Berkley INDUSTRIALCOMP
a Berkley Company

NOTICE TO EMPLOYEES

OF WORKMEN'S COMPENSATION INSURANCE
FOR INDUSTRIAL INJURIES

"Remember, it is important to tell your employer about your injury"

The undersigned, an employer subject to the provisions of the Workmen's Compensation Act of West Virginia, hereby gives notice to his employees and to all other persons interested, that he has secured the payment of the compensation payable to his employees and their dependents, by insuring with

BERKLEY INDUSTRIAL COMP

P.O. BOX 660847

Birmingham, Alabama 35266-08471

800-448-5621
Tammy Ansell

EMPLOYER _____

EXPIRATION DATE OF POLICY _____

ALL ACCIDENTS, NO MATTER HOW MINOR, SHOULD BE REPORTED IMMEDIATELY TO YOUR EMPLOYER

3490 Independence Drive, Birmingham, AL 35209 | P.O. Box 660847 Birmingham, AL 35266-0847
Telephone: 205-870-3535/800-448-5621 | Fax: 205-870-3245 | www.berkindcomp.com

WEST VIRGINIA WORK INJURY REPORTING PROCEDURES

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

Employer's Report of Occupational Injury or Disease (Form OIC-WC-2)

This form must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, Employer's Reports of Occupational Injury or Disease may be submitted to us online at: www.berkindcomp.com. Online Reporting Instructions are enclosed. Maintain a copy of the Employer's Report of Occupational Injury or Disease for your records. Keep a separate file for each workers' compensation claim.

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the Employer's Report of Occupational Injury or Disease. If the Employer's Report of Occupational Injury or Disease is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

Employer's Report of Wages

The Employer's Report of Wages must be completed on claims involving lost time from work.

Please contact our claims department if you have questions about completing the Statement of Wage Information.

Do not delay reporting the Employer's Report of Occupational Injury or Disease for completion of the Employer's Report of Wages.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

Form OIC-WC-2

West Virginia Workers' Compensation
Employers' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I — Employer Information

Insurer:		**Third-Party Administrator:**	
Employer's Name:	Nature of Business:		FEIN:
Address:			
City:	State:	Zip:	Telephone: ( ) -

Section II — Employee Information

Name: (Last):	(First):	(M.I.):	**Occupation/Job Title:**
Address:			**Telephone:** ( ) -
City:	State:	Zip:	**Social Security No.:** - -
Date of Birth: ____/____/____	**6. Sex:** ☐ M ☐ F		**Marital Status:**
Injured Employee is (check all that apply): ☐ Full-Time ☐ Part-Time ☐ Volunteer ☐ Owner/Partner ☐ Officer ☐ Retired – Date Retired: ____/____/____			**Employee's Occupation/Job Title:**

Section III — Information Regarding Injury or Disease

Date of Injury or Last Exposure: ____/____/____ **Time:** ☐ a.m. ☐ p.m.		**Witnesses to Injury:**
Date Employer Notified of Injury or Disease: ____/____/____	**Supervisor to whom Injury or Disease Reported:**	
If Injury was Fatal, Indicate Date of Death: ____/____/____		
Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address or location where injury occurred:		

What was the Employee Doing when Injury Occurred (loading truck, walking down stairs, etc.)**:**

How did the Injury or Disease Occur (be specific; include time that employee began work on the date of injury, any equipment, tools, substances or objects connected to the injury; attach additional sheet if necessary)**:**

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

Body Part(s) Injured:

Are You Aware of, or Do You Suspect, a Prior Injury to this Body Part? ☐ Yes ☐ No

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

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

Section IV — Wage and Lost Time Information

Date Hired: ____/____/____	**Last Day Worked After Occupational Injury or Disease:** ____/____/____	
Number of Work Days Lost:	**Date of Return to Work:** ____/____/____	**Hours Worked per Week:**
Is Light Duty Available? ☐ Yes ☐ No	**Wage on Date of Injury: $** per ☐ hour ☐ day ☐ week ☐ month	
Are Wages Being Paid to Injured Employee During Disability? ☐ Yes ☐ No	**If Employee has Returned to Work, is it Alternative or Modified Work?** ☐ Yes ☐ No If "yes," indicate current wage: **$** per ☐ hour ☐ day ☐ week ☐ month	
Daily rate of pay on the 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:** _____/_____/_____

Employer's Report of Wages

Return completed form to:
Berkley Industrial Comp
P.O. Box 660847 Birmingham,
AL 35266
Fax: (205) 874-8292

EMPLOYERS: PLEASE SUBMIT THIS FORM WITH THE EMPLOYER'S REPORT OF INJURY

Claimant benefit rates are based on both the daily rate of pay and the four quarters of wages preceding the date of injury, whichever is most favorable to the claimant. In the past we obtained this information from the Bureau of Employment Programs. As a private insurance company we no longer have access to this data; therefore, we will begin collecting this information from the employer. The wage information is necessary in any claim where an indemnity payment is anticipated to ensure the claimant receives the appropriate benefit rate.

POLICYHOLDER INFORMATION		
Policyholder Name:		
Policy Number:	Telephone Number:	
Address:		
City:	State:	Zip:

CLAIMANT INFORMATION		
Claimant Name:		
Claim Number:	DOI:	SSN:

Instructions for Calculating and Reporting Wages

The following calculation should be used when an employee routinely works 40 hours a week.

Calculate the hourly rate X 40 hours worked / by 5 = daily rate of pay

The daily rate of pay should include any tips, commissions or other remuneration such as cost of lunches, uniforms, gratuities, etc.

The following calculation should be used when an employee works shifts in excess of eight hours per day, but less than five days per week:

Calculate the hourly rate X # of hours worked for a normal work week / 5 = daily rate of pay

The following calculation should be used when an employee routinely works overtime:
Calculate the number of regular hours X the regular hourly rate and calculate the overtime hours X the overtime rate. These amounts will be added together to obtain the average daily rate of pay to be reported by the employer.

The employer must report the quarterly earnings for the four preceding quarters prior to the date of injury.
Example: for a claim with a date of injury of April 2007, wages should be reported as follows:

- the first quarter of 2007(January, February, March 2007)
- the second quarter of 2006 (April, May, June 2006)
- the third quarter of 2006 (July, August, September 2006)
- the fourth quarter of 2006 (October, November, December 2006)

Full-Time ☐	Part-Time 25 hours or less ☐	**Daily** Rate of Pay: $	**Hourly** Rate of Pay: $	Hours Worked per Week:
First Quarter Jan. Feb. Mar. / **$**	**Second Quarter** Apr. May June/ **$**	**Third Quarter** July Aug. Sept./ **$**	**Fourth Quarter** Oct. Nov. Dec./ **$**	
Does the employer offer a wage continuation plan to this employee? Yes ☐ No ☐				
Does the claimant receive wages from other employment? Yes ☐ No ☐				
Printed Name:				
Signature:		Title:		Date: