



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Claim Kit - Montana



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

Dear Policyholder:

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

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

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

- Online:** 1. Go to our website: www.bhhc.com
2. Highlight "Workers Comp" in the menu
3. Highlight "Claims Center"
4. Click "Report a Claim"

Phone: (800) 661-6029

Fax: (800) 661-6984

E-mail: newclaim@bhhc.com

Montana state law requires employers to report every industrial injury or occupational disease claim to their workers compensation carrier within 6 days of employer knowledge of an injury. BHHC recommends that employers report all potential claims within 5 days of their knowledge to allow enough time to fully investigate the claim while meeting state reporting deadlines.

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

WORKERS' COMPENSATION POSTING REQUIREMENTS

Form ERD-800 – Employee Notice Poster

- Post in one or more conspicuous places at all business locations and temporary or permanent work sites
 - Employees that primarily work off the premises must receive notice of the posting in writing
- Print each page of the Poster on 8.5" x 14" paper

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

- Your company name and address
- Date
- Policy number & effective dates (start and end)
- The name of your designated insurance carrier

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

(Montana Code § 39-71-401(6))

Form ERD-801 – Employee Warning-Cancellation Pending and Form ERD-802 – Employee Warning-Cancellation Request

Please Note, these forms are only utilized if coverage will be cancelled!

- Post in one or more conspicuous places at all business locations and temporary or permanent work sites
 - Employees that primarily work off the premises must receive notice of the posting in writing
 -

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

- Your company name and address
- Date
- Policy number and effective dates (start and end)
- The name of your designated insurance carrier

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

(Montana Code § 39-71-401(6))

WORKERS' COMPENSATION

INSURANCE COVERAGE

EMPLOYEE NOTICE

(Insert business name and address here.)

Date:

Policy Number:

The above-named employer's workers' compensation insurance coverage is active and in good standing for the period of to , provided the employer meets all premium and reporting requirements.

IF YOU ARE INJURED

You should report any on-the-job injury to your supervisor, employer, or insurer as soon as possible. You must report the accident within 30 days. A sole proprietor, partner, manager of a manager-managed limited liability company, member of a member-managed limited liability company, or corporate officer covered under the Montana Workers' Compensation Act must report an accident to the insurer within 30 days.

Report minor injuries to your employer whether or not you receive medical treatment. After you report the injury, your employer has 6 days to notify their insurer. You must submit a written First Report of Injury within 12 months from the date of the accident or within one (1) year from the knowledge of an occupational disease. You can submit this form to your employer, insurer, or the Department of Labor and Industry.

All employees sustaining a compensable work related injury or occupational disease, other than those who are exempted by statute (Section 39-71-401, MCA), are covered for medical and wage-loss benefits.

Prior to the Insurer's designation or approval of a Treating Physician you may choose your initial Health Care Provider.

You may continue to receive treatment from your initial health care provider unless the insurer designates a treating physician other than your initial health care provider. After providing you with a notice of a designated or approved treating physician, the insurer is no longer liable for treatment provided by other health care providers unless authorization is obtained to continue treatment.

For specific information about this policy, call or write your employer's insurance carrier:

(Insert insurer name, address and phone number here)

**FAILURE TO POST THIS SIGN OR POSTING AN ALTERED SIGN IN THE
WORKPLACE WILL RESULT IN A \$50 FINE AGAINST THE EMPLOYER!**

For general information about workers' compensation, call or write: Montana Department of Labor and Industry, Employment Relations Division, P.O. Box 8011, Helena, MT 59604-8011, Phone (406) 444-6532.

Compensación de Trabajadores

Cobertura De Seguro

AVISO DEL EMPLEADO



(Inserte el nombre y la dirección de negocio aquí.)
(Insert business name and address here.)



Fecha:

Número de la Póliza:



La cobertura de compensación para trabajadores de la antedicha compañía esta vigente por el periodo de al, mientras tanto que la compañía halla reunido todos los requisitos de reportes y la prima.

SI USTED ES HERIDO

Usted debe informar cualquiera lesion que ocurre en el trabajo a su supervisor, el empleador o el asegurador tan pronto posible. Usted tiene que reportar el accidente dentro de 30 días. Un propietario único, el socio, el director de una compañía manejado por el director de obligación limitada, el miembro de una compañía miembro-manejado por obligación limitada, oficial corporativo cubierta bajo el Acto de Compensación de Trabajadores de Montana debe informar un accidente al asegurador dentro de 30 días.

Informe las lesiones secundarias a su empleador aunque usted no reciba tratamiento médico. Después que usted informa la lesión, su empleador tiene 6 días para notificar a su asegurador. Usted tiene que entregar un escrito “Primer Informe de la Lesion” dentro de 12 meses de la fecha del accidente o dentro de un (1) año del conocimiento de una enfermedad profesional. Usted le puede entregar esta forma a su empleador, al asegurador, o al Departamento de Labor y de Industria.

Todos los empleados que sostienen una lesion compensable relacionada al trabajo o la enfermedad profesional, con excepción de las que sean eximidas por el estatuto (la Sección 39-71-401, MCA), son cubierta por médico y por los beneficios de perdida de salario.

Antes de la designación de la Aseguradora o aprobación de un médico tratante puede elegir su proveedor de atención médica inicial. Usted puede continuar recibiendo tratamiento de su proveedor de atención médica inicial a menos que el asegurador designa un médico tratante que no sea su proveedor de atención médica inicial. Después de proporcionarle con un aviso de un designado o aprobado médico tratante, el asegurador es no más obligado para el tratamiento proporcionado por otros proveedores de asistencia médica a menos que autorización sea obtenida para continuar el tratamiento.

Para información específica sobre esta póliza, llame o escriba al portador del seguro de su empleador:

number here) (Inserte el número aquí dirección del por

Para información general acerca la compensación de los trabajadores, llame o escriba:

¡EL FRACASO DE ANUNCIAR ESTE LETRERO O ANUNCIAR UN LETRERO MODIFICADO EN EL LUGAR DE TRABAJO RESULTA EN UNA MULTA DE \$50 CONTRA EL EMPLEADOR!

EMPLOYEE WARNING

LOSS OF WORKERS' COMPENSATION INSURANCE COVERAGE

[_____]

Date:
Policy Number:

[_____]

The above named employer's workers' compensation insurance coverage issued by the insurance carrier shown below is pending cancellation. Claims occurring on or after _____ will not be covered for medical or wage-loss benefits due an injured worker as the result of an injury incurred while in the employment of the named employer, unless the insurance coverage requirements are met by _____.

Should this cancellation not occur, the employer will be given written authorization from the insurance carrier to remove this sign.

This sign will remain posted over the current "Employee Notice" sign until effective workers' compensation insurance is obtained by this firm.

**FAILURE TO POST THIS SIGN OR POSTING AN ALTERED SIGN IN THE
WORKPLACE WILL RESULT IN A \$50.00 FINE AGAINST THE EMPLOYER!**

For general information about Workers'
Compensation, call or write:

For specific information about this policy
call or write the insurance carrier:

Workers' Compensation Regulation Bureau
Employment Relations Division
Montana Department of Labor and Industry
PO Box 8011
Helena MT 59604-8011
Phone – (406) 444-6532

EMPLOYEE WARNING

LOSS OF WORKERS' COMPENSATION INSURANCE COVERAGE

[_____]

Date:
Policy Number:

[_____]

The above named employer's workers' compensation insurance coverage issued by the insurance carrier shown below is in a cancellation status at the request of the employer or as of a change of ownership. Claims occurring on or after will not be covered by this insurer for medical or wage loss benefits that may be required as the result of an injury incurred while in the employment of the named insurer.

Should this cancellation not occur, the employer will be given written authorization from the insurance carrier to remove this sign.

This sign will remain posted over the current "Employee Notice" sign until effective workers' compensation insurance is obtained by this firm.

