

ACORD™ WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL. ZIP)		CARRIER CLAIM NUMBER		REPORT PURPOSE CODE	
		JURISDICTION		JURISDICTION CLAIM NUMBER	
		LOCATION CODE			
DEPARTMENT # 01 Administration					
SIC CODE	EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)			PHONE #

CARRIER/CLAIMS ADMINISTRATOR		<small>CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO.)</small>			
SC Association of Counties PO Box 8207 Columbia, SC 29202-8207		POLICY PERIOD TO		Ariel Third Party Administrators, Inc. claims@arieltpa.com PO Box 212159 Columbia, SC 29210 1-855-222-6379	
		CHECK IF APPLICABLE <input type="checkbox"/> SELF INSURANCE			
CARRIER FEIN	POLICY/SELF-INSURED NUMBER			ADMINISTRATOR FEIN	
AGENT NAME & CODE NUMBER					

EMPLOYEE/WAGE											
NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH		SOCIAL SECURITY NUMBER			DATE HIRED		STATE OF HIRE	
ADDRESS (INCL. ZIP)			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN			OCCUPATION/JOB TITLE		VOLUNTEER <input type="checkbox"/> YES <input type="checkbox"/> NO	
PHONE # (H) (W)			# OF DEPENDENTS		EMPLOYMENT STATUS <input type="checkbox"/> F/T <input type="checkbox"/> P/T			INMATE <input type="checkbox"/> YES <input type="checkbox"/> NO		NCCI CLASS CODE	
RATE PER		<input type="checkbox"/> DAY <input type="checkbox"/> WEEK		<input type="checkbox"/> MONTH <input type="checkbox"/> OTHER:		# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

OCURRENCE/TREATMENT											
TIME EMPLOYEE BEGAN WORK: <input type="checkbox"/> AM <input type="checkbox"/> PM		DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE <input type="checkbox"/> AM <input type="checkbox"/> PM		LAST WORK DATE		DATE EMPLOYER NOTIFIED		DATE DISABILITY BEGAN	
CONTACT NAME/SUPERVISOR/PHONE NUMBER				TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED			
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO				WILL EMPLOYER PROVIDE MODIFIED DUTY, IF NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO				PART OF BODY AFFECTED			
DEPARTMENT OR LOCATON 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 OF 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? WERE THEY USED?				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO		
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)					HOSPITAL (NAME & ADDRESS)					INITIAL TREATMENT	
Panel Physician Utilized? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A										<input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR-BY EMPLOYER <input type="checkbox"/> MINOR CLINIC HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED	
WITNESSES (NAME & PHONE #)											
DATE ADMINISTRATOR NOTIFIED			DATE PREPARED			PREPARER'S NAME & TITLE			PHONE NUMBER		