



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Claim Kit - Alabama



BHHC AL Claims Kit Introductory Letter – 07/31/2017 (page 3 of 45)

BHHC Requirements for AL Posting Notices – 08/10/2017 (page 4 of 45)

AL Form WCC-1 – Workers' Compensation Information Poster - 10/2012 (page 5 of 45)

AL Form WCC-2 – Employer's First Report of Injury or Occupational Disease With Instructions
and Codes- 10-2012 (pages 6-35 of 45)

BHHC Employee's Authorization for Release of Information (English & Spanish) – 06/10/2019
(page 36-37 of 45)

BHHC Medical History Request – 02/25/2014 (page 38 of 45)

BHHC General Employee Accident Report – 02/25/2014 (page 39 of 45)

BHHC General Supervisor Accident Report – 02/25/2014 (page 40 of 45)

BHHC General Witness Accident Report – 02/25/2014 (page 41 of 45)

BHHC Express Scripts First Fill Form (English & Spanish) – 12/2018 (pages 42-43 of 45)

BHHC Workers' Compensation Fraud Posters (English & Spanish) - 08/10/2017 (pages
44-45 of 45)



P.O. Box 881236, San Francisco, CA 94105 | Phone: (888) 495-8949 | bhhc.com

Dear Policyholder:

Thank you for placing your workers compensation coverage with Berkshire Hathaway Homestate Companies (BHHC). We look forward to working with you to fulfill all your workers compensation needs.

Enclosed you will find documentation necessary for the processing and administration of a claim in the event of a workplace injury, as well as important information regarding workers compensation requirements for your state (i.e. posting notices, compliance laws, etc). Please utilize the documents included to collect valid information regarding the injured employee and incident, and send the documents in when reporting the claim or upon request. Any completed document should be sent directly to BHHC using mail, e-mail, or fax. The assigned claims professional will forward necessary documentation onto the appropriate state entity.

It is critical that you promptly report all new claims using one of the following methods:

- | | |
|----------------|--|
| Online: | 1. Go to our website: www.bhhc.com
2. Highlight "Workers Comp" in the menu
3. Highlight "Claims Center"
4. Click "Report a Claim" |
| Phone: | (800) 661-6029 |
| Fax: | (800) 661-6984 |
| E-mail: | newclaim@bhhc.com |

Alabama state law recommends employers report every industrial injury or occupational disease claim to their workers compensation carrier as soon as possible or within 5 days of employer knowledge of injury.

State law also requires that employers authorize initial medical treatment within 24 hours of knowledge that an occupational injury or illness has been sustained or reported, regardless of the legitimacy of the claim. Failure to comply may result in the loss of "medical control" and a significant increase in the potential claim cost.

We will attempt to contact you and the injured worker within 24 hours of receiving the First Report of Injury. Your cooperation in allowing the injured employee to speak with one of our Claims Professionals is appreciated.

Should you have any questions regarding the contents of this kit, a claim, or claim reporting, please contact our Customer Care Center at (888) 495-8949. Questions regarding your insurance policy or coverage should be directed to your broker or agent. We thank you for choosing BHHC as your workers compensation carrier and look forward to providing you superior customer service and compassionate care for your injured workers.

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

WORKERS' COMPENSATION POSTING REQUIREMENTS

Requirements for WCC-1 – Workers' Compensation Information Poster

- Post in one or more conspicuous places at all business locations
- Must contain the insurance carrier's name and contact information

To complete the form, please enter the name of you designated insurance carrier in the space provided. For your convenience, our other contact information has been entered on the Form WCC-1.

(Code of Alabama §25 -5 -2 90(d))

STATE OF ALABAMA WORKERS' COMPENSATION INFORMATION



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

Your employer will advise you of
the physician to see for authorized
medical treatment.

