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 ☐ 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? ☐ 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
				Grand total	$

Was this case closed by the Industrial Commission?	If so, how was the case resolved?
☐ Yes / No ☐	☐ Settlement contract / ☐ Arbitration decision / ☐ Commission decision

Report prepared by	Signature	Title and telephone #

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 6/09