



**West Virginia Workers' Compensation**  
**Employee's and Physician's Report of Occupational Injury or Disease**

AN EMPLOYEE OF THE STATE OF WEST VIRGINIA OR ITS POLITICAL SUBDIVISIONS MUST ALSO COMPLETE AN ELECTION OF OPTION FORM

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|---|--|--|
| <b>Section I EMPLOYEE CLAIM INFORMATION</b>   |  | PLEASE PRINT OR TYPE   |
| Insurer: <b>Zurich Insurance</b>  |  |  |
| Name: (Last):   |  | (First): (M.I.):   |
| Address:  |  | Telephone Number:  |
| City:   | State:   | Zip:   |
| Date of birth:  |  | Social Security Number:  |
| Sex: <input type="checkbox"/> M <input type="checkbox"/> F  | Marital Status:  |  |
| Date of Injury or Last Exposure:  | Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.          | Time you Began Work on Date of Injury: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. |
| Date you stopped working due to injury:   | Have you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   |  | If "Yes", what was the date you retired?   |
| Employer's Name:  |  | Supervisor's Name:   |
| Address:  |  |  |
| City:   | State:   | Zip: Telephone: ( )  |
| Job Title/Description:  |  |  |
| Body Part(s) Injured:   |  |  |
| Describe how your injury occurred (Specify the cause, what you were doing and equipment/objects involved):  |  |  |
| Did injury occur on employer's property? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  | Address where injury occurred:   |
| Please Identify any Witnesses to Your Injury:   |  |  |
| <p>I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veteran's Administration or governmental hospital and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.</p> |  |  |
| Employee's Signature: _____   |  | Date: _____  |

**BOTH PAGES OF THIS FORM MUST BE COMPLETED  
AND SENT TOGETHER TO ZURICH**