WORKERS' COMP INSURANCE
CARRIER _____

TELEPHONE NUMBER _____

**ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS'
COMPENSATION LAW INCLUDING MEDIATION SERVICE.**

FOR INFORMATION CALL:

1-800-528-5166

**Alabama Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131**

**CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE
POSTED**

IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

FORM WCC#1 10/12

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE					
1. Insured Report Number		2. Filing Office Claim Number		3. OSHA Log Case Number	
EMPLOYER					
4. Employer Business Name			ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1			10. Mailing Address 1		
6. Physical Address 2			11. Mailing Address 2		
7. City		8. State	9. Zip		12. City
15. Federal ID Number		16. U.C. Account Number		17. NAICS	
INSURER / FILING OFFICE					
18. Insurer Name			21. Filing Office Name		
19. Insurer Federal ID Number			22. Mailing Address 1		
20. Type Insurer Ins Co <input type="checkbox"/> Self-Insurer <input type="checkbox"/> Group Fund <input type="checkbox"/>			23. Mailing Address 2 or Telephone Number		
			24. City		25. State
			26. Zip		
			27. Filing Office Federal ID Number		
EMPLOYEE / WAGES					
28. First Name			32. Employee ID Number		
29. Middle Name			33. Type Employee ID Number		
30. Last Name			SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)			Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1			40. Gender		41. Date of Birth
35. Mailing Address 2			Male <input type="checkbox"/>		42. Nbr of Dependents
36. City			Female <input type="checkbox"/>		
37. State			38. Zip		39. Phone
43. Marital Status Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>					44. Date Hired
45. Occupation Description				46. Number of Days Worked Per Week	
47. Wages \$			49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>			50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>		
INJURY / TREATMENT					
51. Date of Injury		52. Time of Injury a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>		53. Time Employee Began Work a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
54. Date Disability Began		55. Date of Death			
PLACE OF ACCIDENT, INJURY, OR EXPOSURE			61. Injury Occurred on Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>		
56. Site Address			62. Date Employer Notified		
57. City			58. State		59. Zip
60. County					
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)					
PROVIDE DESCRIPTION CODES to identify Nature of Injury , Part of Body that was affected, and Cause of Injury . (FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC)					
64. Nature of Injury Code		65. Part of Body Code		66. Cause of Injury Code	
67. Initial Treatment		No Medical Treatment <input type="checkbox"/>		68. Name of Treatment Facility	
First Aid By Employer <input type="checkbox"/>		Minor Clinic / Hospital <input type="checkbox"/>		69. Address	
Emergency Room <input type="checkbox"/>		Hospitalized Overnight <input type="checkbox"/>		70. City	
Hospitalized > 24 Hours <input type="checkbox"/>		Outpatient Treatment <input type="checkbox"/>		71. State	
72. Zip					
73. Name of Physician or Other Health Care Professional			74. Has Injured Returned to Work Yes <input type="checkbox"/> No <input type="checkbox"/>		If so, 75. Date
			76. Time		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
OTHER					
77. Date Prepared		78. Preparer's First Name		79. Last Name	
		80. Title		81. Preparer's Telephone Number	

