Take Charge, Take Action

IRMA Reports – Useful Information to Reduce Your Losses

Handouts

IRMA

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? ☐ Yes ☐ No
Employer's name		Doing business as	
Employer's mailing address			Employer's email address
Nature of business or service			SIC code
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? ☐ Yes ☐ No
Employee's full name			Birthdate
Employee's mailing address			Employee's e-mail address
Gender ☐ Male ☐ Female	Marital status ☐ Married ☐ Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? ☐ Yes ☐ No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? ☐ Yes ☐ No		Was the employee hospitalized overnight as an inpatient? ☐ Yes ☐ No	
Report prepared by	Signature	Title and telephone #	Email address

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD SPRINGFIELD, IL 62703**

By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any way. This information is confidential. IC45 8/12

PRIVILEGED AND CONFIDENTIAL INSURED-INSURER PRIVILEGE

INTERGOVERNMENTAL RISK MANAGEMENT AGENCY
Four Westbrook Corporate Center, Suite 940
Westchester, IL 60154
(708) 562-0300

SUPERVISOR'S INVESTIGATION REPORT

PLEASE EMAIL ACCIDENT REPORT TO IRMA PROMPTLY – CLAIMS@IRMARISK.ORG
OR SUBMIT VIA FAX - (708) 562-0900

This report shall be completed in ink by the supervisor of the injured, **no later than the end of the injured person's work shift.** The report shall then be forwarded to your claims coordinator **within 24 hours**, along with the completed form IC45.

Any additional information, including a completed wage statement (if applicable), should follow as soon as possible. This completed form shall then be forwarded to IRMA the **same day** the claims coordinator receives it.

The unsafe acts of persons and the unsafe conditions that cause accidents can be corrected only when they are known specifically. It is your responsibility to find them, name them and to state the remedy for them in this report.

NAME OF IRMA MEMBER (MUNICIPALITY)	DATE & TIME OF ACCIDENT / / AM PM
DATE INJURED PERSON REPORTED ACCIDENT AND TO WHOM	
LOCATION OF ACCIDENT (The name or number of building, store, dept., floor, etc.)	

NAME OF INJURED EMPLOYEE / PHONE NUMBER	INJURED EMPLOYEE'S DEPARTMENT	INJURED EMPLOYEE'S JOB
INJURED PERSON'S STATUS ☐ FULL TIME ☐ PART TIME ☐ SEASONAL ☐ CONTRACT ☐ VOLUNTEER ☐ MISC.		SOCIAL SECURITY NUMBER

TIME IN JOB
☐ IN TRAINING ☐ UNDER 6 MONTHS ☐ 6 MONTHS TO 1 YEAR ☐ 1 TO 5 YEARS ☐ OVER 5 YEAR

DATE OF HIRE / /	AVERAGE NUMBER OF HOURS WORKED PER WEEK	HOURLY RATE

DESCRIBE THE INJURY

DESCRIBE THE ACCIDENT (State what the injured was doing and the circumstances leading to the accident)

WAS EMPLOYEE REQUESTED TO GO TO A MEDICAL MANAGEMENT NETWORK FACILITY FOR TREATMENT? ☐ YES ☐ NO	IF RESTRICTED, IS LIGHT DUTY AVAILABLE? ☐ YES ☐ NO
IS EMPLOYEE STILL TREATING WITH A MEDICAL MANAGEMENT NETWORK FACILITY? ☐ YES ☐ NO	IF NO, NAME & ADDRESS OF TREATING DOCTOR:

DID/WILL INJURED PERSON MISS **MORE THAN 3 WORKDAYS** DUE TO THIS ACCIDENT?
☐ YES ☐ NO ☐ UNKNOWN

# OF WORK DAYS INJURED PERSON MISSED :	DATE STARTED LOSING TIME: / /

ANY WITNESSES TO THIS INJURY/ACCIDENT? ☐ YES ☐ NO
IF YES, WITNESS NAME _____ TITLE/JOB DESCRIPTION _____ PHONE # _____
WITNESS NAME _____ TITLE/JOB DESCRIPTION _____ PHONE #_____

HOW COULD THE INJURY/ILLNESS HAVE BEEN PREVENTED?

