Employer's Report of Occupational Pneumoconiosis

PLEASE PRINT OR TYPE

1. Claimant's Full Name (First, Middle, Last)	2. Social Security No	3. Sex ☐ Male ☐ Female	4. Claim Number (For office use only)
5. Claimant's Complete Mailing Address (Street or P.O. Box, City, County, State, Zip)			6. Claimant's Date of Birth (Month/Day/Year)
7. Employer's Complete Name	8. Employer's Phone No.		9. Employer's FEIN
10. Employer's Complete Address (Street or P.O. Box, City, County, State, Zip Code)		11. Employer's Policy Number	
12. Date claimant began working (Month/Day/Year)	13. Is claimant still working for you? ☐ Yes ☐ No If not, date ceased and reason:		

14. While employed by you, was the claimant ever potentially exposed to the hazards of occupational pneumoconiosis for a continuous period of 60 days? ☐ Yes ☐ No

15. Do you question the claimant's alleged disability? ☐ Yes ☐ No If yes, please provide complete details (attach additional sheets if necessary.)

16. What work was regularly performed by the claimant?

17. Based on the alleged last date of exposure, list the exact location where the claimant last worked

Worksite	City, Town or Village	State	County

18. Has the claimant filed for any prior Workers' Compensation benefits while employed by you? ☐ Yes ☐ No
If yes, please provide the following:

Claim Number	Impairment %	Date of Injury	Type of Claim and injured Body Part(s)

19. 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

20. 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	Reason for Unemployment or Layoff

21. 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

22. 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	
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 your workers' compensation carrier.