NATURE OF INJURY	PART OF BODY	CAUSE OF INJURY
01. No Physical Injury	10. Multiple Head Injury	01. Chemicals
02. Amputation	11. Skull	02. Hot Objects or Substances
03. Angina Pectoris	12. Brain	03. Temperature Extremes
04. Burn	13. Ear(s)	04. Fire or Flame
07. Concussion	14. Eye(s)	05. Steam or Hot Fluids
10. Contusion	15. Nose	06. Dust, Gases, Fumes or Vapors
13. Crushing	16. Teeth	07. Welding Operation
16. Dislocation	17. Mouth	08. Radiation
19. Electric Shock	18. Soft Tissue	09. Contact With, NOC.
22. Enucleation	19. Facial Bones	10. Machine or Machinery
25. Foreign Body	20. Multiple Neck Injury	11. Cold Objects or Substances
28. Fracture	21. Vertebrae	12. Object Handled
30. Freezing	22. Disc	13. Caught In, Under or Between, NOC.
31. Hearing Loss or Impairment	23. Spinal Cord	14. Abnormal Air Pressure
32. Heat Prostration	24. Larynx	15. Broken Glass
34. Hernia	25. Soft Tissue	16. Hand Tool, Utensil; Not Powered
36. Infection	26. Trachea	17. Object Being Lifted or Handled
37. Inflammation	30. Multiple Upper Extremities	18. Powered Hand Tool, Appliance
40. Laceration	31. Upper Arm	19. Caught, Puncture, Scrape, NOC.
41. Myocardial Infarction	32. Elbow	20. Collapsing Materials (Slides of Earth) Either Man Made or Natural
42. Poisoning - General	33. Lower Arm	25. From Different Level (Elevation) Off Wall, Catwalk, Bridge, Etc.
43. Puncture	34. Wrist	26. From Ladder or Scaffolding
46. Rupture	35. Hand	27. From Liquid or Grease Spills
47. Severance	36. Finger(s)	28. Into Openings Shafts, Excavations, Floor Openings, Etc.
49. Sprain or Tear	38. Shoulder(s)	29. On Same Level
52. Strain or Tear	39. Wrist (s) & Hand(s)	30. Slipped, Do Not Fall
53. Syncope	40. Multiple Trunk	31. Fall, Slip or Trip, NOC.
54. Asphyxiation	41. Upper Back Area	32. On Ice or Snow
55. Vascular	42. Lower Back Area	33. On Stairs
58. Vision Loss	43. Disc	40. Crash of Water Vehicle
59. All Other Specific Injuries, NOC	44. Chest	41. Crash of Rail Vehicle
60. Dust Disease, NOC	45. Sacrum and Coccyx	45. Collision or Sideswipe With Another Vehicle
61. Asbestosis	46. Pelvis	46. Collision with a Fixed Object Standing Vehicle or Stationary Object
62. Black Lung	47. Spinal Cord	47. Crash of Airplane
63. Byssinosis	48. Internal Organs	48. Vehicle Upset Overturned or Jackknifed
64. Silicosis	49. Heart	50. Motor Vehicle, NOC.
65. Respiratory Disorders	50. Multiple Lower Extremities	52. Continual Noise
66. Poisoning - Chemical, (Other Than Metals)	51. Hip	53. Twisting
67. Poisoning - Metal	52. Upper Leg	54. Jumping
68. Dermatitis	53. Knee	55. Holding or Carrying
69. Mental Disorder	54. Lower Leg	56. Lifting
70. Radiation	55. Ankle	57. Pushing or Pulling
71. All Other Occupational Disease Injury, NOC	56. Foot	58. Reaching
72. Loss of Hearing	57. Toes	59. Using Tool or Machinery
73. Contagious Disease	58. Big Toes	60. Strain or Injury By, NOC.
74. Cancer	60. Lungs	61. Welding or Throwing
75. AIDS	61. Abdomen Including Groin	65. Moving Part of Machine
76. VDT - Related Diseases	62. Buttocks	66. Object Being Lifted or Handled
77. Mental Stress	63. Lumbar & or Sacral Vertebrae	67. Sanding, Scraping, Cleaning Operation
78. Carpal Tunnel Syndrome	64. Artificial Appliance	68. Stationary Object
79. Hepatitis C	65. Insufficient Info to Properly Identify	69. Stepping on Sharp Object
80. All Other Cumulative Injury, NOC	66. No Physical Injury	70. Striking Against or Stepping On, NOC.
90. Multiple Physical Injuries Only	90. Multiple Body Parts	74. Fellow Worker; Patient
91. Multiple Injuries Including Both Physical & Psychological	91. Body Systems and Multiple Body	75. Falling or Flying Object
	99. Whole Body	76. Hand Tool or Machine in Use
		77. Motor Vehicle
		78. Moving Parts of Machine
		79. Object Being Lifted or Handled
		80. Object Handled By Others
		81. Struck or Injured, NOC.
		82. Absorption, Ingestion or Inhalation, NOC
		84. Electrical Current
		85. Animal or Insect
		86. Explosion or Flare Back
		87. Foreign Matter (Body) in Eye(s)
		88. Natural Disasters
		89. Person in Act of a Crime
		90. Other Than Physical Cause of Injury
		91. Mold
		94. Repetitive Motion Callous, Blister, Etc.
		95. Rubbed or Abraded, NOC.
		96. Terrorism
		97. Repetitive Motion Carpel Tunnel Syndrome
		98. Cumulative, NOC
		99. Other - Miscellaneous, NOC

INSTRUCTIONS FOR FILING WC FIRST REPORT OF INJURY

Employers should send a completed legible form to the insurance carrier or, if self-insured, to the designated office handling their workers' compensation claims. The insurance carrier or designated office should forward this First Report on to the Workers' Compensation Division, Department of Labor, Montgomery, Alabama 36131 within fifteen (15) days from the date of injury or date of notification to the employer for all injuries for which compensation is claimed or paid. This includes deaths, permanent disabilities or temporary disabilities exceeding three (3) days).