REMEDY (As a supervisor, what action have you taken or do you propose taking to prevent a repeat accident?)

SUPERVISOR	REVIEWED AND APPROVED BY CLAIMS COORDINATOR	DATE REPORT PREPARED

EMAIL ACCIDENT REPORT TO IRMA PROMPTLY – CLAIMS@IRMARISK.ORG OR SUBMIT VIA FAX - (708) 562-0900

INTERGOVERNMENTAL RISK MANAGEMENT AGENCY
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Westchester, IL 60154
(708) 562-0300

IRMA NON-WORKERS' COMPENSATION ACCIDENT REPORT FORM

PLEASE EMAIL ACCIDENT REPORT TO IRMA PROMPTLY – CLAIMS@IRMARISK.ORG
OR SUBMIT VIA FAX- 708-562-0900

Please complete the applicable sections of the report. The individual having responsibility for reporting the accident should complete the report **by the close of the work shift**. **The claimant should not complete this form**.

The supervisor/department head of the employee who filled out the form should forward to their claims coordinator **by the end of the work shift or within 24 hours**. This completed form shall then be forwarded to IRMA the **same day** the claims coordinator receives it.

I. MEMBER INFORMATION

NAME OF IRMA MEMBER (MUNICIPALITY)	CONTACT PERSON NAME AND PHONE NUMBER	DEPARTMENT

DATE OF LOSS	TIME OF LOSS	WAS EMPLOYEE INJURED
	_____ A.M. _____ P.M.	YES _____ NO_____

LOCATION OF LOSS	EMPLOYEE NAME/DRIVER IF AUTO

POLICE OR FIRE DEPT. REPORT #	STREET/SIDEWALK CONDITIONS:	WEATHER CONDITONS:
	___DRY ___OTHER___WET ____SNOW/ICE	___CLEAR/CLOUDY ___RAIN ___SNOW ___ OTHER

II. MEMBER PROPERTY DAMAGE

ITEMS DAMAGED:	AGE OF ITEM (S) DAMAGED	VIN NUMBER:	ESTIMATE OF DAMAGE $

MAKE OF OUR VEHICLE/MOBILE EQUIPMENT:	YEAR:	MODEL:	LICENSE NUMBER (S)

III. MEMBER DESCRIPTION OF ACCIDENT

IS OTHER PARTY MAKING A CLAIM? ___ YES ___ NO PLEASE EXPLAIN

IV. CLAIMANT ACCIDENT / INJURY INFORMATION

NAME	SEX	AGE/D.O.B.

BUSINESS PHONE	HOME PHONE	ADDRESS

NATURE OF INJURY/PART OF BODY _____ FATALITY	WHAT WAS INJURED PERSON DOING?

WHERE TAKEN? (Name of hospital/clinic, address, phone number)

V. CLAIMANT AUTOMOBILE INFORMATION

OWNER OF OTHER VEHICLE	AGE	ADDRESS	CITY	STATE	ZIP	PHONE

DRIVER, IF OTHER THAN OWNER	AGE	ADDRESS	CITY	STATE	ZIP	PHONE

MAKE OF VEH	YEAR	MODEL	LICENSE NO.	VIN NO.	AREA OF DAMAGE	ESTIMATE OF DAMAGE $

IS VEHICLE INSURED? ____YES ____NO	COMPANY/AGENCY NAME, POLICY NO. & PHONE NO.	WHERE VEHICLE CAN BE SEEN

VI. CLAIMANT NON-AUTO PROPERTY DAMAGE (i.e. fence, building, etc.)					
OWNER OF PROPERTY	ADDRESS	CITY	STATE	ZIP	PHONE ( )
DESCRIBE DAMAGED PROPERTY		LOCATION OF PROPERTY			
IS PROPERTY INSURED? _____YES _____NO	COMPANY/AGENCY NAME, POLICY NO. & PHONE NO.				

