Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Claim Kit - Louisiana

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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

Louisiana 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 Poster

- Post in one or more conspicuous places at all business locations

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

- Your company name and address
- The name and contact information of a company representative
- The name of your designated workers' compensation insurer

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

(Louisiana Revised Statutes 23:1302)

Stop Workers' Compensation Fraud Poster

- Post in one or more conspicuous places at all business locations near the Workers' Compensation Poster.

Workers' Compensation

Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

1 the disease manifests itself.

2 the employee is disabled as a result of the disease.

3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

1 the date of death.

2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

PO Box 881716, San Francisco, CA 94188

Phone Number - 800-661-6029

Fax Number - 415-675-5469

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

_____

_____

_____

_____

Employer

_____

_____

_____

_____

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

Revised May 2003

LOUISIANA WORKFORCE COMMISSION

www.laworks.net

Compensacion del Trabajador

Reportando de lesiones/heridas

Usted debe reportar a su empleador cualquier enfermedad ocupacional o lesión personal que esté relacionada con el trabajo, aún y cuando usted piense que es insignificante o menor.

Enfermedades ocupacionales o muerte

En caso de enfermedad ocupacional, no todos los reclamos son elegibles a menos que el empleado haga el reclamo con su empleador dentro del siguiente año de la fecha que:

1. La enfermedad se manifiesta por si sola.
2. El empleado está desabilitado como resultado de esta enfermedad.
3. El empleado sabe o tiene rezones poderosas para creer que la enfermedad está relacionada con su ocupación.

En caso de muerte que aparece como resultado de una muerte ocupacional, no todos los reclamos son válidos solamente que el o los dependientes hagan un reclamo con el empleador del empleado muerto dentro de 1 (uno) año de:

1. La fecha de muerte.
2. La fecha que el reclamante tenga suficientes pruebas para creer que la muerte fué resultado de muerte ocupacional.

Aviso para reclamar o solicitar

En caso de lesiones o muerte causadas por accidente relacionados al trabajo o accidentes, el empleado lesionado o cualquier persona que haga un reclamando y para tener derecho a la compensación ya sea como reclamante o como el representante de la persona que está reclamando para poder tener derecho a la compensación, deberá dar aviso a su empleador dentro de los 30 días siguientes despues de la lesión. Si el aviso no es dado dentro de los siguientes 30 días, ningún pago será hecho por dicha lesión o muerte. En adición, cualquier acción fraudulenta por el empleador, empleado o cualquier otra persona con el propósito de obtener o buscar cualquier beneficio o pagos a través del Programa de Compensación de Trabajadores dicha persona está sujeta a cargos criminales al igual que a responsabilidad civil.

El aviso arriba mencionado deberá ser presentado con el empleador en la dirección que aparace en el lado derecho.

Un aviso dado no deberá ser invalidado o mantenerse invalidado por cualquier inexactitud en el tiempo, lugar, naturaleza o causa de la lesión al momento de hacer la declaración, o de otra manera, solamente si se demuestra que el empleador fué mal informado para con esto perjudicar. El fallar o faltar de notificar es posible que no perjudique al empleado si el empleador sabe del accidente o si el empleador no es perjudicado por la tardanza o por faltar de hacer la notificación.

Medicos

En caso que usted es lesionado, usted tiene el derecho de elegir al médico para su tratamiento. El empleador puede escoger otro médico y hacer arreglos para otro exámen para el cual usted será requerido para atender.

Reclamo formal

Para poder preservar sus derechos a los beneficios bajo la Ley de Compensación de los Trabajadores del estado de Louisiana, usted debe hacer un reclamo formal con la oficina administrativa del Programa de la Ley de Compensación de los Trabajadores dentro del siguiente año después del accidente si no se han hecho pagos o dentro del año después del último pago de beneficios.

Información

Si usted desea cualquier información relacionada a sus derechos y a los beneficios a los cuales usted tiene derecho descritos por la ley, usted puede llamar o escribir a la Office of Worker's Compensation Administration, PO Box 94040, Baton Rouge, Louisiana 70804-9040 o al teléfono (225) 342-7555.

