PIE INSURANCE

# How to respond to a workplace injury:


For life-threatening medical emergencies, call **911**.

For non-life-threatening injuries, call the **24/7 Nurse Line at (844) 581-0828** to report the incident and get your employee the right care

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**Workers' comp claims**
You can file your first report of injury for a workers' comp claim in three simple ways:
Call the 24/7 claim intake line within 24 hours of the incident: **(844) 581-0828**

**Submit the claim information online here**

Email the claims team within 24 hours of he incident: **claims@pieinsurance.com**

- **In your email, please include the following:**
- The name of your business
- The policy number
- Reporting party's contact information (name. phone, email)
- The name, phone, and email address of the injured employee
- Date of the injury or accident
- A description of the injury or accident

**Thank you.**

pieinsurance.com

# TO THE EMPLOYER: THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE UPON YOUR PREMISES

# NOTICE REGARIDNG WORKERS' COMPENSATION INSURANCE

West Virginia law requires that any employee who is injured while at work should immediately report the injury to their supervisor, employer, or designated representative.

The Workers' Compensation insurance carrier or administrator for _____(name of company) is:

Insurer: Pie Insurance
PO Box 30018
Salt Lake City, Utah 84130-018
(844) 581-0828
Contact: Claims Team
E-Mail: Claims@Pieinsurance.com

# NOTICE TO
# WEST VIRGINIA EMPLOYEES

You may be entitled to Workers' Compensation benefits if you are injured or become ill because of your job.

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer is insured by:

Insurer: Pie Insurance
PO Box 30018
Salt Lake City, UT 84130-0018
(844) 581-0828
Contact: Claims Team
E-Mail: Claims@PieInsurance.com

It is criminal offense to file a false claim or to furnish false information in support of a claim.

STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

Send Completed Form To:
Zurich Insurance
PO Box 66941
Chicago, IL 60666-0941
FAX: 847-240-8172

# West Virginia Workers' Compensation
# Employers' Report of Occupational Injury

PLEASE PRINT OR TYPE

| **Section I** | **Employer Information** | |
|---|---|---|
| Insurer: Zurich Insurance | Address: PO Box 66941 Chicago, IL 60666-0941 | Site Code: |
| Policy Name: State of West Virginia Office of the Insurance Commissioner | | FEIN: |
| Contact Email: | Telephone: ( ) - | |

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

| **Section III** | **Information Regarding Injury** |
|---|---|
| Date of Injury or Last Exposure: Time: ☐ a.m. ☐ p.m. | Witnesses to Injury: |
| Date Employer Notified of Injury : / Supervisor to whom Injury Reported: | |
| If Injury was Fatal, Indicate Date of Death: | |
| Did Injury Occur on Employer's Property? ☐ Yes ☐ No<br>Address or location where injury occurred: | |
| What was the Employee Doing when Injury Occurred (loading truck, walking down stairs, etc.): | |
| How did the Injury 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 (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: | |
| Number of Work Days Lost: | Date of Return to Work: | Hours Worked per Week: |
| Is Temporary Transitional Duty Available? ☐ Yes ☐ No | Wage on Date of Injury: $<br>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<br><br>If "yes," indicate current wage: $<br>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: _____