VII. WITNESS INFORMATION				
NAME	AGE/D.O.B.	ADDRESS	BUS PHONE ( )	HOME PHONE ( )
NAME	AGE/D.O.B.	ADDRESS	BUS PHONE ( )	HOME PHONE ( )

COMMENTS (Optional):

X_____
SUPERVISOR/DEPT. MANAGER SIGNATURE & DATE

X_____
CLAIMS COORDINATOR SIGNATURE & DATE

PLEASE EMAIL ACCIDENT REPORT TO IRMA PROMPTLY – CLAIMS@IRMARISK.ORG
OR SUBMIT VIA FAX- 708-562-0900

PLEASE SEND ALL SUPPORTING MATERIAL (AVAILABLE REPORTS, NEWSPAPER ARTICLES, PICTURES, REPAIR ESTIMATES AND/OR BILLS, POLICE REPORTS, AMBULANCE REPORTS, ESTIMATES OF REPAIR) AS SOON AS POSSIBLE.
NOTE: IF MEMBER PROPERTY IS DAMAGED BY A CLAIMANT VEHICLE, PLEASE FILE A STATE OF ILLINOIS ACCIDENT FORM WITH THE SECRETARY OF STATE.

SUPERVISORS CRITICAL REVIEW WORKSHEET

Name of Injured Person: Click here to enter text. **Date of Injury:** Click here to enter a date.

Is this part of a 48 hour shift: Choose an item. **Hours worked prior to injury:** Click here to enter text.

Type of duty being performed: Choose an item. **Nature of injury:** Choose an item.

Body Area Effected: Choose an item. **Cause of Injury:** Choose an item.

Contributing Factors: Choose an item. **Loss of Time Injury:** Choose an item.

Critically Review the Incident to Complete the Following Questions

What task/duty was the injured member performing that caused the injury: Click here to enter text.

What other members were present when the injury occurred: Click here to enter text.

What was their task/duty when the injury occurred: Click here to enter text.

Did you witness the injury: Choose an item.

If yes, what did you see happen: Click here to enter text.

Were there any issues/problems that contributed to the injury: Click here to enter text.

If yes, were they known and for how long: Click here to enter text.

How did they impact the injury: Click here to enter text.

Breaking down the incident into small detailed parts, what was the sequence of events that led to the injury: Click here to enter text.

Breaking down the sequence of events, what was the root cause of the injury: Click here to enter text.

What can be done to prevent a similar injury in the future: Click here to enter text.

What changes can be made to prevent similar injuries in the future: Click here to enter text.

Are there any risks associated with these changes: Click here to enter text.

Have these changes been completed, if not who is responsible to make them: Click here to enter text.

Supervisor Completing Investigation: Click here to enter text.

Signature _____ Date_____

Shift Commander / Chief Officer reviewing worksheet: Click here to enter text.

