

**IC Form 14
FOR E-MAIL**

**EMPLOYER'S SUPPLEMENTAL REPORT
TO STATE INSURANCE FUND**

P.O. Box 83720
Boise, ID 83720-0044
208-332-2100 • 800-334-2370

Instructions: Employer, complete this form and e-mail it to the State Insurance Fund at ClaimsIM@IdahoSIF.org. Print out a copy, sign it, and save it in your files. **Do not e-mail to the Industrial Commission.**

The form should be completed at the following times:

1. Upon termination of disability (regardless of length of time disabled for work).
2. At the end of 60 days from date disability began if employee is disabled for work that long.

Any employer who fails to make this report upon the termination of the disability of one of his injured employees, and if the disability extends beyond a period of 60 days, at the end of that period, is subject to a penalty not to exceed \$500.00.

Name of injured employee:	Address where mail should be sent:
Date of injury:	Date disability began:
Were wages paid for the day the disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No	What wages, if any, have been paid during the period of disability?
Had the injured employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, on what date was he or she re-employed?
	At what daily wage?
Give date the injured employed recovered sufficiently to return to regular work:	

**THE ABOVE STATEMENTS ARE CORRECT
(Employee MUST NOT sign this form BEFORE
disability for work ceases)**

Employer

Signature of Injured Employee

Date of this report _____ Address _____

"Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony."