Workers Compensation Claim Kit - Iowa

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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

Iowa state law requires employers to report every industrial injury or occupational disease claim to their workers compensation carrier immediately.

State law also requires that employers authorize initial medical treatment within 24 hours of knowledge that an occupational injury of 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

Iowa Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS

Jurisdiction Code______________ Jurisdiction Claim Number______________

CLAIM ADMIN

Claim Administrator Name:

Claim Representative Business Phone Number:

Insurer Name (if different than claim administrator):

Mailing Address, City, State, & Postal Code:

Claim Administrator Claim Number:

Insurer FEIN:

Claim Administrator FEIN:

Claim Type Code:

EMPLOYER

Employer Name:

Employer FEIN:

Insured Report Number:

Employer Type Code:
__ Employer (E)
__ Lessor (L)

Physical Address, City, State, & Postal Code:

Mailing Address, City, State, & Postal Code:

Industry Code:

Insured Location Number:

Employer UI Number:

Nature of Business:

Employer Contact Name and Business Phone Number:

POLICY

Insured Name (parent company if different than employer):

Insured FEIN:

Insured Postal Code:

Policy/Contract Number:

Coverage Effective Date:

Coverage Expiration Date:

Self Insurance License/ Certificate Number:

EMPLOYEE

Employee Name (First, Middle, Last, & Suffix):

Date of Birth:

Gender:
__ Male (M)
__ Female (F)

Tax Filing Status (check one):
____ Single (A)
____ Single/Head of Household (B)
____ Married/Filing Joint (C)
____ Married/Filing Separate(D)

Mailing Address, City, State, & Postal Code:

Date of Hire:

Educational Level (grade completed): ______ [GED = 12]

Marital Status: (check one)
___ Unmarried (U)
___ Married (M)
___ Separated (S)

Employment Status (check one):
____ Piece Worker
____ Volunteer
____ Seasonal
____ Apprenticeship/Full-Time
____ Apprenticeship/Part-Time
____ Regular Employee/Full-Time
____ Part-Time
____ Other

Employee ID Number (check one):
ID # ____________________
____ Social Security Number
____ Employment VISA Number
____ Passport Number
____ Green Card
____ Employee ID Assigned by Jurisdiction

Phone Number (include area code):

Occupation Description:

Manual Classification Code:

Department Where Regularly Worked:

Employee's Authorization to Release the Following:
Medical Records __ yes __ no
Social Security Number __ yes __ no

WAGE

Average Wage $ ___________ (check one):
___ hourly ___ daily ___ semi-monthly ___ monthly
___ bi-weekly ___ annual ___ weekly

Number of Days Regularly Worked Per Week: _______

Salary Continued In Lieu of Compensation: ___ yes ___ no

Full Wages Paid for Date of Injury: ___ yes ___ no

Discontinued Fringe Benefits: $____________

Employee Number of Dependents: _________

Employee Number of Exemptions: __________ (check one)
___ Entitled
___ Withholding

ACCIDENT/INJURY

____________________ Date of Injury
____________________ Date Employer Had Knowledge of the Injury
____________________ Date Claim Administrator Had Knowledge of the Injury
____________________ Initial Date Last Day Worked
____________________ Initial Return to Work Date (if applicable)
____________________ Employee Date of Death (if applicable)

____________________ Time of Injury
____________________ Time Employee Began Work

Pre-Existing Disability Code:
___ Yes
___ No
___ Unknown

Accident Premises Code:
___ Employer (E)
___ Lessee (L)
___ Other (X)

Accident Site Organization Name:

Accident Site Street, City, State, & Postal Code:

Accident Location Narrative (if no street address):

Accident Site County/Parish:

Describe the nature of the injury. (ex. amputation, burn, cut, fracture):

Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):

Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):

Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):

Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties:

Witness Name & Business Phone Number:

MEDICAL

Initial Treatment Code (check one):
___ no medical treatment (0)
___ minor/on-site treatment (1)
___ clinic/hospital visit (2)
___ emergency care (3)
___ hospitalization > 24 hours (4)
___ future medical treatment/lost time anticipated (5)

Initial Medical Provider Name:

Initial Medical Provider Physical Address, City, State, & Postal Code:

Managed Care Organization Name or ID Number:

ICD Primary Diagnostic Code (if known):

Preparer's Name & Title:

Preparer's Company Name:

Phone Number:

Date:

This section is to provide information valuable in handling this claim.
The Iowa Occupational Safety and Health Act

The following is a summary of the recordkeeping, reporting and posting responsibilities of employers under Iowa's Occupational Safety and Health Act.

RECORDKEEPING REQUIREMENTS

Regulations issued under the Iowa Occupational Safety and Health Act of 1972 require establishments subject to the Act to maintain records of recordable occupational injuries and illness. Such records must consist of: (a) a log and summary of occupational injuries and illnesses and (b) a supplementary record of each occupational injury and illness.

LOG AND SUMMARY OF OCCUPATIONAL INJURIES AND ILLNESSES. Each recordable occupational injury and occupational illness must be entered on a log and summary of cases (0SHA Form No. 200) as early as practicable but no later than six working days after receiving information that a recordable case has occurred. A multi-unit employer may maintain the log and summary of occupational injuries and illnesses at a place other than the establishment if there is a copy of the log and summary available in the establishment complete and current to a date within 45 calendar days. If an equivalent of OSHA Form No 200 is used, such as a printout from data-processing equipment, the information shall be as readable and comprehensible to a person not familiar with the data-processing equipment as the OSHA Form No. 200 itself. Logs must be kept current and retained for 5 years following the end of the calendar year to which they relate.

SUPPLEMENTARY RECORD OF OCCUPATIONAL INJURIES AND ILLNESSES. To supplement the Log and Summary of Occupational Injuries and Illnesses, each employer must have available a record for each occupational injury or illness at each establishment within six working days after receiving information that a recordable case has occurred, OSHA Form No. 101 may be used for this purpose. State of Iowa Form No. 14-0001 [(IAIABC Form 1.2 (12/98)], workers' compensation or other reports are acceptable as records if they contain the information required on OSHA Form No 101. These records must be available in the establishment without delay and at reasonable times for examination by representatives of the Iowa Division of Labor Services, the U.S. Department of Labor and the U.S. Department of Health, Education and Welfare. The records must be maintained for a period of not less than 5 years following the end of the calendar year to which they relate.

ANNUAL SUMMARY. Each employer subject to the recordkeeping requirements must prepare a summary of the occupational injury and illness experience of the employees in each of the employer's establishments at the end of each year based on the information contained in the log and summary of occupational injuries and illnesses for the particular establishment. OSHA Form No. 200 shall be used for this purpose. The summary shall be signed and posted in a place accessible to the employees no later than February 1 and shall remain in place until March 1. For employees who do not report to work at a single establishment, or who do not report to any fixed establishment on a regular basis, employers shall satisfy the posting requirement by presenting or mailing a copy of the annual summary during the month of February to all such employees who receive pay during that month. Summaries must be retained for 5 years following the end of the calendar year to which they relate.

EMPLOYEES NOT IN FIXED ESTABLISHMENTS. Employers of employees engaged in physically dispersed operations such as occur in construction, installation, repair or service activities who do not report to any fixed establishment on a regular basis but are subject to common supervision may satisfy the recordkeeping provisions with respect to such employees by:

(a) Maintaining the required records for each operation or group of operations which is subject to common supervision (field superintendent, field supervision, etc.) in an established central place;

(b) Having the address and telephone number of the central place available at each worksite; and

(c) Having personnel available at the central place during normal business hours to provide information from the records maintained there by telephone and by mail.

(Note: This regulation does not automatically apply to all construction, installation, repair or service activities. If in doubt about applicability to your operations, contact the Iowa Division of Labor Services.)

Records for personnel who do not primarily report or work at a single establishment, and who are generally not supervised in their daily work, such as traveling salespersons, technicians, engineers, etc., shall be maintained at the location from which they are paid or the base from which personnel operate to carry out their activities.

REPORTING REQUIREMENTS

Regulations issued under the Iowa Occupational Safety and Health Act require all employers subject to the Act to report to the Iowa Workers' Compensation Commissioner any occupational injury or illness which temporarily disables an employee for more than three days or which results in permanent total disability, permanent partial disability, or death. The report must be filed electronically in conformity with EDI requirements with the Iowa Division of Workers' Compensation within four days from such event when the injury or illness is alleged by the employee to have been sustained in the course of the employee's employment. A report to the Iowa Division of Workers' Compensation is considered to be a report to the Iowa Division of Labor Services. The Iowa Division of Workers' Compensation shall forward all such reports to the Iowa Division of Labor Services.

In addition, employers must report to the Iowa Labor Commissioner within 8 hours each accident or health hazard that results in one or more fatalities or hospitalization of three or more employees.

Those establishments selected to participate in the annual Occupational Injuries and Illnesses Survey will be required to prepare a report (OSHA Form No 200-S) based on entries contained on the Log and Summary of Occupational Injuries and Illnesses.

POSTING REQUIREMENTS

The Iowa Occupational Safety and Health Act requires that employees be informed of the job safety and health protection provided under the Act. The poster, "Safety and Health Protection on the Job," is to be used for this purpose, and must be posted in a prominent place in the establishment to which the employees usually report to work. The poster briefly states the intent and coverage of the Act and the responsibilities of employers and employees to maintain safe and healthful working conditions.

EMPLOYERS WHO MUST KEEP OSHA RECORDS

Employers with 11 or more employees (at any one time in the previous calendar year) in the following industries must keep OSHA records. The industries are identified by name and by the appropriate Standard Industrial Classification (SIC) code:

- Agriculture, forestry, and fishing (SIC's 01-02 and 07-09)
- Oil and gas extraction (SIC 13 and 1477)
- Construction (SIC's 15-17)
- Manufacturing (SIC's 20-39)
- Transportation and public utilities (SIC's 41-42 and 44-49)
- Wholesale trade (SIC's 50-51)
- Building materials and garden supplies (SIC 52)
- General merchandise and food stores (SIC's 53 and 54)
- Hotels and other lodging places (SIC 70)
- Repair services (SIC's 75 and 76)
- Amusement and recreation services (SIC 79)
- Health services (SIC 80), and
- State and local government (Above SIC 's plus 91-97).

If employers in any of the industries listed above have more than one establishment with combined employment of 11 or more employees, records must be kept for each individual establishment.

All employers, including small employers and those in exempted SIC's, must continue to meet the requirement to report fatalities or multiple (3 or more) hospitalizations and all occupational injuries or occupational illnesses that result in a workers' compensation case.

If an employer is notified in writing by the Bureau of Labor Statistics about having been selected to participate in a statistical survey, such employer, including small employers, and those in exempted SIC's, must maintain a log and summary of all occupational injuries and illnesses for that year. The notification will contain the necessary form and instructions to comply with the survey requirements.

The Iowa Workers' Compensation Act

The following is a summary of the recordkeeping and reporting responsibilities of employers under the Iowa Workers' Compensation Act.

RECORDS AND REPORTS

Every employer shall keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day. An employer with notice or knowledge of an injury which temporarily disables an employee for more than three (3) days or results in permanent total disability, permanent partial disability or death is required to electronically file a report with the Workers' Compensation Commissioner within four (4) days from such event when such injury is alleged by the employee to have been sustained in the course of employment.

All books, records, and payrolls of an employer are required to be open for inspection by the Workers' Compensation Commissioner for purposes of administration of the Iowa Workers' Compensation Act.

The Workers' Compensation Commissioner may require an employer to appear and show cause why the employer should not be subject to a civil penalty of $1,000.00 per occurrence for failure to comply with the reporting or inspection requirements. Upon hearing, if the facts indicate, the commissioner may enter an order requiring payment of such penalty. Unless voluntarily paid, the commissioner may petition the district court for entry of judgment on the order. The employer's insurance carrier shall be responsible in the same manner and to the same extent as the employer when a report of injury has been submitted to the employer's insurance carrier and not filed by them with the Workers' Compensation Commissioner.