Signature ____________________________ **Date**_____________________

INTERGOVERMENTAL RISK
MANAGEMENT AGENCY

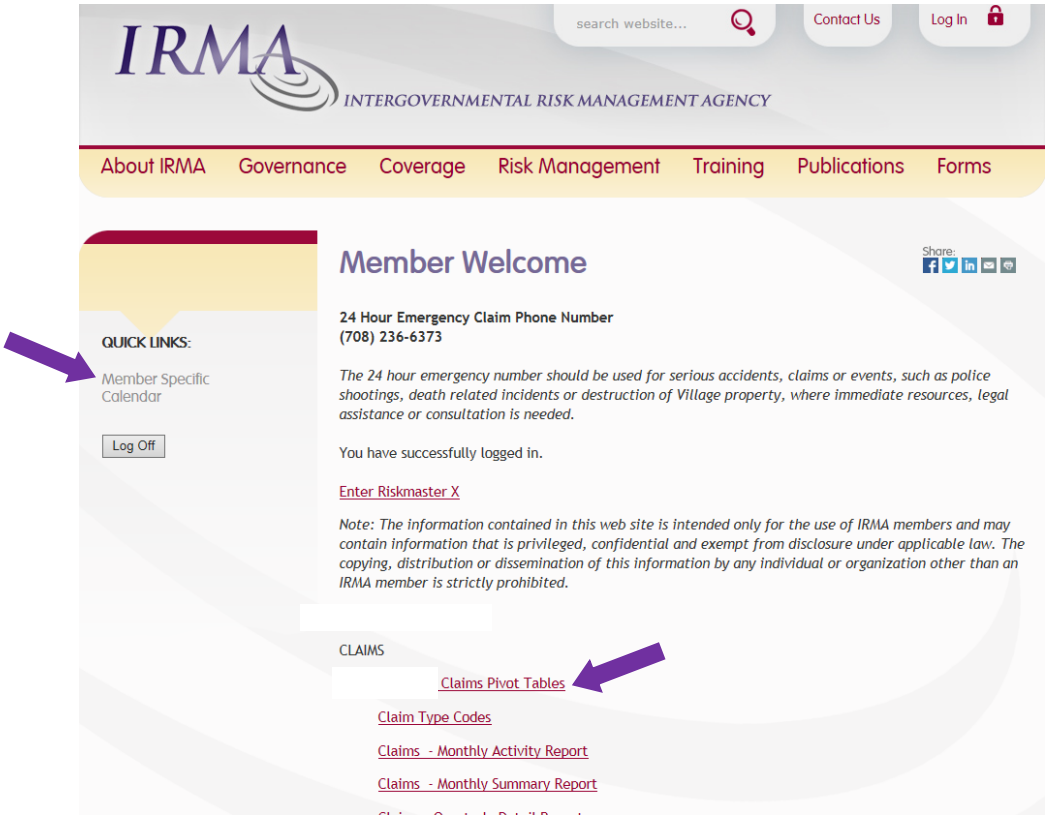
The Risk Management Solution for Local Government

Pivot Tables User Guide:
Make the Data Work for Your Safety Program

Every Spring, IRMA distributes claims data which is specifically tailored to show your entity's losses. This is an excellent tool which should be used to provide further analysis of your loss history and can help you shape your safety program initiatives.

Analysis of your prior losses will assist you in identifying adverse claims trends as well as gain further insight as to the cause, frequency and severity of the losses which are affecting your entity. This data can then be used to focus the goals of your safety program towards actively pursuing remedies for preventable losses through policy review and implementation, staff training and development, and resource allocation.

The pivot tables are created using Microsoft Excel, are uploaded to the IRMA Website and are located under your Member Specific Page for review.



