Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Claim Kit - Massachusetts

BHHC MA Claims Kit Introductory Letter – 09/07/2017 (page 3 of 28)

BHC Requirements for MA Posting Notice – 05/22/2018 (page 4 of 28)

MA Form – Notice to Employees Poster (English, Spanish, Portuguese, Chinese, Arabic, Cape Verdean, Haitian Creole, & Khmer) (pages 5-13 of 28)

MA Form IA-1 – First Report of Injury or Illness – 01/01/2002 (pages 14-16 of 28)

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BHHC Authorization for the Release of Information (English & Spanish) - 06/10/2019 (pages 19-20 of 28)

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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

Massachusetts 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

Notice to Employees 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:

- Name of your designated insurance company
- Policy number and effective dates (start and end)
- Name, address, and phone number of your insurance agent
- Your company name and address
- Name of your company workers' compensation officer (if any)
- Date
- Name and address of a local hospital to provide emergency medical treatment

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

(Annotated Laws of Massachusetts 152 § 21 and § 22)

NOTICE TO EMPLOYEES

NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017

617-727-4900 - http://www.state.ma.us/dia

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above-mentioned chapter by insuring with:

NAME OF INSURANCE COMPANY

PO Box 881716, San Francisco, CA 94188

ADDRESS OF INSURANCE COMPANY

POLICY NUMBER EFFECTIVE DATES

NAME OF INSURANCE AGENT ADDRESS PHONE #

EMPLOYER ADDRESS

EMPLOYER'S WORKERS' COMPENSATION OFFICER (IF ANY) DATE

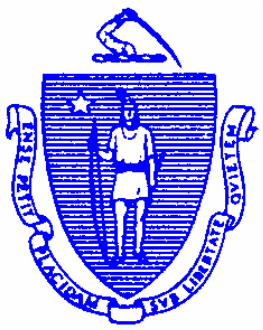
MEDICAL TREATMENT

The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

NAME OF HOSPITAL ADDRESS

TO BE POSTED BY EMPLOYER

AVISO PARA EMPLEADOS



AVISO PARA EMPLEADOS

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017

617-727-4900 - http://www.mass.gov/dia

De acuerdo con lo dispuesto por los artículos 21, 22 y 30 del capítulo 152 de las Leyes Generales de Massachussets, por el presente notificamos que hemos previsto el pago a nuestros empleados lesionados, conforme al capítulo antes mencionado, mediante un seguro con:

_____

NOMBRE DE LA COMPAÑÍA DE SEGURO

PO Box 881716, San Francisco, CA 94188

DOMICILIO DE LA COMPAÑÍA DE SEGURO

NÚMERO DE PÓLIZA FECHAS DE VIGENCIA

NOMBRE DEL AGENTE DE SEGUROS DOMICILIO TELÉFONO

EMPLEADOR DOMICILIO

FUNCIONARIO DEL EMPLEADOR PARA ACCIDENTES DE TRABAJO (SI HUBIERA) FECHA

TRATAMIENTO MÉDICO

En caso de lesiones personales ocurridas a raíz del trabajo o durante el trabajo, la aseguradora cuyo nombre aparece arriba debe prestar servicios médicos y hospitalarios adecuados razonables de acuerdo con lo dispuesto por la Ley de Accidentes de Trabajo. El empleado lesionado debe recibir una copia del Primer Informe de Lesión. El empleado puede elegir su propio médico. El costo razonable de los servicios prestados por el médico que asista en el caso será abonado por la aseguradora, siempre que el tratamiento sea necesario y esté razonablemente relacionado con la lesión ocupacional. En caso de que se necesite atención hospitalaria, por la presente se notifica a los empleados que la aseguradora ha dispuesto que esa atención sea prestada en:

_____

NOMBRE DEL HOSPITAL DOMICILIO

ANUNCIO PUBLICADO POR EL EMPLEADOR

AVISO AOS EMPREGADOS

AVISO AOS EMPREGADOS

Estado de Massachusetts

Departamento de Acidentes de Trabalho

1 Congress Street, Suite 100

Boston, MA 02114-2017

617-727-4900 - http://www.mass.gov/dia

Nos termos da Lei Geral do Estado de Massachusetts, Capítulo 152, Parágrafos 21, 22 e 30, avisam-se os empregados que eu/nós asseguro(amos) o pagamento dos meus/nossos empregados em caso de acidente de trabalho / doença profissional, nos termos legais, através da subscrição de um seguro de acidentes de trabalho na seguinte companhia:

NOME DA COMPANHIA DE SEGUROS

PO Box 881716, San Francisco, CA 94188

ENDEREÇO DA COMPANHIA SEGUROS

N.º DA APÓLICE — VALIDADE DO SEGURO

MEDIADOR — ENDEREÇO — N.º DE TELEFONE

EMPRESA (SEGURADO) — ENDEREÇO

RESPONSÁVEL NA EMPRESA PELO SEGURO DE ACIDENTES (SE EXISTENTE)) — DATA

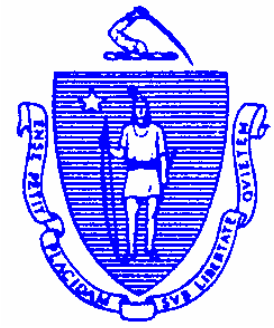
ASSISTÊNCIA MÉDICA EM CASO DE ACIDENTE

A seguradora acima referida deverá, nos casos de lesões corporais decorrentes ou no curso da actividade do segurado, proporcionar assistência médica ou hospitalar adequada e razoável, nos termos da Lei sobre Seguros de Acidentes de Trabalho. Uma cópia do Relatório Inicial de Acidente de Trabalho deverá ser entregue ao trabalhador acidentado. O trabalhador tem direito a seleccionar o seu médico assistente. A seguradora pagará os custos razoáveis dos serviços prestados pelo médico assistente, no caso de o tratamento ser necessário, desde que razoavelmente relacionados com a lesão profissional sofrida pelo trabalhador. Nos casos em que seja necessária assistência hospitalar, avisam-se os empregados de que a seguradora assegura a prestação dos serviços necessários no

NOME DO HOSPITAL — ENDEREÇO

A AFIXAR PELA ENTIDADE EMPREGADORA

員工告示



員工告示

麻薩諸塞州

工傷部

1 Congress Street, Suite100, Boston, Massachusetts 02114-2017

617-727-4900 - http://www.mass.gov/dia

謹此依麻薩諸塞州普通法 152 章第 21、22 和 30 各節規定向您告知，我 (我們) 業已根據上述法令規定向下列公司投保，藉以爲受傷員工付款：

_____

保險公司名稱

PO Box 881716, San Francisco, CA 94188

保險公司地址

_____

保單號碼 生效日期

_____

保險經紀姓名 地址 電話號碼

_____

僱主 地址

_____

僱主的工傷賠償主管 (若有) 日期

醫治

發生因工與工作期間內受傷時，上述保險人必需根據工傷賠償法規定，提供適當與合理的醫院以及醫療服務。受傷員工必須接獲第一份受傷報告。員工可以自行選擇他/她的醫生。如果所獲治療確屬必要且與其工傷有合理關聯，治療醫師所提供服務的合理費用將由保險人支付。若必需到醫院就醫，我們謹此告示員工，保險人已與下列單位做好就醫安排

_____

醫院名稱 地址

由僱主張貼

إخطار إلى
أصحاب العمل

كومنولث ولاية ماساتشوستس
إدارة الحوادث الصناعية

1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
617-727-4900 - http://www.mass.gov/dia

بموجب القانون العام لولاية ماساتشوستس، القانون 152، المواد 21 و22 و 30، سوف يعطيك هذا إخطارًا بأن أنا (نحن) قد قمنا بالسداد لموظفينا المصابين بموجب القانون المذكور أعلاه من خلال توفير الغطاء التأميني بواسطة:

_____
اسم شركة التأمين

PO Box 881716, San Francisco, CA 94188
_____
عنوان شركة التأمين

_____
رقم البوليصة — تواريخ السريان

_____
اسم وكيل التأمين — العنوان — رقم الهاتف

_____
صاحب العمل — العمل

_____
تاريخ مسؤول تعويض موظفي صاحب العمل (إن وجد)

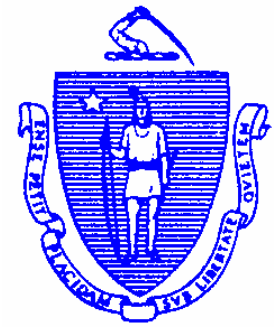
العلاج الطبي

مطلوب من شركة التأمين المذكور اسمها أعلاه في حالات الإصابات الشخصية الناتجة عن التوظيف وأثناء فترة التوظيف أن توفر مستشفى وخدمات طبيةمعقولة طبقًا لمواد قانون تعويض العمال. ويجب إعطاء نسخة من أول تقرير إصابة إلى الموظف المصاب. ويمكن للموظف اختيار الطبيب الخاص به أو الطبيبة الخاصة بها. وسيتم سداد التكلفة المعقولة لهذه الخدمات التي قدمها الطبيب المعالج بواسطة شركة التأمين إذا كان العلاج مرتبط بالضرورة وبشكل معقول بإصابة خاصة بالعمل. في الحالات التي تستدعي رعاية بالمستشفى، فإن الموظفين بموجب هذه الوثيقة قد تم إبلاغهم بأن شركة التأمين قد قامت بالترتيب لهذه الرعاية في