Block 1. A number assigned by the insured to identify a specific claim

Block 2. An identifier for a specific claim within a claim administrator's claims processing system.

Block 3. Case number from log maintained for OSHA

Block 4 - Block 14. Self Explanatory

Block 15. Employer Federal ID number

Block 16. Employer Unemployment Compensation Account Number

Block 17. NAICS Industry Codes http://dir.alabama.gov/docs/forms/wc_naics.pdf

Block 18. Carrier's name

Block 19. Carrier's FEIN

Block 20. A code representing the kind of entity providing financial responsibility for the claim, exp: (I)
Insurance Carrier (S) Self Insurer (G) Guarantee Fund/Group

Block 21 through Block 63. Self Explanatory

Block 64. Nature of Injury Codes http://dir.alabama.gov/docs/forms/wcio_nature_table.pdf

Block 65. Part of Body Codes http://dir.alabama.gov/docs/forms/wcio_part_table.pdf

Block 66. Cause of Injury Codes http://dir.alabama.gov/docs/forms/wcio_cause_table.pdf

Block 67 through Block 81. Self Explanatory

NAICS Codes and Titles: 6-digit Codes Only

For more information please visit: [North American Industry Classification System \(NAICS\) Main Page ? U.S. Census Bureau](#)

327910	Abrasive Product Manufacturing
325520	Adhesive Manufacturing
924110	Administration of Air and Water Resource and Solid Waste Management Programs
924120	Administration of Conservation Programs
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925110	Administration of Housing Programs
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923120	Administration of Public Health Programs
925120	Administration of Urban Planning and Community and Rural Development
923140	Administration of Veterans' Affairs
541611	Administrative Management and General Management Consulting Services
541810	Advertising Agencies
541870	Advertising Material Distribution Services
711410	Agents and Managers for Artists, Athletes, Entertainers, and Other Public Figure
333912	Air and Gas Compressor Manufacturing
333411	Air Purification Equipment Manufacturing
488111	Air Traffic Control
333415	Air-Conditioning and Warm Air Heating Equipment and Commercial and Industrial Re
336412	Aircraft Engine and Engine Parts Manufacturing
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325181	Alkalies and Chlorine Manufacturing
713990	All Other Amusement and Recreation Industries
112990	All Other Animal Production
811198	All Other Automotive Repair and Maintenance
325188	All Other Basic Inorganic Chemical Manufacturing
325199	All Other Basic Organic Chemical Manufacturing
561499	All Other Business Support Services
532299	All Other Consumer Goods Rental
322299	All Other Converted Paper Product Manufacturing
315299	All Other Cut and Sew Apparel Manufacturing
452990	All Other General Merchandise Stores
111199	All Other Grain Farming
446199	All Other Health and Personal Care Stores
442299	All Other Home Furnishings Stores
333298	All Other Industrial Machinery Manufacturing
519190	All Other Information Services
524298	All Other Insurance Related Activities
316999	All Other Leather Good Manufacturing
541199	All Other Legal Services
212299	All Other Metal Ore Mining
621999	All Other Miscellaneous Ambulatory Health Care Services
325998	All Other Miscellaneous Chemical Product and Preparation Manufacturing
111998	All Other Miscellaneous Crop Farming
225999	All Other Miscellaneous Nonmetallic Mineral Product Manufacturing

