# WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
Name
Address
City State MD
Zip -
INDUSTRY CODE
EMPLOYER FEIN

CARRIER/ADMINISTRATOR CLAIM | OSHA LOG | REPORT PURPOSE
JURISDICTION | JURISDICTION CLAIM NUMBER
INSURED REPORT NUMBER
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION # ( ) -
Address
City State MD Zip - | PHONE # ( ) -

CARRIER (NAME, ADDRESS, & PHONE #)
Name
Address
City State MD
Zip - Phone ( ) -
CARRIER FEIN
POLICY/SELF-INSURED NUMBER

POLICY PERIOD
/ /
TO
/ /
CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Name
Address
City State MD
Zip - Phone ( ) -
ADMINISTRATOR FEIN

EMPLOYEE Last Name | Middle
First Name
Address
City State MD
Zip - Phone ( ) -
# OF DEPENDENTS

DATE OF BIRTH / /
SOCIAL SECURITY - -
DATE HIRED / /
STATE OF HIRE MD
SEX
☐ Male ☐ Female ☐ Unknown
MARITAL STATUS
☐ Unmarried Single/Divorced ☐ Married ☐ Separated ☐ Unknown
OCCUPATION/JOB TITLE
EMPLOYMENT STATUS
NCCI CLASS CODE

WAGE RATE | PER: ☐ Day ☐ Week ☐ Month ☐ Other | # DAYS WORKED/WEEK
FULL PAY FOR DAY OF INJURY? ☐ Yes ☐ No
DID SALARY CONTINUE? ☐ Yes ☐ No

TIME EMPLOYEE BEGAN : ☐ AM ☐ PM
DATE OF INJURY/ILLNESS / /
TIME OF OCCURRENCE : ☐ AM ☐ PM ☐ Unknown
LAST WORK DATE / /
DATE EMPLOYER NOTIFIED / /
DATE DISABILITY BEGAN / /

CONTACT NAME | CONTACT PHONE ( ) - | 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
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)
Name
Address
City State MD -

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)
Name
Address
City State MD -

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

WITNESS NAME | PHONE ( ) -
ADMINISTRATOR NOTIFIED / /
DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER ( ) -
**PREPARER'S EMAIL ID:**

FORM IA-1(r 1-1-02) IAIABC 2002

**WCC Web Form IA-1**

RE: Maryland's First Report of Injury

Dear Policyholder:

Once you file a worker's compensation claim with us, a First Report of Injury is required on any lost time claim, which means that the injured worker has at least three (3) days of disability due to the work incident, as determined by his/her physician. A First Report of Injury filing with the State of Maryland is not required on a medical only claim.

At Markel Service Incorporated, a servicing entity of Markel Insurance Company, we will complete the First Report of Injury on any lost time claim and file this form timely with the State of Maryland.

Please do not file any First Report of Injury filings with the State or contact the State to file a First Report of Injury. This form does not actually exist, but is created by the Markel adjusters handling your lost time claims and then filed with the State of Maryland.

If you have questions on this procedure, please feel free to contact our Claims Department at 888-500-3344.

**Markel - Claims**
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