AMCS
American Mining Claims Service
WEST VIRGINIA UNIT

# Employers' Report of Occupational Pneumoconiosis

Please return completed form to:
American Mining Claims Service
P.O. Box 660988
Birmingham, AL 35266-0988

PLEASE PRINT OR TYPE.

| 1. Claimant's Full Name (First, Middle, Last) | 2. Social Security Number | 3. Sex ☐ Male ☐ 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? ☐ Yes ☐ 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?
☐ Yes ☐ No

14. Do you question the claimant's alleged disability? ☐ Yes ☐ 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? ☐ Yes ☐ No If yes, please provide the following:

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

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.

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 | Reason for Unemployment or Layoff |
|---|---|---|---|
| | | | |
| | | | |

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 | |
| 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: American Mining Claims Service, P.O. Box 660988, Birmingham, AL 35266-0988. If you have any questions regarding this form, please contact American Mining Claims Service at 1.888.823.4496.