Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Claim Kit - Idaho

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Berkshire Hathaway HOMESTATE COMPANIES

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

Idaho 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 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

WORKERS' COMPENSATION POSTING REQUIREMENTS

Workers' Compensation Law Poster

- Post in one or more conspicuous places at all business locations
- Must contain the surety/insurer name and address

To complete the form, please enter the following information in the spaces provided:

- Your company name
- Name of your designated surety/insurer
- Enter the name of your designated workers' compensation insurer
- Date
- Signature of an authorized agent

For your convenience, our other contact information has been entered on the Poster.

(Idaho Code § 72-312)

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

NOTICE

REGARDING WORKERS' COMPENSATION INSURANCE

ALL WORKERS EMPLOYED BY THE UNDERSIGNED ARE HEREBY NOTIFIED THAT THE EMPLOYER HAS COMPLIED WITH THE LAW AS TO SECURING THE PAYMENT OF COMPENSATION TO EMPLOYEES AND THEIR DEPENDENTS, IN ACCORDANCE WITH THE PROVISIONS OF THE WORKERS' COMPENSATION LAW**.**

An employee receiving an injury by accident must immediately notify his/her supervisor, superintendent, or the undersigned, who will provide medical attendance.

Claims for compensation must be made in writing and given to the employer. Forms for giving notice of injury and making a claim for compensation will be furnished by the employer, by the surety, or upon application, by the Industrial Commission in Boise, Idaho.

Employer

Surety/Insurer Name

PO Box 881716, San Francisco, CA 94188

Surety/Insurer Address

800-661-6029

Surety/Insurer Phone Number

415-675-5469

Surety/Insurer Fax Number

Date

Signature of Employer's Authorized Agent

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)		Carrier/Administrator Claim Number	Report Purpose Code
		Jurisdiction	Jurisdiction Claim No.
		Insured Report No.	
		Employer's Location Address (if different)	Location No.
NAICS Code	Employer FEIN		Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)	Policy Period To ☐ Check if self insured	Claims Admin (Name, Address & Phone Number)
Carrier FEIN	Policy Number or Self-Insured Number	Administrator FEIN
Agent Name & Code Number		

Employee

Legal Name (Last, First, Middle)	Birth Date	Social Security Number	Date Hired	State of Hire
Address (Incl. Zip)	Sex: ☐ Male ☐ Female ☐ Unknown	Marital Status: ☐ Unmarried/Single/Div. ☐ Married ☐ Separated ☐ Unknown	Occupation/Job Title	
Phone	No. of Dependents		Employment Status	
			NCCI Class Code	
Wage Rate $ ☐ Day ☐ Week	☐ Month ☐ Other	# Days Worked/WK # Hrs Worked per Day	Full Pay for Date of Injury? ☐ Yes ☐ No Did Salary Continue? ☐ Yes ☐ No	

Occurrence

Time Employee Began Work ☐ AM ☐ PM	Date of Injury or Illness	Time Occurred ☐ AM ☐ PM	Last Work Date	Date Employer Notified	Date Disability Began
Employer Contact Name/Phone Number		Type of Illness/Injury	Part of Body Affected		
Did Injury/Illness Exposure Occur on Employer's Premises? ☐ Yes ☐ No		Type of Illness/Injury Code	Part of Body Affected Code		
Department or location where accident or illness exposure occurred		All Equipment, Materials, or Chemicals Employee Using upon Occurrence			
Specific Activity Employee Engaged in at Time of Occurrence		Work Process the Employee Was Engaged in at Time of Occurrence			
How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill.			Cause of Injury Code		
Date Returned to Work	If Fatal, Date of Death	Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No			
		Were they used? ☐ Yes ☐ No			

Treatment

Physician/Health Care Provider (Name & Address)	Hospital (Name & Address)	Initial Treatment
		0 ☐ No Medical Treatment 1 ☐ Minor: By Employer 2 ☐ Minor Clinic/Hosp 3 ☐ Emergency Care 4 ☐ Hospitalized – 24 hr. 5 ☐ Anticipated Major Med/Lost Time

Other

Signature of Injured Employee, or Signature on File, Date	Witness to Accident (Name & Phone Number)	
Date Administrator Notified / Date Prepared	Preparer's Name & Title	Preparer's Phone Number

Filing this report is not an admission of liability. This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made. Idaho Industrial Commission, P.O. Box 83720, Boise, ID 83720-0041 IC Form IA-1 (08/2013)

Instructions for Filling Out the Workers' Compensation First Report of Injury or Illness (IC1A-1)

1) The form should be filled out by the employer or a representative; however, the injured employee may fill out the form if necessary.
2) Fill out non-shaded areas as completely as possible.
3) Distribute copies of the completed form as follows:

    - The original to:
      Idaho Industrial Commission
      PO Box 83720
      Boise, ID 83720-0041
      (If the form is completed by the injured employee, an additional copy should be sent to the Idaho Industrial Commission. The Idaho Industrial Commission will then send a copy to the adjuster.) **The PDF can be emailed to the Commission; however, you must fill out the form, save it under a different name, and then sent as an email attachment to froi@iic.idaho.gov.**

    - One copy to the employer's workers' compensation insurer or adjuster.

    - One copy retained for the employer's files.

4) The Idaho Industrial Commission will be happy to answer your questions or provide you with helpful brochures on Facts for Injured Workers and Guides for Employers. To obtain this service, please contact the Idaho Industrial Commission at (208) 334-6000; or you may access many of these brochures on these web pages.

I.C. Form 14

File No.

ORIGINAL
Mail to
Surety

Employer's Supplemental Report

Employer: Fill out this form in duplicate. Mail copy to Industrial Commission (P.O. Box 83720, Boise, Idaho 83720-0041) and the original to your workers' compensation insurer at the following times:

1. Upon termination of disability (regardless of length of time disabled for work).
2. At the end of 60 days from the date disability began if employee is disabled that long.

Any employer who fails to make this report upon termination of the disability of one of his insured employees and (if the disability extends beyond a period of 60 days) at the end of that period is subject to a penalty not to exceed $500.00.

<table>
<tr><td>Name of injured employee:</td><td>Address where mail should be sent:</td></tr>
<tr><td>Date of injury:</td><td>Date disability began:</td></tr>
<tr><td>Were wages paid for the day the disability began?
☐ Yes ☐ No</td><td>What wages, if any, have been paid during the period of disability?</td></tr>
<tr><td rowspan="2">Has the injured employee returned to work?
☐ Yes ☐ No</td><td>If so, on what date was he re-employed?</td></tr>
<tr><td>At what daily wage?</td></tr>
<tr><td>At light or regular work?
☐ Light duty ☐ Regular work</td><td>If re-employed at less wages than received before the injury, give reason:</td></tr>
<tr><td colspan="2">Give date the injured employee recovered sufficiently to return to regular work:</td></tr>
</table>

THE ABOVE STATEMENTS ARE CORRECT
(The employee MUST NOT sign this form BEFORE the work disability ceases)

_____
Employer

_____
Signature of injured employee

_____
Signature of Authorized Agent

Date of this report _____

Address _____

Berkshire Hathaway HOMESTATE COMPANIES

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

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 divisiónes 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 filminas, 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)

Berkshire Hathaway HOMESTATE COMPANIES

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

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.

-

_____

_____

_____

(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** _____

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.

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

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

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.