## ILLINOIS FORM 85: EMPLOYER'S SUPPLEMENTARY REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of repo	Date of report		Case or File #		This report is	
					Supplemen	itary / Final	
Employer's name			Doing business a	as			
Employer's full mailing address			Employer's ema	il address			
				n .			
Nature of business or service				SIC code			
Name of workers' compensation	eervier /edmin		Policy/Contract	щ	Self-insured?		
Name of workers compensation	camer/aumin.		Policy/Contract	#			
Insurer's mailing address			City		Yes / State	No Zip code	
			City		State		
Employee's full name					Birthdate		
Employee's full mailing address			Employee's email address				
Date of injury/diagnosis	Date of first payment	Date of first payment Employee's av		rage weekly wage		# Dependents	
Period of disability		If the employee	died as a result o	f the accident, giv	ve the date of dea	ath.	
BENEFIT INFORMATION	0/						
Please provid Payment Type Weekly		<i>ide a comprehensive history of payments.</i> Number of Benefit Paic		Benefit Paid	l Total		
(TTD, medical, etc.)	Payment Weeks		From Through		h	Payments	
(TTD, mouldal, ctc.)	Fayment					raymento	
	Fayment					rayments	
	rayment					- dynienco	
	Fayment						
	rayment						
					···		
			he case resolved?	Grand total		\$	
Was this case closed by the Indu		If so, how was t	t contract / A	Grand total		\$	
		If so, how was t		Grand total	n / Commissi	\$ on decision	
Was this case closed by the Indu Yes / No	Istrial Commission?	If so, how was t		Grand total	n / Commissi	\$ on decision	

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