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924120	Administration of Conservation Programs
923110	Administration of Education Programs
926110	Administration of General Economic Programs
925110	Administration of Housing Programs
923130	Administration of Human Resource Programs (except Education, Public Health, and
923120	Administration of Public Health Programs
925120	Administration of Urban Planning and Community and Rural Development
923140	Administration of Veterans' Affairs
541611	Administrative Management and General Management Consulting Services
541810	Advertising Agencies
541870	Advertising Material Distribution Services
711410	Agents and Managers for Artists, Athletes, Entertainers, and Other Public Figure
333912	Air and Gas Compressor Manufacturing
333411	Air Purification Equipment Manufacturing
488111	Air Traffic Control
333415	Air-Conditioning and Warm Air Heating Equipment and Commercial and Industrial Re
336412	Aircraft Engine and Engine Parts Manufacturing
336411	Aircraft Manufacturing
325181	Alkalies and Chlorine Manufacturing
713990	All Other Amusement and Recreation Industries
112990	All Other Animal Production
811198	All Other Automotive Repair and Maintenance
325188	All Other Basic Inorganic Chemical Manufacturing
325199	All Other Basic Organic Chemical Manufacturing
561499	All Other Business Support Services
532299	All Other Consumer Goods Rental
322299	All Other Converted Paper Product Manufacturing
315299	All Other Cut and Sew Apparel Manufacturing
452990	All Other General Merchandise Stores
111199	All Other Grain Farming
446199	All Other Health and Personal Care Stores
442299	All Other Home Furnishings Stores
333298	All Other Industrial Machinery Manufacturing
519190	All Other Information Services
524298	All Other Insurance Related Activities
316999	All Other Leather Good Manufacturing
541199	All Other Legal Services
212299	All Other Metal Ore Mining
621999	All Other Miscellaneous Ambulatory Health Care Services
325998	All Other Miscellaneous Chemical Product and Preparation Manufacturing
111998	All Other Miscellaneous Crop Farming
335999	All Other Miscellaneous Electrical Equipment and Component Manufacturing
332999	All Other Miscellaneous Fabricated Metal Product Manufacturing
311999	All Other Miscellaneous Food Manufacturing
333999	All Other Miscellaneous General Purpose Machinery Manufacturing
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AUTHORIZATION FOR THE RELEASE OF INFORMATION
AUTORIZACIÓN PARA LA LIBERACIÓN DE INFORMACIÓN

Claim Number / Número de Reclamo _____ Date of Injury / Fecha de la Lesión _____
Employee / Empleado _____ Date of Birth / Fecha de Nacimiento _____

I hereby authorize the divisions of Berkshire Hathaway Homestate Companies, their representative or bearer, to review, inspect, copy, and/or photograph any and all of the following documents:

Por este medio autorizo las divisiones de Berkshire Hathaway Homestate Companies, su representante o portador, a revisar, inspeccionar, copiar, y/o fotografiar cualquier y todo de los siguientes documentos:

1. Any and all medical records, including but not limited to office and hospital records, laboratory results, diagnostic reports and films, psychiatric records, medical correspondences, doctor's and nurse's notes, and medical histories relevant to my workers' compensation claim. I also hereby give permission to Berkshire Hathaway Homestate Company representatives to contact the attending physicians involved in the treatment of all related conditions.

Cualquier y todo expediente médico, incluyendo pero no limitado, a los expedientes de la oficina y hospitales, resultados de laboratorios y filmas, expedientes psiquiátricos, correspondencia médica, notas de los doctores y enfermeros(as), e historiales médicos relevantes a mi reclamo de compensación de trabajadores. También, por este medio le doy permiso a los representantes de Berkshire Hathaway Homestate Company para comunicarse con el médico tratante envuelto en el tratamiento de todas las condiciones relacionadas.

2. All employment and human resource information including but not limited to: hiring and employment records, payroll and income statements, documentation related to this or any other relevant injury and any other information pertinent to providing benefits and services necessary for the completion of this claim.

Toda información del empleo y de recursos humanos, incluyendo pero no limitado a: expedientes de contratación y empleo, declaraciones de nómina e ingresos, documentación relacionada a esta o cualquier otra lesión relevante, y cualquier otra información pertinente que provea los beneficios y servicios necesarios para completar este reclamo.

