



Employers' Report of Occupational Pneumoconiosis

Please return completed form to:
BrickStreet Mutual Insurance
P.O. Box 3151
Charleston, WV 25332-3151

1. Claimant's Full Name (First, Middle, Last)		2. Social Security Number		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		4. Claim Number (For office use only)		
4. Claimant's Complete Mailing Address (Street or P.O. Box, City, County, State, Zip Code)						5. Claimant's Date of Birth (Month/ Day./Year)		
6. Employer's Complete Name			7. Employer's phone number		8. Employer's FEIN			
9. Employer's Complete Address (Street or P.O. Box, City, County, State, Zip Code)						10. Employer's BrickStreet Policy Number		
11. Date claimant began working (Month/ Day./Year)			12. Is claimant still working for you? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, date ceased and reason:					
13. While employed by you, was the claimant ever potentially exposed to the hazards of occupational pneumoconiosis for a continuous period of 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No								
14. Do you question the claimant's alleged disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide complete details (attach additional sheets if necessary).								
15. What work was regularly performed by the claimant?								
16. Based on the alleged last date of exposure, list the exact location where the claimant last worked								
Worksite		City, Town or Village			State		County	
17. Has the claimant filed for any prior Workers' Compensation benefits while employed by you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following:								
Claim Number		Impairment %		Date of Injury		Type of Claim and injured Body Part (s)		
18. Claimant's Employment History - Start with the most recent position (or current position if still employed). List every position the claimant has held with your company as well as previous or other employment of which you are aware. List breaks in employment. Please use a month/day/year format for all dates. (Attach additional sheets if necessary).								
From	To	Company	Location or Worksite	City and State	Department	Job Title		

PLEASE PRINT OR TYPE.

Please print or type.	19. Please give the dates of any unemployment or layoff. Please use a month/day/year format for all dates. (Attach additional sheets if necessary.)		
	From	To	Company
	20. What was the claimant's daily rate of pay on the date of last employment (Or the date the application was filed if employee is still working)?		\$ _____ Daily
	21. What were the total earnings of the claimant during the prior four full quarters from the alleged date of exposure:		
	Time Period	Gross Wages	
	Most Recent Full Quarter		
	Prior Quarter		
	Prior Quarter		

Any person or firm, or the officer of any corporation, who knowingly and willfully makes a false report or statement under oath, affidavit or certification respecting any information required to be provided under this chapter, shall be guilty of a felony and, upon conviction thereof, shall be fined not less than \$1,000 nor more than \$10,000 or confined in the penitentiary for a definite term of imprisonment of not less than one year nor more than three years or both.

Name of Employer or Employer's Representative	Title	Phone Number	Date
Signature of Employer or Employer's Representative			
Return completed form to: BrickStreet Mutual Insurance, P.O. Box 3151 , Charleston, West Virginia, 25332-3151. If you have any questions regarding this form, please contact the BrickStreet Mutual Insurance, Occupational Pneumoconiosis Unit at 304. 941.1000 or 1.866.45BRICK (1.866.452.7425).			