

Send Completed Form To: Zurich Insurance PO Box 968044 Schaumburg, IL 60196-8044 FAX: 973-394-5262

Employee's Report of Occupational Pneumoconiosis

PLEASE PRINT OR TYPE	1. Claimant's Name (First, Middle, Last)					2. Social Security Number			3. Sex Male Female		
	4. Claimant's Com Address (Street,	Zip)	5. Claimant's Telephone Number (include area code)								
	6. Date of Birth		7. Marita Single Wido		8. Do you reside within 25 miles of Charleston, WV? ■ Yes ■ No						
	9. Date of last exposure to minute particles of dust for a continuous period of 60 days:					10. Have you ceased work? ■ Yes ■ No If yes, when? (month/date/year) and reason:					
	 11. Are you currently receiving Federal Black Lung or workers' compensation benefits from any state? Yes No If yes, please provide the following: What type of payments are you receiving? Date payment began (month-day-year): Monthly amount: \$ 12. List all workers' compensation claims (WV and other states) – please place impairment rating (%)/award by each claim number. Attach a separate sheet if necessary. 										
	Claim Number	Impairment %		Date of Injury	Employer		State In Injury C		Type of Claim and Injured Body Part(s)		
	13. List all disability claims you have filed with federal agencies (includes social security, veterans' administrations, etc.)										
	Currently Receiving? (Yes/No)			Type of Injury and/or Medical Condition		Date Began		Mo	onthly Amount		
	14. Do you have family physician? ☐ Yes ☐ No If yes,						-11 1 1 1	S			
	Physician's name			Complete Mailing Ad City, State, Zip)				Phone Number (include area code)			
	15. Other serious illnesses? Yes No If yes, please describe illness and indicate date of onset. Include the name of physician and facility where treated.										

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16. Surgery? ■ Yes ■ No If yes, please describe the surgery and indicate date and name of physician and facility where surgery was performed.											
17. Accidents? ■ Yes ■ No If yes, please describe the accident and indicate date of accident and name of physician and facility where treated.											
18. Do you have medical reports indicating that you have occupational pneumoconiosis? Yes No If yes, attach a copy of these reports to this application and provide the date of the first diagnosis along with the name, address and phone number of the attending physician who made the diagnosiss.											
Date of Diagnosiss	Physic	ians Name	Complete Mai (Street, City,						Phone Number (include area code)		
19. Have you had an Following inform		following p	orocedure	es performe	d within the	last five	years? If y	yes, pl	ease provide the		
Procedure		Yes/No	Date of P		Procedure	rocedure Attending Phy		cian	Hospital Name and Address		
Chest X-Ray											
Blood Gas Analysis											
Breathing Studies											
Tuberculosis Check											
20. Please list all pre Additional sheets			you are	currently ta	king and list	the phys	sician preso	cribing	g each drug. Attach		
	Prescription Drug		Prescribing Physicia		an Presc		cription Drug		Prescribing Physician		
21. List all medical of physicians, clinic necessary.											
Medical Condition			Treated By				С	linic a	and / or Hospital		

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empl	loyer if still e	ment history prior to employed). Union ha format for all dates.	ll employment his	tory printouts sh	ould be attache							
From	То	Company	Location or Worksite	City and State	Type of Industry	Job Title	Alleged Exposure					
							□ Yes □ No					
							□ Yes □ No					
							□ Yes □ No					
23. How	long have yo	ou been exposed to the	ne hazards of occur	l pational pneumo	oconiosis while	working in We	l st Virginia?					
24. Pleas	24. Please list the dates of any unemployment or layoff. Please use a 'month/day/year' format for all dates.											
	From		То	Com	pany	Reason for unemployment or layoff						
employed include the Social Se	25. Proof of wages must be provided for the full three years prior to the last day you were allegedly exposed (or current date if still employed in an exposed environment). This proof can be W-2 reports, pay stubs or notarized statements from employers which include their Federal Employer Identification Number (FEIN). If none of this documentation can be obtained, please contact the Social Security Administration and complete a SSA-7050-F4, Request for Social Security Earning Information. If the employment documentation is not included, your application will not be processed and it will be returned to you for completion.											
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belief. I a false state Insurance condition I acknow my emplo and in fur Security I needed in Administ informati Security I	I hereby certify that the statements and answers set forth in this application are true and correct to the best of my knowledge and belief. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit to which I am not entitled. By signing this application, I authorize Zurich Insurance to obtain and examine any medical, health, vocational, employment or records pertaining to this application and any condition for which I have previously received medical attention as well as all Social Security Retirement and Disability records; and, I acknowledge the provisions of West Virginia Code 23-4-7 providing the release of medical information by a health care provider to my employer or employer representative. In recognition of the fact that I have filed for West Virginia workers' compensation benefits and in further recognition that access by Zurich Insurance to any and all past wage and prior employment information and prior Social Security Retirement and Disability Decisions that are in the possession of the United States Social Security Administration, may be needed in order to obtain a correct ruling on my claim for benefits, I hereby authorize the United States Social Security Administration to release to Zurich Insurance, its officers, employees, and agents, any and all wage, employment and medical information and records and any and all past Social Security Retirement and Disability Decisions that the United States Social Security Administration has in its possession regarding me. Note: This release has no expiration date as long as the claim is subject to action by Zurich Insurance.											
Claiman	t's Signature	:		Date:								
If you ha	If you have an attorney, please provide:											
Name of attorney	claimant's	Date hired:		Attorney's add	dress:	Attorney's ph (include area						
Attorney	's Signature			<u> </u>								

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