Nombre y Dirección de la Compañía de Seguros

PO Box 881716, San Francisco, CA 94188

Phone Number - 800-661-6029

Fax Number - 415-675-5469

La notificación deberá ser dada ya sea lleváandola personalmente o enviándola por correo certificado regresando o regresar el recibo solicitado a:

Representante del empleador

_____

_____

_____

_____

Empleador

_____

_____

_____

_____

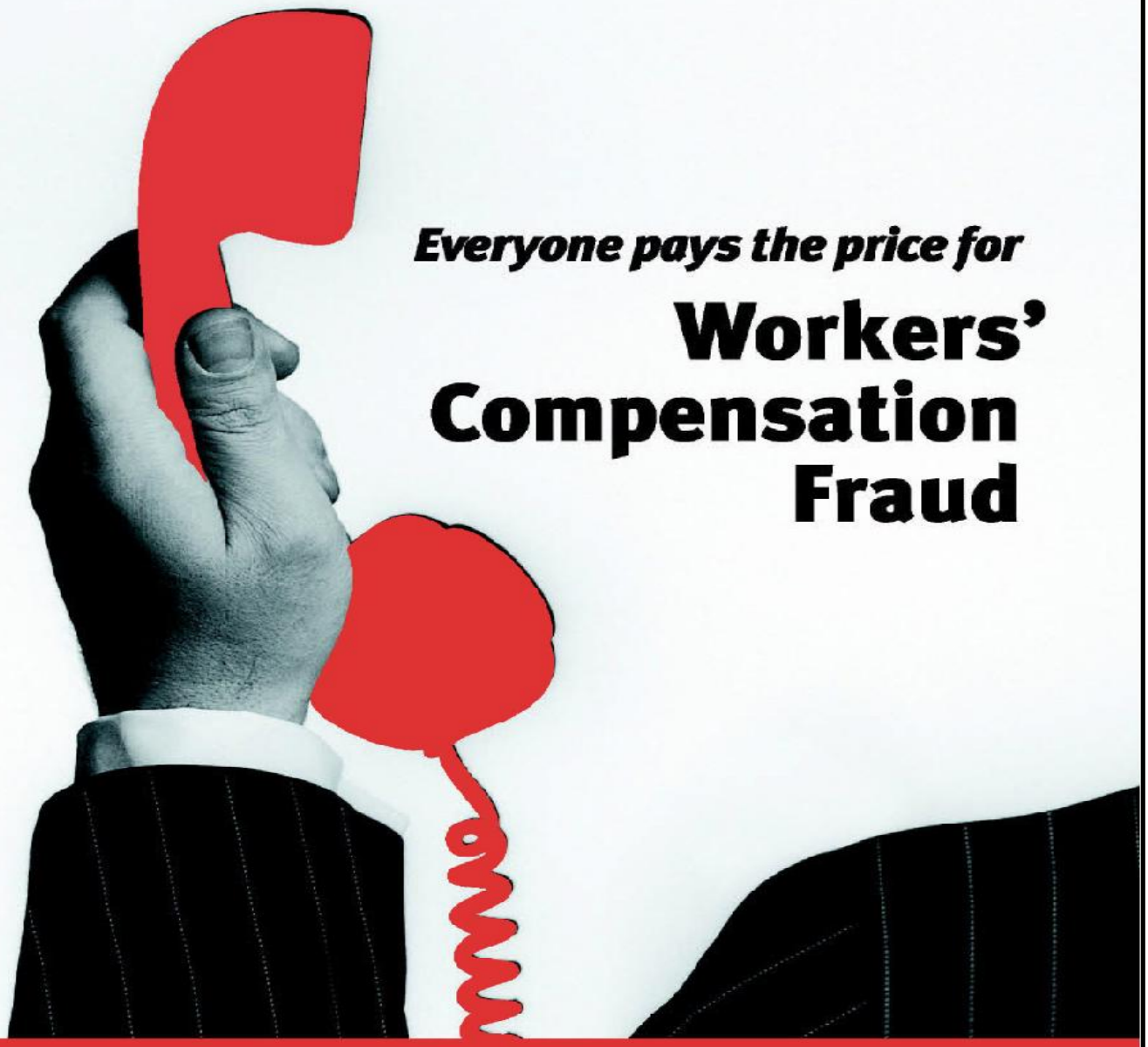
R.S. 23:1302 manifiesta que éste aviso debe estar puesto en un lugar visible y conveniente en el negocio del empleador.

Revisado Mayo 2003

LOUISIANA WORKFORCE COMMISSION

www.laworks.net

Is someone you know cheating the system?