The released information is required for the following reasons:

La información liberada es requerida por las siguientes razones:

1. To provide for adequate preparation, investigation, evaluation, review, and discovery of a claim for workers' compensation benefits. Specifically, to determine the causation and the nature and extent of any possible pre-existing, concurrent or aggravating medical conditions with potential medical, legal, or factual implications in the this work-related injury or injuries.

Para proporcionar una preparación, investigación, evaluación, revisión, y descubrimiento adecuado del reclamo de beneficios de compensación de trabajadores. Específicamente, para determinar la causa y la naturaleza y extensión de cualquier posible condición médica pre-existente, concurrente o agravante con potencial médico, legal, o implicaciones fácticas en esta lesión o lesiones relacionadas al trabajo.

2. To provide the treating physician, consultant or evaluator with medical information necessary to provide you with the best possible medical care and medical advice.

Para proporcionar al médico tratante, consultor, o evaluador con la información médica necesaria para proporcionarle el mejor cuidado médico posible y consejería médica.

(CONTINUED ON PAGE 2)
(CONTINÚA EN LA PÁGINA 2)



AUTHORIZATION FOR THE RELEASE OF INFORMATION (PAGE 2)
AUTORIZACIÓN PARA LA LIBERACIÓN DE INFORMACIÓN (PÁGINA 2)

Claim Number / Número de Reclamo _____ Date of Injury / Fecha de la Lesión _____
Employee / Empleado _____ Date of Birth / Fecha de Nacimiento _____

3. To facilitate recovery of all benefits paid toward your workers' compensation claim from any third party responsible for this injury.

Para facilitar la recuperación de todos los beneficios pagados por su reclamo de compensación de trabajadores de cualquier tercer parte responsable de esta lesión.

4. To ensure that you are accurately compensated for any amount of lost wages, time or resources while undergoing evaluation, treatment and recovery for this injury.

Para asegurar que usted se encuentra compensado correctamente por cualquier cantidad de salarios, tiempo, o recursos perdidos mientras se somete a la evaluación, tratamiento, y recuperación de esta lesión.

5. To obtain any information necessary to appropriately determine further actions as a result of the injury or condition and to prevent further issues for you and other employees.

Para obtener cualquier información necesaria para determinar apropiadamente acciones adicionales como resultado de la lesión o condición, y para prevenir problemas adicionales para usted y otros empleados.

This consent and authorization is effective immediately, and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate on conclusion of the claim without express revocation.

Este consentimiento y autorización es efectivo inmediatamente, y está sujeto a la revocación del abajo firmante en cualquier momento excepto a la extensión en que se hayan tomado acciones en dependencia con esto de aquí en adelante, y si no es revocado anteriormente, terminará con la conclusión del reclamo si no se presenta una revocación expresa.

A copy or fax is as valid as the original.

Una copia o fax es tan válida como el original.

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(Names, addresses, and phone numbers of providers) (Nombres, direcciones, y números de teléfonos de los proveedores)

I have read this authorization and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

He leído esta autorización y entendido completamente su contenido en su totalidad. He hecho preguntas sobre todo lo que no estaba claro para mí y estoy satisfecho con las contestaciones que he recibido. Yo entiendo que tengo derecho a recibir una copia de esta autorización una vez lo solicite.

Signed /
Firma _____

Date /
Fecha _____

MEDICAL HISTORY REQUEST

Employee Name: _____ Date of Injury: _____
Employer Name: _____ Completion Date: _____

Please complete this form by providing your medical history for the past 5 years. This will help ensure that we are able to provide all of your medical records to your current treating physician for you to receive the proper care for your work injury.

Thank you for your cooperation.

Past Injuries, Disabilities, or Other Medical Conditions

--

Hospitalizations

HOSPITAL NAME, ADDRESS AND PHONE	DATES ADMITTED

Treating Physicians or Groups

DOCTOR OR GROUP NAME, ADDRESS AND PHONE	DATES OF TREATMENT



EMPLOYEE'S ACCIDENT REPORT

To be completed by the injured worker

Employee name	
Employer name	

Date of accident	
Time of accident	
Time you began work on day of accident	
Location of accident (specify if off-site address)	

How did the injury occur? What job duties were you performing? Please describe in your own words.