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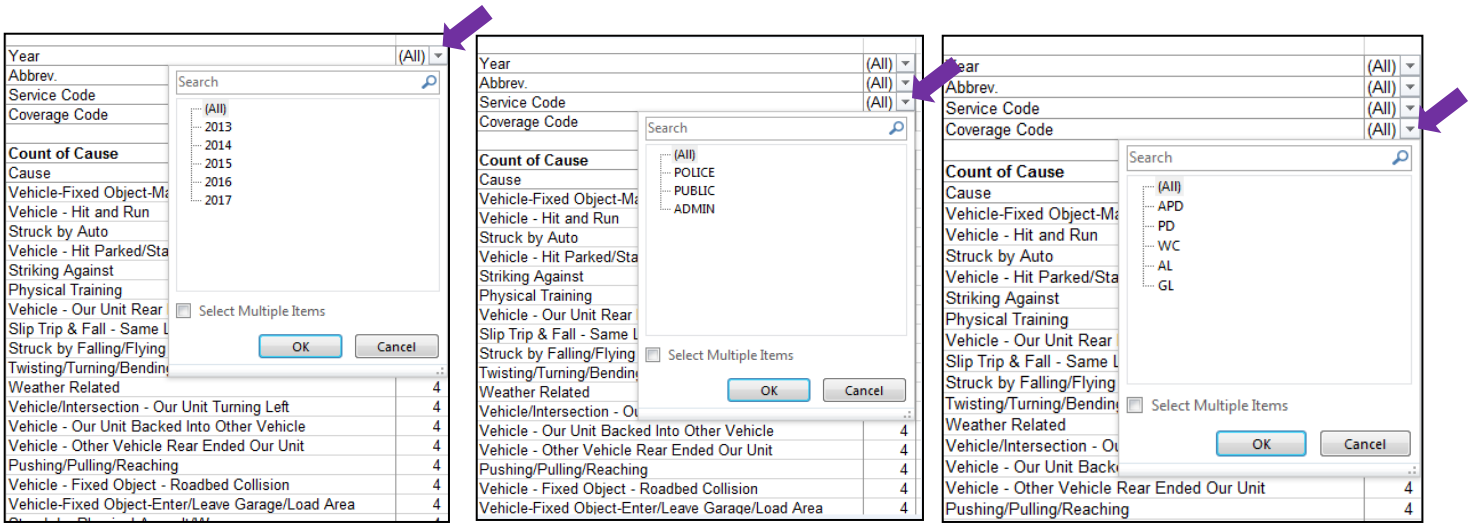
Select the Claims Pivot Table hyperlink to open the table in a separate window. IRMA recommends you save this report to your computer system for ease of use. Each table includes causes of injury, types of injury, and affected body parts and can be manipulated to display data via different operating departments, years or coverage.



Once your desired combination is selected from the category drop-down menus, the data is automatically populated and ready for analysis. The sample data shown below may indicate an increased need for driver training, such as distracted driving training or vehicle backing.

Year	2017
Abbrev.	(All)
Service Code	PUBLIC
Coverage Code	APD

Count of Cause	
Cause	Total
Vehicle-Fixed Object-Enter/Leave Garage/Load Area	1
Vehicle - Hit Parked/Standing Vehicle	1
Vehicle - Fixed Object - Collision with Building	1

Year	2017
Abbrev.	(All)
Service Code	PUBLIC
Coverage Code	APD

Sum of Incurred	
Cause	Total
Vehicle-Fixed Object-Enter/Leave Garage/Load Area	5,187
Vehicle - Fixed Object - Collision with Building	3,280
Vehicle - Hit Parked/Standing Vehicle	210

The generated data can be verified by reviewing a separate tab, called Data. This tab lists additional information, such as the claim number, which will further direct your claims analysis and risk remediation efforts.

Remember, IRMA is here to help! Should you have any questions regarding the use or operation of your member specific data, please contact us. We also have many resources which can greatly assist in the implementation of your safety program goals. From member discounts to grants, model policies to on-site trainings and more, we are your partner in risk management.

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M E M O R A N D U M

TO: **Sample Village**

FROM: **Rita Boserup, Director of Financial Services & Administration**

DATE: **December 15, 2017**

RE: **Allocation of IRMA's 2018 Contribution Based on Actual Claims**

Several Members have asked IRMA for recommendations on allocating the annual IRMA contribution to individual departments. Following is a cost allocation table based on the member's actual department loss experience, using the sliding scale amounts for the prior 5 years (2012-2016). It is broken down by the four major departments: administration, fire, police and public works.

Based on our calculations, you may want to allocate the IRMA contributions to the departments using the following percentages.

Department	Percentage
Administration	0.00%
Fire	36.62%
Police	9.41%
Public Works	53.97%

The following table indicates the line of coverage breakdown for the same claim information.

Coverage	Percentage
Auto Liability	0.11%
Auto Property Damage	0.56%
General Liability	26.16%
Property Damage	1.90%
Workers Compensation	71.26%

If you have any questions, please contact Rita at (708) 236-6335 or ritab@irmarisk.org.