



Employer's Report of Injury

For BrickStreet Use Only	
Claim Number:	
Team Assigned:	
ICD9:	

YOU MUST READ THE INSTRUCTIONS ON THE BACK OF THIS FORM PRIOR TO COMPLETING IT

I have been informed of my responsibilities under WV Workers' Compensation Law and agree to abide by such in the administration of services provided by BrickStreet Insurance. I am aware the law provides for severe penalties for providing false statements or information.

Initials of Employer Representative:

1. BrickStreet Insurance policy number:		FEIN or SSN:	
2. Industrial code:		Phone number:	
3. Name of employer as listed with BrickStreet:			
Address of employer:			
City:		County:	State:
Zip Code:			
4. Injured employee SSN:		Date of injury:	
5. Injured employee Name:		Marital status:	
Job title/description:		Telephone:	
6. Address of Employee:			
City:		County:	State:
Zip Code:			
7. Injured employee date of birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
8. Injured employee is (check all that apply):			
<input type="checkbox"/> Owner/Part Owner <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time			
<input type="checkbox"/> Officer <input type="checkbox"/> Volunteer <input type="checkbox"/> Leased (If Leased Employee, complete 8a, 8b, and 8c.)			
8a. Name and policy number of leasing company:			
8b. Name and policy number of client employer:			
8c. Date the injured worker was first assigned to the client employer:			
9. If owner, part owner, or officer, are wages included on wage reports? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. Date employee was first employed by you? / /			
11. Stopped work for injury: Date: / /		Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Date employee returned to work: / /		Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Time employee began work on date of injury: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.			
Time of injury: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.			
Is the disability expected to last longer than four (4) days? <input type="checkbox"/> Yes <input type="checkbox"/> No			
12. Do you have a BrickStreet approved Return-To-Work program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. If employee has returned to work, is it alternate or modified work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, indicate wages: Hourly rate: \$		Hours per week:	
14. Daily rate of pay on the date of injury: \$			
15. If part-time employee: Hourly rate: \$		Hours per week (25 or less):	
16. Did injury occur on employer's property? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Address where injury occurred:			
17. Nature, body part and type of injury:			
17a. Nature:			
17b. Body part:			
17c. Type of injury:			
18. Do you have reason to question this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, you must attach a specific explanation to this form.</i>			
19. Was an incident report completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, see instructions.</i>			
20. Initial Medical Contact:		Phone Number:	
21. Are you aware of or suspect a previous injury to this body part? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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 § 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 by BrickStreet Insurance. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly with fraudulent intent to aid or abet anyone in securing or attempting to secure benefits to which he or she is not entitled.

Signature: _____ **Date:** / /

ALL INFORMATION MUST BE COMPLETED.

General instructions for completing the BI-3, “Employer’s Report of Injury”

- Please Read Carefully -

General Overview: The claim initiation process now involves the filing of three individual forms:

BI-1, Employee’s Report of Injury: To be completed by the injured worker

BI-3, Employer’s Report of Injury: To be completed by the employer

A claim cannot be established until BrickStreet Mutual Insurance has received at least one of the forms listed above. This form should not be used to file occupational pneumoconiosis or hearing loss claims.

Please note that W.V. Code 23-4-1 provides that employees of the state and its political subdivisions are ineligible to receive workers’ compensation benefits while drawing sick leave benefits at the same time for the same reason. **The employee must make his/her choice known in Question 15 on the BI-1, Employee’s Report of Injury form.**

To the Employer: W.V. Code 23-4-1b requires you to complete and submit the BI-3 form within five days of receipt of notification of the employee’s injury, or within five days after the employer has been notified by BrickStreet Insurance that a claim for benefits has been filed on account of an injury. This information is used to assign the liability of the claim. After completing this form, make a copy for your records. If you have any questions, you may contact BrickStreet at 1-888-4WV-COMP, or 1-866-452-7425.

Question Number	Explanation
1.	BrickStreet Policy Number indicated on your BrickStreet wage reports and FEIN or Social Security number.
4.	Injured employee’s Social Security number.
5.	Injured employee’s Name, Marital Status, Job Title/Description, and Telephone number.
7.	Injured employee’s Date of Birth and Gender.
8.	Leased employees are workers provided by one business to another business.
8a.	Leasing companies/employers provide workers to other businesses.
8b.	Client employers accept employees from leasing companies to work a specified period of time.
8c.	List the specific date the injured worker was first assigned to the Client Employer.
12.	The Return-to-Work Program must be approved by BrickStreet Insurance.
14.	Enter the employee’s daily rate of pay on the date of injury.
17a.	Define injury, i.e., sprain/strain, fracture, laceration.
17b.	Part(s) of body injured and how injury occurred, i.e., lifting, fall, motor vehicle accident.
19.	Attach copy to form. Fax or mail to BrickStreet Insurance.
20.	Name of medical provider where injured employee first sought treatment.

Return completed form to: **BrickStreet Mutual Insurance**
P. O. Box 3151
Charleston, WV 25332-3151

When completing this form, enclose attachments if additional space is needed.