The employer is required to furnish to an employee, on request, one statement of earnings, wages, or salary for the year preceding the injury. An employer may be subject to a civil penalty of $1000.00 per offense for refusal to furnish such wage statement.

INSTRUCTIONS

An employer with notice or knowledge of an injury which temporarily disables an employee for more than THREE (3) days or results in permanent total disability, permanent partial disability or death is required to electronically file a first report of injury with the Iowa DIVISION OF WORKERS' COMPENSATION within **FOUR (4)** days from such event when such injury is **alleged** by the employee to have been sustained in the course of the employee's employment. A report to the Iowa DIVISION OF WORKERS' COMPENSATION is considered to also be a report to the Iowa DIVISION OF LABOR SERVICES. The Iowa DIVISION OF WORKERS' COMPENSATION forwards the report to the Iowa Division of Labor Services. Employers should report ALL injuries to their insurance carrier or third party administrator. **ALL REPORTS MUST BE FILLED IN COMPLETELY AND SIGNED. PLEASE TYPE OR PRINT LEGIBLY.**

This form contains all items requested on OSHA form No 101, "Supplementary Record of Occupational Injuries and Illness."

THE INFORMATION PROVIDED WILL BE OPEN FOR PUBLIC INSPECTION UNDER Iowa Code § 22.11.

Instructions for Completing the Iowa First Report of Injury

GENERAL INFORMATION

- ***Dates*** - Enter all dates in MM/DD/CCYY format.
- ***Addresses*** - Enter street address, city, state and postal code (9 digits, if known).
- ***Names*** - Enter all names first name, middle initial, last name, and last name suffix (Jr., Sr., etc., if applicable).
- ***FEIN's*** - Enter the Federal Employer Identification Number of the entity.
- ***Phone Numbers*** - Enter the area code and telephone number (include extension, if applicable).
- ***Employee*** - The individual about whom this form is being filed.
- ***Jurisdiction Code*** – Please use "IA" or "19" to represent the codes used for Iowa.
- ***Jurisdiction Claim #*** - The number assigned by the jurisdiction to identify this claim.
- ***Claim Type Code*** - Enter one of the following codes which represents the current benefit classification of the claim according to jurisdictional requirements:

M	Medical only	**I**	Indemnity	**N**	Notification only
B	Became medical only	**L**	Became lost time	**T**	Transfer (claim jurisdiction changed)

CLAIM ADMINISTRATOR:

- ***Claim Administrator Name*** - Enter the name of the carrier, third party administrator, or self-insured responsible for administering the claim. (Refers to question 8 on prior Iowa form).
- ***Claim Administrator Claim #*** - An identifier which distinguishes a specific claim within a claim administrator's claims processing system assigned by the claim administrator.
- ***Insurer Name*** - The legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim.

EMPLOYER:

- ***Physical Address*** - Enter the address of the employer's facility where the employee was employed at the time of injury. See Accident Site Information question. (Refers to question 2 on prior Iowa form).
- ***Mailing Address*** – Enter the employer's mailing address. (Refers to question 1 on prior Iowa form).
- ***Employer Contact Name*** - Enter the name of the individual at the employer's premises to be contacted for additional information.
- ***Nature of Business*** - Enter the narrative description of the nature of the employer's business related to the specific business operation for which the employee was employed at the time of injury. (Refers to question 3 on prior Iowa form).
- ***Insured Report Number*** - Enter a number that may be assigned by the insured to identify a specific claim. This may be the OSHA 101 number. If no number is assigned, this may be left blank.
- ***Industry Code*** - The code, which represents the nature of the employer's business which may be found in either the Standard Industrial Classification Manual (SIC) or the North American Industrial Classification System (NAICS).
- ***Employer Type Code*** – A code that indicates whether the employer for whom the employee worked at the time of the injury is a lessor. If the employee is paid directly by the employer, check E. If the employee is paid by a leasing company, check L.
  NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.
- ***Employer UI Number*** - Enter the unemployment insurance number assigned for each employer by the state unemployment agency.
- ***Insured Location Number*** - Enter a code defined by the insured which is used to identify the employer's location of the accident. If there is no number, this should be left blank.

