TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)

CLAIMS ADM CLAIM # (INSURER CLAIM #)

OSHA LOG CASE #

CLAIM TYPE CODE
- ☐ MED ONLY
- ☐ INDEMNITY
- ☐ BECAME LOST TIME
- ☐ BECAME MED ONLY
- ☐ NOTIFY ONLY
- ☐ TRANSFER

NAME OF INSURANCE CARRIER: Berkley Casualty Company

CARRIER FEIN

CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER)

FEIN OF CLMS ADM

CLAIMS ADJUSTER NAME

CLMS ADJ PHONE #

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE TENNESSEE WORKERS' COMPENSATION LAW AND MUST BE COMPLETED AND FILED WITH YOUR INSURANCE CARRIER IMMEDIATELY AFTER NOTICE OF INJURY.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS' COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

IF YOU HAVE QUESTIONS, THE STATE NOW HAS A BENEFIT REVIEW SYSTEM WHERE A WORKERS' COMPENSATION SPECIALIST CAN PROVIDE ASSISTANCE. CALL 1-800-332-2667 (TDD).

CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2: P.O. Box 49129

CITY: Greensboro | STATE: NC | ZIP: 27419

EMPLOYER

EMPLOYER NAME: Sumner County Board of Education

EMPLOYER FEIN: 62-0681064

SIC CODE

PHONE NUMBER: 615-451-5200

EMPLOYER ADDRESS LINE 1 AND LINE 2: 685 E. Main Street

NATURE OF BUSINESS: School District

CITY: Gallatin | STATE: TN | ZIP: 37066

INSURED REPORT #

EMPLOYER LOCATION

POLICY

INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)

POLICY NUMBER: KEY0145256

SELF INSURED? ☐ YES ☒ NO

EFF DATE: 07/01/2023

EXP DATE: 07/01/2024

EMPLOYEE

EMPLOYEE LAST NAME

PHONE INCL AREA CODE

FIRST | MI

DEPARTMENT REGULARLY WORKED

GENDER
- ☐ MALE
- ☐ FEMALE
- ☐ UNKNOWN

EMPLOYMENT STATUS CODE
- ☐ FULL TIME/REGULAR
- ☐ PART TIME
- ☐ PIECE WORKER
- ☐ SEASONAL
- ☐ VOLUNTEER
- ☐ APPRENTICE FULL TIME
- ☐ APPRENTICE PART TIME

ADRRESS LINE 1 & 2

OCCUPATION DESCRIPTION

CITY | STATE | ZIP

MARITAL STATUS
- ☐ UNMARRIED, SINGLE, DIVORCED
- ☐ MARRIED
- ☐ SEPARATED
- ☐ UNKNOWN

NCCI CLASS CODE

SSN | DATE OF BIRTH | DATE OF HIRE

WAGE

WAGE $

PERIOD
- ☐ HOURLY
- ☐ DAILY
- ☐ WEEKLY
- ☐ BI-WEEKLY
- ☐ MONTHLY

NUMBER OF DAYS WORKED PER WEEK

SALARY CONTINUED IN LIEU OF COMPENSATION ☐ YES ☐ NO

FULL WAGES PAID FOR DATE OF INJURY ☐ YES ☐ NO

ACCIDENT/INJURY

DATE OF INJURY

TIME OF INJURY ☐ AM ☐ PM
☐ COULD NOT BE DETERMINED

TIME EMPLOYEE BEGAN WORK ON INJURY DATE ☐ AM ☐ PM

DATE EMPLOYER NOTIFIED OF INJURY

BODY PART AFFECTED CODE

NATURE OF INJURY CODE

CAUSE OF INJURY CODE

DATE CLAIM ADM NOTIFIED OF INJURY

HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE INCIDENT INCLUDING WHAT THE EMPLOYEE WAS DOING JUST BEFORE, THE PART OF THE BODY AFFECTED AND HOW, AND OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE EMPLOYEE.

DATE LAST DAY WORKED

DATE DISABILITY BEGAN

RETURN TO WORK DATE (IF APPLICABLE)

DATE OF DEATH (IF APPLICABLE)

IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP
- ☐ WIDOW
- ☐ WIDOWER
- ☐ MOTHER
- ☐ FATHER
- ____ DAUGHTER
- ____ SON
- ____ SISTER
- ____ BROTHER
- ____ HANDICAPPED CHILD

TOTAL # DEPENDENTS

DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)

CITY | STATE | ZIP

COUNTY OF INJURY

TREATMENT

PHYSICIAN NAME

HOSPITAL OR OFF SITE TREATMENT NAME

ADDRESS LINE 1 AND 2

ADDRESS LINE 1 AND 2

CITY | STATE | ZIP

CITY | STATE | ZIP

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

OTHER

DATE PREPARED

PREPARER'S NAME & TITLE

PREPARER'S COMPANY NAME

PHONE NUMBER

RDA 10183

LB-0021 (REV. 12/07)

#1

Key Risk
a Berkley Company

Authorization

The undersigned has filed a claim for workers compensation benefits (hereinafter referred to as the "Claim"). The amount and type of information sought pursuant to this authorization will depend upon the nature of the Claim, but will be used solely to facilitate determination regarding the validity of the Claim and the payment of benefits or the administration of the insurance program under which the Claim has been made. Authorizing the disclosure of information is voluntary, and acceptance of the Claim will not be conditioned upon signing this authorization. This authorization is subject to revocation at any time, except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to Key Risk, P.O. Box 14817, Lexington, KY 40512.

The undersigned authorizes the release of information and communication between my health care provider(s) (including without limitation, medical laboratories, pharmacies, and medical suppliers) and representatives of Key Risk Management Services/ Berkley Insurance Company ("Key Risk").

This release of information applies to all applicable medical records, medical information, bodily fluid and tissue samples, and benefit payment information with respect to any illness, injury, medical history, consultation, prescription, treatment, or benefit, and copies of all applicable records thereof, which may be appropriate or necessary throughout the course of this Claim. This authorization shall specifically include, but shall not be limited to, medical records, medical information and benefit payment information pertaining or relating to the treatment of Acquired Immune Deficiency Syndrome, HIV, mental illness, and drug or alcohol related medical problems.

To comply with federal law, DO NOT include genetic testing or family medical history records.

The undersigned also authorizes the Social Security Administration and the Centers for Medicare & Medicaid Services (CMS), its agents and contractors, to release to Key Risk information concerning my workers compensation injury, entitlement dates and benefit amounts for my dependents and me.

The undersigned further authorizes Key Risk to release any such information as described above to its reinsurers, attorneys, second injury fund consultants, medical laboratories, medical peer review panels, CMS, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, and the undersigned's employer and its excess insurer, to the extent that Key Risk considers doing so to be reasonably appropriate or necessary for purposes of its administration of the Claim or the insurance program under which the Claim has been made.

Information disclosed to Key Risk is from records whose confidentiality is protected by various state or federal laws. Any further disclosure of this information may no longer be subject to certain protections provided under federal privacy regulations. Unless revoked earlier by the undersigned, in writing, this authorization shall be valid for three years after Key Risk has closed the Claim. A copy of this authorization is to be considered as valid as the original.

Employee Signature: _____ Date: _____

Employee Name: _____ Employer: Sumner County Board of Education

Claim Number: _____ Date of Birth: _____

#2