Everyone pays the price for

Workers' Compensation Fraud

Nationwide Toll–free Fraud Hotline

1.800.201.3362
(all information remains anonymous)

Louisiana Workforce Commission
www.LAWORKS.net

Office 225.342.7558
Fax 225.342.1880
Email WCFraud@ldol.state.la.us

182202

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE SELF INSURANCE ☐	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX M MALE F FEMALE U UNKNOWN	MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ☐ AM ☐ PM ( ) CANNOT BE DETERMINED	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE		
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
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 RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO			
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)		INITIAL TREATMENT 0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED		

OTHER

WITNESSES (NAME & PHONE #)			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

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:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of $500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized self-insured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to $10,000, imprisonment with or without hard labor for not more than 1 year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than $500, or imprisoned with or without hard labor for not more than one year, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined up to $10,000, imprisoned with or without hard labor for up to 10 years, or both depending on the amount of benefits unlawfully obtained or defeated. In addition to these criminal penalties, you may be assessed a civil penalty of up to $5,000.

EMPLOYER CERTIFICATION

I certify that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT)	Signature Date
Company Name	Company Address
( ) Phone Number	Insurance Policy Number
Employee Name	- - Employee Social Security Number

LWC-WC-1025.ER
REV. 7/08

NOTICE
TO INJURED WORKERS

YOU HAVE THE RIGHT TO CHOOSE YOUR OWN DOCTOR!

WHEN YOU ARE INJURED AT WORK OR BECOME SICK BECAUSE OF SOMETHING THAT HAPPENED AT WORK, THE LAW GIVES YOU THE RIGHT TO CHOOSE YOUR OWN DOCTOR IN ANY FIELD OR SPECIALTY OF MEDICINE FOR MEDICAL TREATMENT.

THE LAW ALSO ALLOWS YOUR EMPLOYER TO HAVE YOU SEE HIS/HER DOCTOR, BUT YOU DO NOT HAVE TO AGREE TO CONTINUE TREATMENT WITH YOUR EMPLOYER'S DOCTOR UNLESS THAT IS WHAT YOU WANT.

IF YOU WANT YOUR EMPLOYER'S DOCTOR TO CONTINUE TREATING YOU AFTER YOUR FIRST VISIT WITH HIM/HER, AND AFTER RECEIVING THIS FORM, YOU MAY CHOOSE YOUR EMPLOYER'S DOCTOR AS YOUR TREATING DOCTOR.

ONCE YOU CHOOSE EITHER YOUR EMPLOYER'S DOCTOR OR YOUR OWN DOCTOR AS YOUR TREATING DOCTOR, YOU MAY NOT BE PERMITTED TO CHOOSE ANOTHER DOCTOR IN THAT SAME FIELD OR SPECIALTY OF MEDICINE TO TREAT YOU FOR YOUR INJURY OR ILLNESS LATER ON. HOWEVER, YOU ARE NOT REQUIRED TO GET YOUR EMPLOYER'S APPROVAL TO CHANGE TO A DOCTOR IN ANOTHER FIELD OR SPECIALTY OF MEDICINE (La. R.S. 23:1121(B)(1).

IF YOUR EMPLOYER DENIES YOUR RIGHT TO CHOOSE YOUR DOCTOR, YOU HAVE A RIGHT TO A SPEEDY HEARING BEFORE A WORKERS' COMPENSATION JUDGE TO RESOLVE THE DENIAL OF YOUR RIGHT (La. R.S. 23 1121 (B)(1) and 1124 (B).

I HEREBY CHOOSE MY OWN DOCTOR TO TREAT ME FOR MY INJURY OR ILLNESS:
DR. _____.

OR

BY SIGNING THIS FORM, I STATE THAT I KNOW ABOUT MY RIGHT TO CHOOSE MY OWN TREATING DOCTOR, AND BEING SO ADVISED, I HEREBY ACCEPT AND CHOOSE TO CONTINUE TREATING WITH MY EMPLOYER'S DOCTOR:
DR. _____.

_____ _____
DATE **SIGNATURE OF EMPLOYEE**

_____ _____
DATE **SIGNATURE OF EMPLOYER REPRESENTATIVE**

(Note: If the employee is illiterate or has a language barrier, an authorized representative of the employer/insurer shall attest by their signature that this form and right of physician choice has been reasonably explained to that employee prior to his/her signature on this form. Failure to do so can jeopardize the employer's/insurer's right to subsequently refuse consent to the employee's request for treatment by a different physician within the same field or specialty.)

(Form LWC – WC 1121)

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.