



**DOWNEY**  
**INSURANCE**  
*Protecting Those Who Serve<sup>SM</sup>*

Please return to:

Downey Insurance, Inc.  
P. O. Box 690  
Kokomo, IN 46903-0690  
1-800-382-8837  
1-765-868-3310 FAX

**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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		OCCUPATIONAL TITLE		NCCI CLASS CODE			
LAST NAME		FIRST	MIDDLE		MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED		DATE HIRED	STATE OF HIRE	EMPLOYEE STATUS		
ADDRESS (INCL ZIP)				# OF DEPENDENTS		WAGE PER <input type="checkbox"/> HR <input type="checkbox"/> DAY <input type="checkbox"/> WK <input type="checkbox"/> MO <input type="checkbox"/> YR <input type="checkbox"/> OTHER	HRS/DAY	DAYS/WK	AVG W/W	PAID DAY OF INJ <input type="checkbox"/>	SALARY CONT'D <input type="checkbox"/>
PHONE											

EMPLOYER INFORMATION				
EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP)		EMPLOYER FEDERAL ID#	SIC CODE	INSURED REPORT NUMBER
Shelby County Government		356000196		
25 West Polk Street		LOC #	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
Shelbyville, IN 46176		PHONE #	317-398-5537	
Actual Location of Accident/Exposure (if not on employer's premises):			CARRIER/ADMINISTRATOR CLAIM NUMBER	REPORT PURPOSE CODE

CARRIER/CLAIMS ADMINISTRATOR INFORMATION				
CLAIMS ADMINISTRATOR (NAME, ADDRESS, PHONE NO)		CARRIER FEDERAL ID#	CHECK IF APPROPRIATE <input checked="" type="checkbox"/> SELF INSURANCE	
Downey Insurance Inc. (IPEP)		<input type="checkbox"/> INSURANCE CARRIER	POLICY/SELF-INSURED NUMBER	
P. O. Box 690		<input checked="" type="checkbox"/> THIRD PARTY ADMIN	POLICY PERIOD	
Kokomo, IN 46903-0690			FROM TO	
PHONE: 800-382-8837				
AGENT NAME		CODE NUMBER		

OCCURRENCE/TREATMENT INFORMATION							
DATE OF INJ/EXP	TIME OF OCCURRENCE	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?	<input type="checkbox"/> YES <input type="checkbox"/> 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						INITIAL TREATMENT <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 > THAN 24HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LT	
WITNESSES (NAME, PHONE#)				DATE ADMINISTRATOR NOTIFIED			
DATE PREPARED	PREPARER'S NAME		TITLE	PHONE NUMBER			



Downey Insurance Inc.
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.



INDIANA PUBLIC EMPLOYERS' PLAN, INC.  
**SUPERVISOR'S INCIDENT INVESTIGATION REPORT**

(Please Complete All Sections)

1. Company or Location Shelby County Government	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: 1-800-245-1736  
Claims Fax: 1-765-868-3310  
Local: 1-765-457-9161

# WAGE STATEMENT



DATE \_\_\_\_\_ CLAIM NUMBER \_\_\_\_\_  
 EMPLOYEE \_\_\_\_\_ EMPLOYER Shelby County Government

I have examined our payroll records and the following table shows the weeks worked and the wages earned by the above-named employee during the period stated therein (including bonus and overtime pay).

I have examined our payroll records and find that the above-named employee did not work for said employer for a sufficient period to determine a proper average weekly wage. Therefore, the following table shows the weeks worked and wages earned by \_\_\_\_\_ a fellow employee of the same class who was similarly engaged by the same employer and who did work a substantial part of the year prior to \_\_\_\_\_

(Date of alleged injury)

Position: \_\_\_\_\_ Signed By: \_\_\_\_\_

	Week Ending			Days Worked	Amount Paid		Week Ending			Days Worked	Amount Paid	
	Month	Day	Year				Month	Day	Year			
1						27						
2						28						
3						29						
4						30						
5						31						
6						32						
7						33						
8						34						
9						35						
10						36						
11						37						
12						38						
13						39						
14						40						
15						41						
16						42						
17						43						
18						44						
19						45						
20						46						
21						47						
22						48						
23						49						
24						50						
25						51						
26						52						
<b>Total \$</b>					0.00						<b>Total \$</b>	0.00
						<b>Entire Total \$</b>						0.00

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 Kokomo, Indiana 46903-0690

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**Type of Accident**

Bite by Animal  
Bite by Human  
Bite by Insect/Sting  
Body Reaction  
Burn  
Caught In/Between/On  
Contacted Harmful Substance  
Contagious Disease Exposure  
Electrical Contact  
Fall From  
Fall Level  
Fell Through  
Foreign Body  
Gunshot  
Motor Vehicle  
Other  
Overexertion  
Pierced/Punctured By  
Public Transportation  
Repetitive Action/Motion  
Slipped (Not Fall)  
Smoke Inhalation  
Stepped In/On  
Stress  
Struck Against  
Struck By  
Struggle/Resistive Subject

**Nature of Injury**

Abrasion  
Amputation  
Asphyxia  
Avulsion  
Bruise, Contusion  
Burn Caused by Chem.  
Burn Caused by Heat  
Carpal Tunnel Syndrome  
Concussion  
Cut, Laceration  
Crush  
Death  
Dermatitis  
Dislocation  
Electrical Shock  
Fracture  
Frostbite/Freezing  
Hearing Loss  
Heart Attack  
Heat Stroke  
Hernia  
Infection  
Inflammation/Swelling  
Multiple Injuries  
Other  
No Injuries  
Poisoning  
Puncture  
Radiation  
Soreness/Pain  
Sprain/Strain  
Stress  
Tendonitis

**Part of Body**

Abdomen  
Arm - Lower  
Arm - Upper  
Back/Spinal, Back/Non-spinal  
Buttocks  
Chest  
Ears, External  
Ears, Internal  
Elbow  
Eyes  
Face  
Fingers  
Foot  
Groin  
Hand  
Head  
Hips  
Jaw  
Knee  
Leg - Lower  
Leg - Upper  
Mouth  
Multiple Parts  
Neck/Spinal, Neck/Non-spinal  
Nervous System  
Nose  
Other  
Respiratory System  
Shoulder  
Teeth  
Thigh  
Thumb  
Toes  
Trunk/Non-spinal  
Wrist