BI-3

06/17

Employer's Report of Injury

For BrickStreet Use Only
Claim Number:
Team Assigned:

EMPLOYER INFORMATION

1. BrickStreet Insurance Policy Number: WCB1025339	2. FEIN: 47-2045326	3. Site Code:
4. Employer's Name:		
5. Address:		
City:	State:	Zip:	6. Telephone: - -

EMPLOYEE INFORMATION

1. Name: Last	First	MI	6. Date Hired:
2. Address:			7. Telephone: - -
City:	State:	Zip:	8. Social Security Number:
3. Date of Birth:	4. Sex: ☐ M ☐ F		9. Marital Status:
5. Injured Employee is: (check all that apply) ☐ Full-Time ☐ Part-Time ☐ Volunteer ☐ Seasonal/Temporary ☐ Retired – Date Retired:			10. Employee's Occupation / Job Title:

INFORMATION ABOUT INJURY / DISEASE

1. Date of Injury or Last Exposure:	Time: ☐ a.m. ☐ p.m.	5. Witnesses to Injury:
2. Date Employer Notified of Injury or Disease:		
3. Supervisor to Whom Injury or Disease Reported:		
4. If Injury was Fatal, Indicate Date of Death:		

6. Did Injury Occur on Employer's Property? ☐ Yes ☐ No

Address or location where injury occurred:

7. What was the Employee Doing When Injury Occurred? (loading truck, walking down stairs, etc.)

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 the injury; attach additional sheet(s) if necessary)

9. Nature of Injury or Disease (cut, bruise, strain, etc.)

10. Body Part(s) Injured:

11. Are you Aware of, or Do You Suspect, a Prior Injury to this Body Part? ☐ Yes ☐ No (If "yes", attach a specific explanation to this form.)

12. Do you Have Reason to Question this Injury? ☐ Yes ☐ No (If "yes", attach a specific explanation to this form.)

13. Location of Initial Treatment: Emergency Room? ☐ Yes ☐ No Hospitalized? ☐ Yes ☐ No

WAGE AND LOST TIME INFORMAITON

1. Last Day Worked After Occupational Injury or Disease:

2. Number of Work Days Lost:	3. Date of Return to Work:	4. Hours Worked Per Week:
5. Is Light Duty Available? ☐ Yes ☐ No	6. Wage on Date of Injury: $ Per ☐ Hour ☐ Day ☐ Week ☐ Month	
7. Are Wages Being Paid to Injured Employee During Disability? ☐ Yes ☐ No	8. If Employee Has Returned to Work, is it Alternative or Modified Work? ☐ Yes ☐ No If "yes," indicate current wage: $ Per ☐ Hour ☐ Day ☐ Week ☐ Month	

9. Daily Rate of Pay on Date of Injury: $ and best quarter wages of preceding four quarters: $

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically West Virginia Code § 61-3-24e provides for severe penalties if I knowingly certify a false report or statement and / or withhold a material fact regarding any information requested. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly with fraudulent intent aiding or abetting anyone in securing or attempting to secure benefits to which he or she is not entitled.

Print Name:	**Title:**
Signature:	**Date:**

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.

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

Return the completed form to BrickStreet using the following reporting options:

- Call BrickStreet at 1-866-452-7425 and provide the information via the telephone.

- Email the completed form and any attachments to **claimsintake@brickstreet.com**.

- Mail via USPS to**: BrickStreet Mutual Insurance**

P. O. Box 3151
Charleston, WV 25332-3151

Please ensure you make a copy for your records.