_____
اسم المستشفى — العنوان

يتم نشرها بواسطة صاحب العمل

AVIZU PA ENPREGADUS



AVIZU PA ENPREGADUS

The Commonwealth of Massachusetts

DEPARTMENTU DI ASIDENTI INDUSTRIAL

1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017

617-727-4900 - http://www.mass.gov/dia

Konformi rikizitu di Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, kel li e pa notifikabu ki mi (nos) ta fazi pagamentu pa nos enpregadus asidentadu pa kapitulo mensionadu di riba pa seguru ku:

_____

NOMI DI KONPANHIA DI SEGURU

PO Box 881716, San Francisco, CA 94188

ENDERESU DI KONPANHIA DI SEGURU

_____

NUMBRU DI APOLISE DATAS EM EFEITU

_____

NOMI DI AGENTI DI SEGURU ENDERESU TELEF #

_____

PATRON ENDERESU

_____

REPREZENTANTI (SI TEN) DI PATRON PA KONPENSASON DI TRABADJADOR DATA

TRATAMENTU MEDIKU

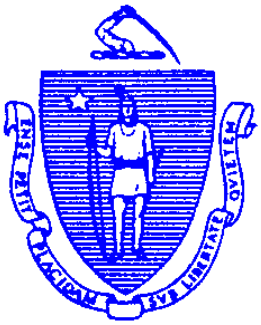
Konpanhia di seguru nomiadu di riba ten obrigason di na kazu di danu pesual ki kontisi na, o pur kauza di trabadju, di da serbisus mediku y di hospital adekuadu y razuavel di akordu ku stipuladu pa Lei di Konpensason di Trabadjador (*Workers' Compensation Act*). Enpregadu asidentadu debi resebi un kopia di Prumeru Relatorio di Pankada. Enpregadu podi skodji se propi dotor. Seguru ta paga kustu di sirbisus di tratamentu pa dotor, si tratamentu for nesesario y razuavelmenti ligadu ku pankada na trabadju. Na kazu ki mesti tratamentu di hospital, enpregadus ta fika asin notifikadu ki konpanhia di seguru dja ranja hospital pa tal tratamentu na

_____

NOMI DI HOSPITAL ENDERESU

PA SER PUBLIKADU PA PATRON

AVI POU ANPLWAYE



AVI POU ANPLWAYE

Commonwealth of Massachusetts

DEPATMAN AKSIDAN ENDISTRIYÈL

1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017

617-727-4900 - http://www.mass.gov/dia

Daprè lalwa jeneral leta Massachusetts, chapit 152, seksyon 21, 22 & 30, dokiman sa a ap mete w okouran ke mwen (nou) ap peye pou anplwaye blese ou a daprè chapit ki make anlè a e ki gen asirans ak :

_____

NON KONPAYI ASIRANS LAN

PO Box 881716, San Francisco, CA 94188

ADRÈS KONPAYI ASIRANS LAN

_____

NIMEWO KONTRA A DAT KONTRA A

_____

NON AJAN KONPAYI ASIRANS LAN ADRÈS # TELEFÒN

KONPAYI TRAVAY ADRÈS

_____

REPREZANTAN ASIRANS POU AKSIDAN NAN TRAVAY (SI GENYEN) DAT

SWEN MEDIKAL

Konpayi asirans ki make anlè a oblije, si gen aksidan pèsonèl nan travay, ofri sèvis medikal ak sèvis lopital rezonab daprè paragraf nan lwa pou aksidan nan travay la. Li enpòtan pou remèt anplwaye blese a yon fotokopi dokiman premye rapò sou aksidan li a. Anplwaye a ka chwazi nenpòt doktè li vle. Se konpayi asirans lan ki va peye pou frè sèvis rezonab doktè a ofri, si tretman an nesesè epi rezonab pou aksidan nan travay la. Si anplwaye a gen pou li entène, anplwaye a gen pou l di konpayi asirans lan ap peye pou sa nan

