

Employer's Report of Injury

	08/08			
For BrickStreet Use Only				
Claim Number:				
Team Assigned:				

Z			2. FEIN or SSN:		3. Nature of Business:		
OYER IATIC	4. Employer's Name:						
EMPLOYER INFORMATION	5. Address:						
ᄪᄬ	City:	State:	Zip:	6. Te	elephone:		
N	1. Name: Last First		MI	6. Date	Hired:		
IATIO	2. Address:			7. Tele	7. Telephone:		
ORIV		- Zin:		Social Security Number:			
N N	City: State				,		
EMPLOYEE INFORMATION	3. Date of Birth:	4. Sex:	□ M □ F		9. Marital Status:		
EMPL				10. Employee's Occupation / Job Title:			
	Owner / Partner Officer	Retired – Date Retired	<u>d:</u>				
	Date of Injury or Last Exposure:	Time:	a.m.	☐ p.m.	5. Witnesses to Injury:		
	2. Date Employer Notified of Injury or Diseas	se:			1		
Щ.	3. Supervisor to Whom Injury or Disease Rep	•			1		
SEAS	4. If Injury was Fatal, Indicate Date of Death:				1		
/ / DI	6. Did Injury Occur on Employer's Property?						
JUR	Address or location where injury occurred:						
Ž L	7. What was the Employee Doing When Injury Occurred? (loading truck, walking down stairs, etc.)						
BOU	8. How did the Injury or Disease Occur? (Be	8. How did the Injury or Disease Occur? (Be specific, include time that employee began work on date of injury, any equipment, tools substances or objects connected to					
INFORMATION ABOUT INJURY / DISEASE	the injury; attach additional sheet(s) if necessary)	the injury; attach additional sheet(s) if necessary)					
MAT	9. Nature of Injury or Disease (cut, bruise, strain, etc.)						
FOR	10. Body Part(s) Injured:	10. Body Part(s) Injured:					
₹	•	11. Are you Aware of, or Do You Suspect, a Prior Injury to this Body Part? Yes No					
	12. Do you Have Reason to Question this Inj	njury? Yes No	· , ,	•	•		
	13. Location of Initial Treatment:	_	Emergency Room?	Yes	□ No Hospitalized? □ Yes □ No		
	Last Day Worked After Occupational Injury or Disease:						
ш							
TIME	2. Number of Work Days Lost:				4. Hours Worked Per Week:		
WAGE AND LOST I	5. Is Light Duty Available? Yes No	6. Wage on Date of	f Injury: \$ Per	er 🗌 Hour	r 🗌 Day 🗌 Week 🔲 Month		
AND ORN	7. Are Wages Being Paid to Injured Employee 8. If Employee Has Returned to Work, is it Alternative or Modified Work? Yes No						
SE F	During Disability? ☐ Yes ☐ No If "yes," indicate current wage: \$ Per ☐ Hour ☐ Day ☐ Week ☐ Month						
W	9. Daily Rate of Pay on Date of Injury: \$		and best quarter wages of	preceding '	four quarters: \$		
			·		<u>'</u>		
	I certify the statements and answers set forth in this	s section are true and correct	to the best of my knowledge. I	am aware th	he law specifically West Virginia Code § 61-3-24e		
	provides for severe penalties if I knowingly certify a	a false report or statement and	d / or withhold a material fact re	egarding any	information requested. I acknowledge the		
	provisions of the aforementioned code and the seve which he or she is not entitled.	ere penaities for knowingly will		betting arryon	ne in securing or attempting to secure periodis to		
	Print Name:		Title:				
	Signature:		Date:				
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General instructions for completing the BI-3, "Employer's Report of Injury"

Please Read Carefully

To the Employer: W.V. Code 23-4-1b requires you to report the injury to your carrier within five days of receipt of notification from an employee's injury.

This form should not be used to file occupational pneumoconiosis or hearing loss claims.

To report a claim, please contact BrickStreet at 1-866-452-7425. If completing this form, make a copy for your records.

Return completed form to: BrickStreet Mutual Insurance

P. O. Box 3151

Charleston, WV 25332-3151

When completing this form, please attach additional pages if space is needed. Also attach any witness statements and reports you wish to submit.