Form Instructions

Please complete as much information as you have available. If you need help completing the form, contact Claims at (208) 332-2100 or (800) 334-2370.

Please save a copy for your records.

Submission options:

- **Upload** at https://hub.idahosif.org/Document/Upload
- **Email** as an attachment to: ClaimsIM@IdahoSIF.org
- **Mail to:**
  SIF, Idaho Workers' Compensation
  P.O. Box 83720
  Boise, ID 83720-0044

Note: Mistakes happen, if you spot or realize an error, please contact us and we will work with you to sort things out. Please be aware that any person who knowingly, and with intent to defraud or deceive any insurance company, submits a statement or claim containing any false, incomplete, or misleading information is violating the law.

IDAHO WORKERS' COMPENSATION

Employer's Supplemental Report

Employers complete this form 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 their 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.

Please save a copy for your records.

<table>
<tr><td>Claim #:
Name of injured employee:</td><td rowspan="2">Address where mail should be sent:</td></tr>
<tr><td>Date of injury:</td><td>Date disability began:</td></tr>
<tr><td>Were wages paid for the day the disability began? ☐ Yes ☐ No</td><td>What wages, if any, have been paid during the period of disability?</td></tr>
<tr><td rowspan="2">Has the injured employee returned to work? ☐ Yes ☐ No</td><td>If so, on what date was he or she re-employed?</td></tr>
<tr><td>At what daily wage?</td></tr>
<tr><td colspan="2">Give the date the injured employee recovered sufficiently to return to regular work:</td></tr>
</table>

THE ABOVE STATEMENTS ARE CORRECT *(The employee MUST NOT sign this form BEFORE the work disability ceases.)*

Employer (print name of Employer/Business)

Signature of injured employee

Signature of employer/authorized agent

Employer address:

Date of this report

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.

PO Box 83720 • Boise, ID 83720-0044 • 208-332-2100 • www.idahosif.org