## 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<br>Supplementary / Final |
|---|---|---|---|

| Employer's name | Doing business as |
|---|---|

| Employer's mailing address | City | State | Zip code |
|---|---|---|---|

| Nature of business or service | SIC code |
|---|---|

| Name of workers' compensation carrier/admin. | Policy/Contract # | Self-insured?<br>Yes / No |
|---|---|---|

| Insurer's mailing address | City | State | Zip code |
|---|---|---|---|

| Employee's full name | Social Security # | Birthdate |
|---|---|---|

| Employee's street address | City | State | Zip code |
|---|---|---|---|

| 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 |
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| | | | | Grand total | $ |

| Was this case closed by the Industrial Commission?<br>Yes / No | If so, how was the case resolved?<br>Settlement contract / Arbitration decision / Commission decision |
|---|---|

| Report prepared by | Signature | Title and telephone # |
|---|---|---|

Please send this form to the **ILLINOIS INDUSTRIAL COMMISSION 701 S. SECOND STREET SPRINGFIELD, IL 62704** IC85 1/02

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.