____ PATIENT OR REP SIGNATURE

_____ PATIENT ADDRESS

_____ PATIENT NAME OR REP (PLEASE PRINT)

_____ CITY, STATE, ZIP

_____ REPRESENTATIVE'S RELATIONSHIP TO PATIENT

_____ PATIENT PHONE NUMBER

_____ DATE

_____ SOCIAL SECURITY

_____ DATE OF BIRTH

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION COMMITS A FELONY.

11/04