POLICY:

- ***Insured Name*** - Indicate the named entity of the policy. (Refers to question 7 on prior Iowa form).
- ***Policy/Contract Number*** - Enter number identifying the coverage policy in effect for the claim. (Refers to question 52 on prior Iowa form).
- ***Coverage Effective Date*** - Enter the date that the employer's insurance policy or self-insurance license/certificate became effective. (Refers to question 50 on prior Iowa form).
- ***Coverage Expiration Date*** - Enter the date that the employer's insurance policy or self-insurance license/certificate expired. (Refers to question 51 on prior Iowa form).

EMPLOYEE:

- ***Employee Name*** - Indicate the employee's legally recognized name. (Refers to question 9 on prior Iowa form).
- ***Occupation Description*** - Indicate the primary occupation of the employee at the time of the accident or injurious exposure. (Refers to question 14 on prior Iowa form).
- ***Date of Hire*** - Provide the date the employee began his/her employment with the specified employer. If there have been multiple periods of employment, the beginning date of the current employment period should be indicated. (Refers to question 13 on prior Iowa form).
- ***Manual Classification Code*** - Provide the code that corresponds to the primary occupation in which the employee was engaged at the time of accident/injury, or injurious exposure, if known.
- ***Employment Status*** - Indicate the employee's work status at the time of injury. In the event that multiple Employment Status Codes apply to the employee, use the following hierarchy to determine which status, the topmost, to report. (i.e., if employee is a part time seasonal worker, report as seasonal worker.) (Refers to question 42 on prior Iowa form).

1	**Piece Worker** - the injured employee was paid for employment according to the number of products/services completed or number of trips completed.
2	**Volunteer** - the injured employee was serving at one's own free will without legal obligation of payment.
3	**Seasonal** - the injured employee was employed in a position dependent on or controlled by the season of the year.
4	**Apprenticeship Full-Time** - the injured employee was bound by a legal agreement to work full-time for another in return for instruction in a trade or occupation.

5 **Apprenticeship Part-Time** - the injured employee was bound by a legal agreement to work part-time for another in return for instruction in a trade or occupation.
6 **Regular Employee Full Time** - the injured employee was employed on a full-time basis. (schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time). This status is NOT used when reporting experience for full-time seasonal, volunteer, apprenticeship, or piece workers.
7 **Part-time** - the injured employee was employed on a part-time basis (whose work history in the preceding months shows that the person worked on less than a full- time basis). This status is NOT used when reporting experience for part-time seasonal, volunteer, apprenticeship or piece workers.
8 **Other** - the injured employee had an employment status at the time of injury other than those previously listed.

- ***Marital Status*** - U = Widowed, Divorced, Single, Unmarried. (Refers to question 36 on prior Iowa form).

- ***Tax Filing Status*** - Indicate the employee's federal tax filing status used on the Internal Revenue tax forms.
  NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Employee ID Number*** - SSN is preferred. Critical to matching existing claims. If no SSN, please contact Iowa DWC. (Refers to question 10 on prior Iowa form).

- ***Education level*** - Indicate the highest number of years or equivalency level of formal education completed.
  (High school graduate/GED = 12)

- ***Employee Authorization to Release***: *NOTE*: Iowa Division of Workers' Compensation will not collect this information at this time.
  Medical - Indicate whether the employee has provided written authorization to release medical records related to the injury.
  SSN- Indicate whether the employee has provided a written authorization to release the employee's Social Security Number.

WAGE:

- ***Salary Continued in Lieu of Compensation*** - The status of whether the employer is currently paying the employee's salary in lieu of compensation caused by a work related injury.

- ***Number of Dependents*** - *NOTE*: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Number of Entitled Exemptions*** - The maximum number of exemptions that the employee is entitled to claim on their annual Federal Income Tax. Exemptions include marital status, maximum exemptions employee can claim (e.g. self, 65 and over, blind, spouse, etc.), number of dependent children, and other dependents. Refer to questions 36 & 37 on prior Iowa form).

