STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

UNINSURED EMPLOYER FUND

PO Box 11682
Charleston, WV 25339-1682

Telephone: 1-888-TRY-WVIC
Fax: 304-558-5586

Employee's Report of Occupational Injury and Proof of Employment

Mail or Fax Form & All Attachments To Location Indicated at Left

FOR OIC USE ONLY

Date Received: _____

Date Employer Notified of Claim: _____

Date Assigned to Administrator: _____

Reviewed By: _____

ALL INFORMATION MUST BE COMPLETED TO OBTAIN BENEFITS FROM THE WV WORKERS' COMPENSATION UNINSURED EMPLOYER FUND

CLAIMANT INFORMATION

1) Last Name: First Name: Middle Name:

2) Social Security Number: - - **3)** Gender: ❑ Male ❑ Female

4) Date of Birth: **4a)** Age on Date of Accident/Injury:

5) Martial Status: ❑ Married ❑ Single ❑ Divorced **5a)** If Married, Name of Spouse:

6) # of Dependent Children: **6a)** Ages of Dependent Children:

7) Mailing Address:

Street

City County State Zip

8) Telephone Numbers:
Work: Home: Cell:

What is best way and time of day to contact you:

9) Name of Closest Relative (Other Than Spouse):

9a) Relationship: **9b)** Telephone Number:

DETAILS OF OCCUPATIONAL ACCIDENT/INJURY

10) Date of Injury: **11)** Time of Injury: ❑ a.m. ❑ p.m.

12) Date Stopped Work Due to Injury: **13)** Time Stopped Work Due to Injury: ❑ a.m. ❑ p.m.

14) Time You Began Work on Date of Injury: ❑ a.m. ❑ p.m.

15) Briefly describe how you were injured including what occurred, the cause of the accident, what you were doing and any equipment involved:

16) What Part(s) of Your Body Was Injured:

17) Address/Location Where Working When Injury Occurred:

Street

City County State Zip

18) Did Injury Occur on Employer's Property: ❑ Yes ❑ No **19)** Did Injury Occur on Customer/Client's Property: ❑ Yes ❑ No

20) Identity of Witness(es) to Industrial Accident/Injury:

20a) Name: Telephone Number:

Address:

Street

City County State Zip

20b) Name: Telephone Number:

Address:

Street

City County State Zip

DETAILS OF OCCUPATIONAL ACCIDENT/INJURY, CONTINUED

21) Have You Filed Previous Workers' Compensation Claims While Working for This Employer: ❑ Yes ❑ No

If Yes, Date(s) of Injury:

22) Have You Filed Other Workers' Compensation Claims With Previous Employers: ❑ Yes ❑ No

If Yes, List Name(s) of Previous Employer and Date(s) of Injury:

Name of Previous Employer	Date(s) of Injury

INITIAL MEDICAL CONTACT AS RESULT OF ACCIDENT OR INJURY

23) Date First Sought Medical Treatment: Time First Sought Medical Treatment: ❑ a.m. ❑ p.m.

24) Name of Hospital, Physician, Clinic or Other Medical Facility Initially Consulted:

Address Where Treated:

Street

City County State Zip

25) Name of Treating Physician: **25a)** Telephone Number:

26) Were you Hospitalized: ❑ Yes ❑ No If Yes, Name of Hospital:

27) Did a Physician Tell You How Long You Might Be Off Work: ❑ Yes ❑ No If Yes, How Long: _____ Days

If No, Do You Anticipate Being Off Work More Than Four (4) Days: ❑ Yes ❑ No

PROOF OF EMPLOYMENT

28) Name of Employer: **29)** Name of Supervisor:

30) Employer's FEIN (From Your Pay Stub or W-2): **31)** Date of Hire:

32) Name of Person That Hired You: **33)** City, State Where You Were Hired:

34) Employer's Address:

Street

City County State Zip

35) Employer's Telephone:

36) Employment Status: ❑ Full Time ❑ Part Time ❑ Sporadic ❑ Temporary ❑ Volunteer ❑ Leased ❑ Other _____

If Employment is Part Time, How Many Hours Do You Normally Work Per Week:

37) Frequency and Rate of Pay (Indicate Below How Often You Are Paid, Gross Amount Paid, and How Paid:

Frequency (Check All That Applies)	At	Rate of Pay Per Hour (If Applicable)	Gross Wages	Indicate How Paid Cash, Check, Money Order, Direct Deposit, ATM Card, Other (Must Specify)
❑ I Get Paid Daily	@	$	$	
❑ I Get Paid Weekly	@	$	$	
❑ I Get Paid Every 2 Weeks	@	$	$	
❑ I Get Paid Monthly	@	$	$	
❑ I Get Paid in Draws	@		$	
❑ I Get Paid Upon Completion of a Job	@		$	
❑ I Get Paid on Commission	@		$	
❑ I Get Paid by Unit of Work Completed	@		$	
❑ Other _____	@	$	$	

38) Proof of Employment **(MUST BE ATTACHED):** ❑ Pay Stub ❑ Employment Contract ❑ Job Contract ❑ Other _____

39) How Long Have You Worked For This Employer: **40)** Normal Number of Hours Worked Per Day:

41) Normal Start / Stop Time: Start _____ ❑ a.m. ❑ p.m. Stop _____ ❑ a.m. ❑ p.m.