What part(s) of your body was injured (indicating right and/or left)?

Have you sought any medical treatment for these injuries? If so, specify where and when.

Have you ever injured this part of your body before (yes or no)? If so, please describe how and when the previous injury(s) occurred.

What witnesses were present when the accident occurred? Please provide names if applicable.

Who did you report the injury to? When was the injury reported? Please provide name(s) and job title(s).

What did you do after the accident occurred?

The above report is true and correct:

SIGNATURE:	DATE FORM COMPLETED:

SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT

Employee name	
Employer name	

Date of accident			
Time of accident			
Date accident reported			
Did the employee report the accident immediately?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Location of accident (<i>specify if off-site address</i>)			

How did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were reported as injured?

Has the employee sought any medical treatment for these injuries? If so, specify where and when.

What witnesses were present when the accident occurred (including self)?

Do you have any reason to question the legitimacy of the accident? If so, please explain:

Indicate working conditions present that led to accident (please check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Unused/unavailable lifting equipment
<input type="checkbox"/> Unused/unavailable PPE (gloves, hardhat, goggles, etc.)
<input type="checkbox"/> Unused/unavailable sharps container
<input type="checkbox"/> Unguarded or improperly guarded equipment
<input type="checkbox"/> Electrical exposure
<input type="checkbox"/> Obstructed view
<input type="checkbox"/> Lack of training
<input type="checkbox"/> Defective tools or equipment | <input type="checkbox"/> Wet/slippery floor
<input type="checkbox"/> Poor housekeeping
<input type="checkbox"/> Interaction with co-worker
<input type="checkbox"/> Interaction with patient or resident
<input type="checkbox"/> Interaction with customer
<input type="checkbox"/> Chemical exposure
<input type="checkbox"/> Motor vehicle accident
<input type="checkbox"/> Other: _____ |
|---|---|

What changes could be made to eliminate or reduce the hazard(s) identified above?

The above report is true and correct:

Prepared by:	Title:	Date prepared:

WITNESS' REPORT/STATEMENT OF EMPLOYEE ACCIDENT

Employee name	
Witness name & phone number	
Witness Address	

Date of accident	
Time of accident	
Location of accident (specify if off-site address)	

Did you witness the above-reported accident? If so, how did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were injured? Describe the type of injury (strain, bruise, etc.)

What did the injured employee say at the time of injury? Did the injured employee complain of pain at the time of injury? If they complained of pain, please specify the body part(s).

What did the employee do after the accident occurred?

Were any other witnesses present at the time of the accident? If so, please list them below.

The above report is true and correct:

Signature of witness:	Date signed:

NOTE: Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties.

»» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.

»» To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of \$150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: ____/____/____
MM/DD/YYYY

G3YA

Group #: _____

Employee Date of Birth: ____/____/____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

»» **To the Supervisor:** Please fill in the information requested for the injured worker.

Employee Information

First M Last

Street Address or PO Box

City State ZIP

Employer Name

Participating Retail Network Pharmacies



A & P	Drug Emporium	Longs Drug Store	Sav-On
Acme Pharmacy	Drug Fair	Major Value	Save Mart
Albertson's	Drug Town	Marsh Drugs	Schnucks
Albertson's/Acme	Drug World	Medic Discount	Scolari's
Albertson's/Osco	Eckerd	Medicap	Sedano
Albertson's/Sav-On	Econofoods	Medistat	Shaw's
Amerisource Bergen	EPIC Pharmacy	Meijer	Shop 'N Save
Anchor Pharmacies	Network	Minyard	Shopko
Arrow	FamilyMeds	NCS HealthCare	ShopRite
Aurora	Farm Fresh	Neighborcare	Snyder
Bartell Drugs	Farmer Jack	Network	Stop & Shop
Bigg's	Food City	Pharmaceuticals	Sun Mart
Bi-Lo	Food Lion	Northeast Pharmacy	Super Fresh
Bi-Mart	Fred's	Services	Super Rx
BJ's Wholesale Club	Gemmel	Osco	Target
Brooks	Giant	P & C Food Markets	Texas Oncology Srvs
Brookshire Brothers	Giant Eagle	Pamida	The Pharm
Brookshire Grocery	Giant Foods	Park Nicollet	Thrifty White
Bruno	Hannaford	Pathmark	Times
Carrs	Harris Teeter	Pavilions	Tom Thumb
Cash Wise	H-E-B	Price Chopper	Tops
Coborn's	Hi-School Pharmacy	Publix	Ukrop's
Costco	Hy-Vee	Quality Markets	United Drugs
Cub	Jewel/Osco	Raley's	United Supermarkets
CVS	Kash n Karry	Randalls	Vons
D&W	Keltsch	Rite Aid	Waldbaums
Dahl's	Kerr	Rosauers	Walgreens
Dierbergs	Kmart	Rx Express	Walmart
Discount Drugmart	Knight Drugs	RXD	Wegmans
Doc's Drugs	Kroger	Safeway	Weis
Dominicks	LeaderNet (PSAO)	Sam's Club	Winn Dixie