- ***Number of Withholding Exemptions*** - The number of exemptions that the employee claims on their withholding information provided to the employer.
- *NOTE*: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Average Wage*** - The employee's pre-injury wage for the wage period as statutorily defined by the jurisdiction. The amount may include commissions, piecework earnings and other forms of income converted to a normal scheduled work wee, plus the estimated value of lodging, food, laundry and other payments in kind, as per jurisdictional requirements. Average wage includes discontinued fringes and concurrent employer wages, if any. It is preferred that hourly wage be calculated into a weekly wage. (Refers to question 38 - 42 on prior Iowa form).

ACCIDENT/INJURY:

- ***Time*** - indicate the time military format 00:00 through 23:59 for:
  - ***of Injury*** (Refers to question 22 on prior Iowa form).
  - ***Employee began work*** (Refers to question 23 on prior Iowa form).

- ***Initial Date Last Day Worked*** - Enter the last day the employee was able to work prior to the original lost time from work due to the occupational injury or disease. This date may be the date of injury or the first date prior to the initial lost time.

- ***Initial Return to Work Date*** - Enter the date following the first disability period on which the employee returned to work.

- ***Accident Premises Code*** - Check the code that indicates the premises on which the accident occurred.

- ***Accident Site Information*** - If accident site is different than the Employer Physical Address, then the accident site address information must be completed. For ease of description, Accident Site Address formatting has been developed. (Refers to question 5 on prior Iowa form).

MEDICAL:

- ***Initial Treatment Code*** - Select one of the six choices listed on the form. The choice should indicate the initial treatment only that the injured worker received immediately after the injury. If none, select "No medical treatment". The intent is to reflect care rendered at the time of reporting. Not anticipated care or severity of injury at the time of initial report.

- ***Initial Medical Provider*** - Name of the physician, clinic, hospital or in house treatment provider at the time of the report. (Refers to question 45-47 on prior Iowa form).

- ***Managed Care Organization Name or ID Number*** – *NOTE*: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Primary ICD Diagnostic Code*** - This is only needed if medical treatment was rendered. The medical provider should determine the selected code. If code is provided, enter the ICD (International Classification of Diagnosis or Disease) code depending on jurisdictional requirements at the time of injury.
  NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.

AUTHORIZATION TO RELEASE INFORMATION
REGARDING CLAIMANTS SEEKING WORKERS' COMPENSATION BENEFITS

Name of Patient:____ Date of Birth:______________

SECTION I. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR REDISCLOSURE

I authorize____
to disclose and deliver to:____
the following information related to me: Any and all information EXCEPT substance abuse (drug or alcohol), mental health, and AIDS-related information, unless specifically authorized to be released in section II of this form.

NOTE: If the information includes mental health treatment, substance abuse treatment or HIV-related information it will not be released unless the undersigned patient agrees to the release on the reverse side of this form.

I understand the information is being disclosed and may be used only for legal and/or litigation purposes relating to claims and/or suit against ____
I understand that this Authorization may be used to obtain information from health care providers, schools, former and current employers, providers of vocational rehabilitation services, the Social Security Administration, and the Iowa Department of Workforce Development. I understand that I have a right to inspect the disclosed information at any time. This authorization is effective until the conclusion of a contested case on the claim. I understand that I may revoke this Authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper. I also understand that if I revoke, the revocation will take effect on the day it is received in writing by the entity from whom disclosure is sought. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care services.

I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

Iowa and Federal law provide that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below. I understand that the Recipient of this Authorization, WITHOUT FURTHER AUTHORIZATION, may redisclose this information to:

Parties and their legal counsel, insurers, experts, potential experts, but only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information; Agents, employees or representatives of the parties, but only after they are involved in conducting the prosecution or defense of the case, and only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information; Administrative agency and court officials hearing the claim, and their support staff.

I SPECIFICALLY AUTHORIZE AND CONSENT TO ANY SAID DISCLOSURE AND REDISCLOSURE DESCRIBED ABOVE.