_____

NON LOPITAL LA ADRÈS

POU KONPAYI TRAVAY LA AFICHE

លេខប័ណ្ណដំណឹង
ជូន
និយោជិក

លេខប័ណ្ណដំណឹង
ជូន
និយោជិក

The Commonwealth of Massachusetts

(នាយកដ្ឋានឧស្សាហកម្ម)

DEPARTMENT OF INDUSTRIAL ACCIDENTS

(ក្រុមប្រឹក្សាគ្រប់គ្រងគ្រោះថ្នាក់ឧស្សាហកម្ម)

1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
617-727-4900 - http://www.mass.gov/dia

ដូចដែលត្រូវបានតម្រូវដោយច្បាប់ទូទៅរដ្ឋម៉ាសាឈូសែត (Massachusetts General Law) ជំពូក 152 សេចក្តីនីង 21, 22 និង 30 តាមរយៈនេះសូមជូនដំណឹងដល់អ្នកថា ខ្ញុំ (ឬយើងខ្ញុំ) បានផ្តល់នូវការបង់ប្រាក់ជូននិយោជិកដែលរងរបួសរបស់យើងខ្ញុំ ដោយផ្អែកតាមជំពូកដែលបានប្រើប្រាស់ខាងលើ តាមរយៈការបានភ៉ាប់ប៉ងជាមួយ :

_____
ឈ្មោះក្រុមហ៊ុនបានភ៉ាប់ប៉ង

PO Box 881716, San Francisco, CA 94188
_____
អាសយដ្ឋានក្រុមហ៊ុនបានភ៉ាប់ប៉ង

_____
លេខប័ណ្ណសន្យាភ៉ាប់ប៉ង កាលបរិច្ឆេទមានប្រសិទ្ធិភាព

_____
ឈ្មោះភ្នាក់ងារបានភ៉ាប់ប៉ង អាសយដ្ឋាន លេខទូរស័ព្ទ

_____
និយោជក អាសយដ្ឋាន

_____
មន្ត្រីទទួលបន្ទុកសំណងនិយោជិកបង់និយោជក (ប្រសិនបើមាន) កាលបរិច្ឆេទ

ការព្យាបាលវេជ្ជសាស្ត្រ

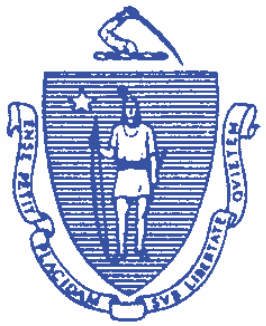
ក្រុមហ៊ុនបានភ៉ាប់ប៉ងបង់លោមានឈ្មោះដូចខាងលើ ត្រូវបានតម្រូវឱ្យមាននៅក្នុងករណីនីការងរបួសផ្សាល់ខ្លួន ដែលកើតចេញមកពី និងដោយសារការងារ បើម្បីផ្តល់ឱ្យនូវសោនៅមន្ទីរពេទ្យ និងវេជ្ជសាស្ត្រតាមគ្រប់គ្រាន់ និងសមរម្យ ដោយយោងតាមបញ្ញត្តិនៃច្បាប់ស្តីពីសំណងនិយោជិក (Workers' Compensation Act)។ សេចក្តីចម្លងនៃរបាយការណ៍ដំបូងនៃរបួស (First Report of Injury) ត្រូវតែបានផ្តល់ជូននិយោជិកដែលរងរបួស។ និយោជិកអាចជ្រើសរើសក្នុងការផ្តល់ជូនវេជ្ជបណ្ឌិត។ ចំពោះសោកម្មសម្បើមដែលបានផ្តល់ជូនដោយត្រូវការព្យាបាលនិងត្រូវបង់ប្រាក់ដោយក្រុមហ៊ុនបានភ៉ាប់ប៉ង ប្រសិនបើការព្យាបាលសំខាន់ និងពាក់ព័ន្ធសម្បើមទៅនឹងការងរបួសការងារ។ នៅក្នុងករណីត្រូវការសោយកិច្ចតុណាក់នៅមន្ទីរពេទ្យ តាមរយៈនេះនិយោជិកត្រូវបានជូនដំណឹងថា ក្រុមហ៊ុនបានភ៉ាប់ប៉ងបានប្រើប្រាស់ចំការយកិច្ចតុណាក់នេះនៅ

