## 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 Zip code Insurer's mailing address State City Birthdate Employee's full name Employee's street address State City 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 Weekly Number of Benefit Paid Total (TTD, medical, etc.) Payment Weeks From Through **Payments** Grand total \$ Was this case closed by the Industrial Commission? If so, how was the case resolved?

Signature

Report prepared by

Settlement contract /

Arbitration decision /

Title and telephone #

Commission decision