____ ____________________
Claimant or Legal Representative Date

____
Printed Name and Relationship of Claimant's Legal Representative

SECTION II. SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT OR AIDS-RELATED INFORMATION

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Place "YES" or "NO" in ALL applicable boxes:]

____ Substance Abuse (Drug or Alcohol) information from all health care providers and facilities and any other person or entity in possession of records concerning me.

____ Mental Health information from all health care providers and facilities and any other person or entity in possession of records concerning me.

____ HIV or AIDS-related information, Diagnosis, and test results from all health care providers and facilities and any other person or entity in possession of records concerning me.

Furthermore, I SPECIFICALLY AUTHORIZE disclosure and re-disclosure of this confidential information to all of the persons referred to in the REDISCLOSURE Section I.

In order for the above information to be released you must sign here AND at the end of Section I

_______________________________________ _______________________

Signature of Claimant or Legal Representative Date

____

Street Address City/State/ Zip Code

____

Printed Name and Relationship of Claimant's Legal Representative

Federal and/or State law specifically require that any disclosure or REDISCLOSURE of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

See also Chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.

Authorization to Release Information

1. Employee Information.

I, the undersigned, provide the following information to allow the Iowa Division of Workers' Compensation (DWC) to identify me and verify that I signed this Authorization:

Full Name: ______________________

Social Security Number: ______________________

Date of Birth: ______________________

Telephone Number: ______________________

Address: ______________________

____

2. Records to Be Released.

I authorize the DWC to release the following confidential information filed within the past ______ years:

- ☐ All confidential records of any nature
- ☐ Information from all First Reports of Injury (FROI)
- ☐ Information from all Subsequent Reports of Injury (SROI)
- ☐ All evidence received in contested case hearings
- ☐ All transcripts from contested case hearings
- ☐ Other (describe the records that you want released):

3. Recipient(s) of Records.

I authorize the DWC to release the confidential information identified in Section 2 to:

Name(s): ______________________

4. Signature.

I understand that I have the right under Iowa Code section 86.45 to keep confidential certain information filed with the DWC.

By signing this Authorization, I authorize the DWC to release the confidential information identified in Section 2 to the recipient(s) identified in Section 3.

X ______________________ ______________________

Signature Date

Berkshire Hathaway
HOMESTATE COMPANIES

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (800) 661-6029 • FAX: (415) 675-5469

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:**

Berkshire Hathaway HOMESTATE COMPANIES

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** ☐ **NO** ☐
Location of accident *(specify if off-site address)*	

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):

- ☐ Unused/unavailable lifting equipment
- ☐ Unused/unavailable PPE (gloves, hardhat, goggles, etc.)
- ☐ Unused/unavailable sharps container
- ☐ Unguarded or improperly guarded equipment
- ☐ Electrical exposure
- ☐ Obstructed view
- ☐ Lack of training
- ☐ Defective tools or equipment
- ☐ Wet/slippery floor
- ☐ Poor housekeeping
- ☐ Interaction with co-worker
- ☐ Interaction with patient or resident
- ☐ Interaction with customer
- ☐ Chemical exposure
- ☐ Motor vehicle accident
- ☐ 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:**

Berkshire Hathaway HOMESTATE COMPANIES

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.

myMatrixx
An Express Scripts Company

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.

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

Group #: G3YA

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 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

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

____

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Participating Retail Network Pharmacies

myMatrixx®
An Express Scripts Company

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

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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 intrepretation 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 REPRESENTE 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 demando fraudulenta. Berkshire Hathaway dividirá la recompensa por partes iguales entre aquellas persones que aportaron informaciones para obtener la convicción. Berkshire Hathaway se reserva el derecho de determinar qué informacion presentará a la agencia judicial correspondiente. El proceso de crímenes es la responsibilidad exclusiva de las autoridades, que pueden decidir si el proceso debe entablarse or no. Cualquier disputa que pudiera surgir en la interpretación de esta ofreta será resuelta por la propia Compañia de Seguros Berkshire Hathaway. Este programa está sujeto a cambios a cancelación sin aviso previo.