42) Circle Normal Work Days: Mon Tues Wed Thurs Fri Sat Sun

43) Job Title/Position Description:

44) Does Employer Have Return to Work Program: ❑ Yes ❑ No **45)** Does Employer Offer Alternate/Modified Work: ❑ Yes ❑ No

PROOF OF EMPLOYMENT, CONTINUED

46) Are You Related to Any of the Owners: ❑ Yes ❑ No **47)** Do you Own or Partially Own the Business: ❑ Yes ❑ No

46a) If Yes, Identify Relationship (i.e., Brother, Sister-in-Law, Father): _____ of _____

48) Were You Sub-Contracted to Perform Work or Provide Service for this Employer: ❑ Yes ❑ No

49) Do You Have Business License, Certificate or Permit Required to Perform Work in WV (i.e., Contractors License, Nursing License): ❑ Yes ❑ No

If Yes, Type and ID Number: _____

50) Name of Previous Employer: _____ Dates Employed: _____ To _____

IDENTITY OF EMPLOYER

51) List Any "Trading As" or "Doing Business As" Names Used By This Employer: _____

52) List the Names of Any and All Other Businesses Owned or Operated By This Employer: _____

53) List All Known Owner(s), Manager(s), Supervisor(s), By Name, Address and Phone Number:

Name	Address	Phone Number

54) Describe Type of Work Performed by Employer: _____

55) Identify Current and Last 2 Customers/Clients for Whom Work Was Performed or Services Provided (If Applicable):

Customer Name	Customer's Location/Address

56) Identity of Additional Employees for This Employer:

Name of Additional Employee	Telephone Number for Additional Employee

57) Were you aware that your employer did not carry mandatory workers' compensation coverage? ❑ Yes ❑ No

VERIFICATION AND SIGNATURE

I understand that filing a claim for workers' compensation benefits with the West Virginia Workers' Compensation Uninsured Employer Fund assumes the employer identified below is in violation of WV workers' compensation law, which makes it mandatory that every employer as defined by statute provide workers' compensation insurance to its employees. I understand that the assignment of a claim number under the Uninsured Employer Fund does not automatically entitle me or my dependents to benefits. I understand that I have the responsibility to provide proof of employment, and if I am unable to do so, I may not be entitled to benefits with the Uninsured Employer Fund. Further, I agree to cooperate fully with the West Virginia Insurance Commissioner and its agents to identify and locate the alleged uninsured employer identified above. Further, associated with, and I understand it is a felony for knowingly and with fraudulent intent withholding a material fact or making a false statement in order to obtain or increase workers' compensation benefits.

I certify the statements and answers set forth in this application for workers' compensation benefits are true and correct to the best of my knowledge. I am aware of that it is a felony to knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase workers' compensation benefits, as specifically provided for under W. Va. Code §61-3-24g, and that, if convicted, I can be imprisoned up to ten years and/or fined up to ten thousand dollars ($10,000).

By signing this application I authorize the Insurance Commissioner and its designated agents to examine all hospital and medical records or any medical information pertaining to this injury and or any condition for which I have previously received medical attention. Further, by signing this application, in the event that my claim is accepted into the Uninsured Employer Fund, I give the Insurance Commissioner and its designated agents, as administrator for the Uninsured Employer Fund, an irrevocable assignment of the right to subrogate this workers'

compensation claim on my behalf. This means that if I have any other claim for damages against a party as a result of the occurrence which resulted in my injury, I will permit the Insurance Commissioner, or its designated agents, to pursue a legal action in my name for such claim. Further, I will cooperate fully with the Insurance Commissioner, or its designated agents, in such a legal action, and will permit the Insurance Commissioner to keep all funds paid as part of a settlement or jury verdict in such a legal action up to the amount of benefits paid to me by the Uninsured Employer Fund, as well as any amounts incidental to the administration of my claim, or the prosecution of the above described legal action, including all legal fees.

Signature of Injured Worker: _____ Date Signed: _____

Attach all requested documents such as proof of employment and mail or fax to the location indicated at the top of the application.