Berkshire Hathaway
HOMESTATE COMPANIES

\$1000 Reward!

For information leading to the arrest and conviction of
any co-worker, health care professional, or attorney representing
a fraudulent workers compensation claim to
Berkshire Hathaway Homestate Companies (BHHC)*

In most states, it is a felony to make or cause to be made a knowingly false or fraudulent material statement in order to obtain workers compensation benefits. BHHC believes that any party engaging in such fraud should be prosecuted to the fullest extent of the law, including jail sentences.

Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

**Call our toll-free fraud hotline immediately if you have information on
a fraudulent claim:**



1 (800) 300-JAIL



BHHC Workers Compensation Division • Representing Financial Strength & Integrity

*Maximum reward of \$1,000 per conviction. In the event that more than one individual submits information regarding the same fraudulent claim, BHHC will equally divide the reward among those providing information used in obtaining the conviction. BHHC reserves the right to determine what information, if any, will be provided to the appropriate law enforcement agency. Criminal prosecutions are the sole responsibility of the authorities and may or may not be pursued at their discretion. Any issues regarding the interpretation of this policy shall be resolved by BHHC at their sole discretion. Program subject to change or termination without prior notice.



Berkshire Hathaway
HOMESTATE COMPANIES

\$1000 RECOMPENSA!

INFORMACIÓN QUE LLEVA AL ARRESTO Y A LA CONDENA DE CUALQUIER COMPAÑERO DE TRABAJO, PROFESIONAL DE CUIDADO MEDICO, O ABOGADO QUE REPRESENTA UN RECLAMO FRAUDULENTO EN CONTRA DE BERKSHIRE HATHAWAY HOMESTATE COMPANIES*

En la mayoría de los estados es un delito grave hacer que haga una declaración de material fraudulento para obtener beneficios de Compensación al Trabajador. Berkshire Hathaway Homestate Companies cree que cualquier persona que se involucre en tal fraude debe ser procesado con todo el rigor de la ley, incluyendo SER SENTENCIADO A LA CARCEL.

Ayúdenos de su parte. El poner a estos delincuentes fuera de operaciones nos beneficia a todos, incluso esto ayuda a mantener los réditos bajos de la aseguranza de su empleador.

Si usted tiene información sobre un reclamo fraudulento por favor llame de inmediato a nuestra LINEA GRATUITA DE FRAUDE.



(800) 300-JAIL



BHHC Workers Compensation Division • Representing Financial Strength & Integrity

*La recompensa máxima es de \$1,000 por convicción. En caso de que más de una persona presente informaciones sobre la misma demanda fraudulenta. Berkshire Hathaway dividirá la recompensa por partes iguales entre aquellas personas que aportaron informaciones para obtener la convicción. Berkshire Hathaway se reserva el derecho de determinar qué información presentará a la agencia judicial correspondiente. El proceso de crímenes es la responsabilidad exclusiva de las autoridades, que pueden decidir si el proceso debe entablarse o no. Cualquier disputa que pudiera surgir en la interpretación de esta oferta será resuelta por la propia Compañía de Seguros Berkshire Hathaway. Este programa está sujeto a cambios o cancelación sin aviso previo.