

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



<b>CLAIMS ADM/CARRIER</b>	JURISDICTION CLAIM # (STATE FILE #)		CLAIM TYPE CODE <input type="checkbox"/> MED ONLY <input type="checkbox"/> INDEMNITY <input type="checkbox"/> BECAME LOST TIME <input type="checkbox"/> BECAME MED ONLY <input type="checkbox"/> NOTIFY ONLY <input type="checkbox"/> TRANSFER		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).		
	CLAIMS ADM CLAIM # (INSURER CLAIM #)		CARRIER FEIN <b>22-3590451</b>				
	OSHA LOG CASE #		FEIN OF CLMS ADM <b>56-2060285</b>				
	NAME OF INSURANCE CARRIER <b>STARNET INSURANCE COMPANY</b>		CLMS ADJ PHONE # <b>(800) 942-0225</b>				
	CLAIMS ADMIN FIRM NAME (IF DIFFERENT FROM CARRIER) <b>KEY RISK MGMT SERVICES</b>						
	CLAIMS ADJUSTER NAME						
CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE <b>P.O. Box 8000</b>				CITY <b>Daphne</b>	STATE <b>AL</b>	ZIP <b>36526-8000</b>	
<b>E EMPLOYER</b>	EMPLOYER NAME <b>SOUTHERN ADVENTIST UNIVERSITY</b>		EMPLOYER FEIN <b>62-0536733</b>		SIC CODE <b>8221</b>	PHONE NUMBER <b>423.236.2266</b>	
	EMPLOYER ADDRESS LINE 1 AND LINE 2 <b>ATTN: RISK MANAGEMENT 4881 TAYLOR CIRCLE</b>				NATURE OF BUSINESS <b>HIGHER EDUCATION</b>		
	CITY <b>COLLEGEDALE</b>		STATE <b>TN</b>	ZIP <b>37315</b>		INSURED REPORT #	EMPLOYER LOCATION
<b>POLICY</b>	INSURED NAME (PARENT CO. IF DIFFERENT THAN EMPLOYER)		POLICY NUMBER <b>KEY0137735</b>		EFF DATE <b>07/01/2020</b>	EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL TIME/REGULAR <input type="checkbox"/> PART TIME <input type="checkbox"/> PIECE WORKER <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> APPRENTICE FULL TIME <input type="checkbox"/> APPRENTICE PART TIME	
			SELF INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		EXP DATE <b>07/01/2021</b>		
<b>EMPLOYEE</b>	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		
	FIRST	MI	DEPARTMENT REGULARLY WORKED		OCCUPATION DESCRIPTION		
	ADDRESS LINE 1 & 2						
	CITY		STATE	ZIP		MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED	<input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN
	SSN	DATE OF BIRTH	DATE OF HIRE		NCCI CLASS CODE		
<b>WAGE</b>	WAGE \$	PERIOD <input type="checkbox"/> HOURLY <input type="checkbox"/> DAILY	<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY	NUMBER OF DAYS WORKED PER WEEK		SALARY CONTINUED IN LIEU OF COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO	
						FULL WAGES PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>ACCIDENT/INJURY</b>	DATE OF INJURY		TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> COULD NOT BE DETERMINED		TIME EMPLOYEE BEGAN WORK ON INJURY DATE <input type="checkbox"/> AM <input type="checkbox"/> PM		
	DATE EMPLOYER NOTIFIED OF INJURY		BODY PART AFFECTED CODE		NATURE 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				
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> WIDOW	<input type="checkbox"/> FATHER	<input type="checkbox"/> SISTER	TOTAL # DEPENDENTS	
		<input type="checkbox"/> WIDOWER	<input type="checkbox"/> DAUGHTER	<input type="checkbox"/> BROTHER			
		<input type="checkbox"/> MOTHER	<input type="checkbox"/> SON	<input type="checkbox"/> HANDICAPPED CHILD			
ADDRESS WHERE INJURY OCCURRED (IF OTHER THAN EMPLOYER'S PREMISES)						COUNTY OF INJURY	
CITY						STATE	
ZIP							
<b>TREATMENT</b>	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 <input type="checkbox"/> NO MEDICAL TREATMENT			<input type="checkbox"/> MINOR BY EMPLOYER <input type="checkbox"/> MINOR BY CLINIC/HOSPITAL	<input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> EMERGENCY CARE	<input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED	
<b>OTHER</b>	DATE PREPARED		PREPARER'S NAME & TITLE		PREPARER'S COMPANY NAME	PHONE NUMBER	