ILLINOIS FORM 85: EMPLOYER'S SUPPLEMENTARY REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File#	This report is

Employer's name	Doing business as

Employer's full mailing address	Employer's email address

Nature of business or service	SIC code

Name of workers' compensation carrier/admin.	Policy/Contract #	Self-insured?

Insurer's full mailing address

Employee's full name	Birthdate

Employee's full address	Employee's email address

Date of injury/diagnosis	Date of first payment	Employee's average weekly wage	# Dependents

Period of disability	If the employee died as a result of the accident, give the date of death.

BENEFIT INFORMATION *Please provide a comprehensive history of payments.*

Payment Type (TTD, medical, etc.)	Weekly Payment	Number of Weeks	Benefit Paid From	Benefit Paid Through	Total Payments
			Grand total		

Was this case closed by the Industrial Commission?	If so, how was the case resolved?

Report prepared by	Signature	Title, telephone #, and email address

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE ROAD SPRINGFIELD, IL 62703-5118**

In addition to the *Employer's First Report of Injury* (IC45), employers shall file this report when 1) benefits begin or are stopped; 2) there is a change in the employee's status; 3) final compensation is made. This information is confidential. IC85 8/12