_____
ឈ្មោះមន្ទីរពេទ្យ អាសយដ្ឋាន

ត្រូវបានបិទផ្សាយដោយនិយោជក

Print Form

THÔNG BÁO CHO NHÂN VIÊN



THÔNG BÁO CHO NHÂN VIÊN

Khối Cộng Đồng Massachusetts

BAN TAI NẠN KỸ NGHỆ

1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017

617-727-4900 - http://www.mass.gov/dia

Theo đòi hỏi từ M.G.L. (Luật Lệ Chung của Massachusetts), Chương 152, Đoạn 21, 22 & 30, nơi đây thông báo cho quý vị biết rằng tôi (chúng tôi) đã lo liệu vấn đề chi trả cho nhân viên bị thương tật theo chương nhắc đến bên trên bằng cách mua bảo hiểm tại:

TÊN HÃNG BẢO HIỂM

PO Box 881716, San Francisco, CA 94188

ĐỊA CHỈ HÃNG BẢO HIỂM

SỐ HỢP ĐỒNG NGÀY CÓ HIỆU LỰC

TÊN ĐẠI LÝ BẢO HIỂM ĐỊA CHỈ SỐ ĐIỆN THOẠI

HÃNG SỞ ĐỊA CHỈ

VIÊN CHỨC BỒI THƯỜNG TAI NẠN LAO ĐỘNG CỦA HÃNG SỞ (NẾU CÓ) NGÀY

ĐIỀU TRỊ Y TẾ

Nếu xảy ra thương tật cá nhân - xuất phát từ việc làm và trong quá trình làm việc - thì nơi bảo hiểm nhắc đến bên trên phải lo liệu dịch vụ y tế và dịch vụ bệnh viện thích đáng và hợp lý đúng theo các điều khoản của Đạo Luật Bồi Thường Tai Nạn Lao Động. Phải giao bản sao Khai Báo Đầu Tiên về Thương Tật cho nhân viên bị thương tật. Nhân viên có thể chọn bác sĩ riêng của mình. Chi phí dịch vụ hợp lý do bác sĩ điều trị thực hiện sẽ do nơi bảo hiểm chi trả, nếu chữa trị đó là cần thiết, hợp lý, và can hệ với thương tật liên quan đến công việc. Nếu cần phải săn sóc tại bệnh viện, thì nhân viên cũng được thông báo rằng nơi bảo hiểm đã lo liệu công việc chăm sóc đó tại

TÊN BỆNH VIỆN ĐỊA CHỈ

HÃNG SỞ PHẢI NIÊM YẾT THÔNG BÁO NÀY

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

☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS

☐ UNMARRIED SINGLE/DIVORCED
☐ MARRIED
☐ SEPARATED
☐ 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 ☐ CANNOT BE DETERMINED ☐ AM ☐ PM | 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

☐ NO MEDICAL TREATMENT
☐ MINOR: BY EMPLOYER
☐ MINOR CLINIC/HOSP
☐ EMERGENCY CARE
☐ HOSPITALIZED > 24 HOURS
☐ 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.

FORM 127

The Commonwealth of Massachusetts
Department of Industrial Accidents
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line (800) 323-3249 Inside Mass. / (857) 321-7470 Outside Mass.
www.mass.gov/dia

DIA USE ONLY

AVERAGE WEEKLY WAGE COMPUTATION SCHEDULE

Print or Type

1. Employer's Name and Address:	2. Insurer's Case File #:
	3. DIA Board # (if known):
4. Employee's Name and Address:	5. # of dependent children:
	6. # of other dependents:

7. Date of Injury (mm/dd/yyyy):	8. Date of Disability (mm/dd/yyyy):	9. Date of Employment (mm/dd/yyyy):

10. Has employee been certified by U.S. Veterans Administration for any type of disability? ☐ Yes ☐ No

Indicate only those wages earned by the injured worker during the 52 week period immediately preceding the accident. If the injured employee has worked for less than 52 weeks, report wages from the time worked and, for the remaining weeks on this schedule, substitute wages of a fellow employee in the same class of employment who has worked for one year or more.

11. Week No.	Year: / Week Ending Month	Day	Gross Amount Before Taxes	Week No.	Year: / Week Ending Month	Day	Gross Amount Before Taxes	Week No.	Year: / Week Ending Month	Day	Gross Amount Before Taxes
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				**Total:**			
18				36							

12. Was room furnished to the employee? ☐ Yes ☐ No	13. If tips or other benefits were earned, describe and state value per week:

THIS IS A TRUE COPY OF THE PAYROLL RECORD OF THE ABOVE NAMED EMPLOYEE OR FELLOW EMPLOYEE IN THE SAME CLASS OF EMPLOYEMENT

14. Name of Fellow Employee (if applicable):	15. Employer/Preparer Signature:	16. Date Signed (mm/dd/yyyy):

Make any comments on the reverse side of this form or on a separate sheet.

Comments:

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

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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.