**FAILURE TO POST THIS SIGN OR POSTING AN ALTERED SIGN IN THE
WORKPLACE WILL RESULT IN A \$50.00 FINE AGAINST THE EMPLOYER!**

For general information about Workers'
Compensation, call or write:

Workers' Compensation Regulation Bureau
Employment Relations Division
Montana Department of Labor and Industry
PO Box 8011
Helena MT 59604-8011
Phone – (406) 444-6532

For specific information about this policy
call or write the insurance carrier:

Worker

Last Name		First Name		M.I.	Date of Birth	Social Security Number	
Mailing Address				City		State	Postal Code
Phone Number	Education	<input type="checkbox"/> Less Than High School <input type="checkbox"/> GED or High School Diploma <input type="checkbox"/> Beyond High School	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Marital Status	Number of Dependents	
					<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed, Divorced, Single, Unmarried Unknown <input type="checkbox"/>		

Wages

Date Hired	Gross earnings for <u>four</u> pay periods preceding the injury														
Date/Amount		/		Date/Amount		/		Date/Amount		/		Date/Amount		/	
Employment Status				Number of Days worked per week		Wage	Wage Period								
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Piece Worker <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer <input type="checkbox"/> Other							<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Bi-Weekly								
In addition to gross earnings cited above worker received							Estimated value if any			Time Employee began work					
<input type="checkbox"/> Room & Board <input type="checkbox"/> Overtime <input type="checkbox"/> Bonus <input type="checkbox"/> Commissions <input type="checkbox"/> Other:															
Worked next scheduled shift		Off work more than 4 work days		Date Last Worked		Date of Return to Work		Full wages paid for date of injury			Salary Continued				
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure						<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No				

Accident Description

Job Title		Description of Accident									
Cause of Injury		Cause Code	Part of Body		Part Code	Nature of Injury		Nature Code	Date of Injury	Time of Injury	
Date Disability Began		Date of Death		Names of Witnesses							
				1) 2) 3)							
Accident on Employer's Premises		Accident Address or Location									
<input type="checkbox"/> Yes <input type="checkbox"/> No		City State Postal code									
Date Employer Notified		Accident Reported to					Safety Equipment Provided		Safety Equipment Used		
							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Medical

Attending Physician's Name		Address		State	Postal Code	Phone Number
Hospital Name		Address		State	Postal Code	Phone Number
Type of initial medical treatment received <input type="checkbox"/> No Treatment <input type="checkbox"/> Emergency Room/Urgent Care <input type="checkbox"/> Treatment on-site by Employer or Medical Staff <input type="checkbox"/> Clinic/Dr. Office <input type="checkbox"/> Hospital > 24 hours						

Signature

“This is my claim for workers’ compensation benefits due to the on-the-job injury, occupational disease, or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers’ compensation insurer (and its agents) and to the Montana Uninsured Employers’ Fund of: Social Security records; rehabilitation records; and all health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA), that are directly relevant to the claimed injury, disease, or death. I also understand that if I obtain or exert unauthorized control over workers’ compensation benefits to which I am not entitled, I may be prosecuted for theft.”

Signature of Injured Worker or BeneficiaryDate:

Employer

Employer Name		Doing Business as		Federal Employer Identification Number (Tax I.D.)			
Mailing Address		City		State	Postal Code	Phone Number	
Location of operation, if different from mailing address				Nature of Business SIC/NAICS Code		Self-Insured <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer is a <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company		Injured worker is a <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company					
		<input type="checkbox"/> A member of the employer's (sole proprietor) family living in the employer's household.					
Do you have any reason to question this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No						Was worker injured while in your employ <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain fully. Use separate sheet if you need additional space							
Prepared By		Official Title		Phone Number		Date	
Payroll Classification Code under which you report Employee's wages		Authorized Employer's Signature					Date

Insurer

Claim Administrator Claim Number		Date Reported to Claim Administrator:		The above information is correct with the following exceptions <input type="checkbox"/> (Attach extra sheets if box at right is checked)	
Claim Administrator Name		Claim Administrator Address			Claim Administrator FEIN
Insurer Name				Insurer FEIN	
Policy Number				Policy Effective Date	Policy Expiration Date

First Report of Injury or Occupational Disease

Instructions

Workers' compensation insurance is a state-required insurance, which provides medical benefits, wage compensation and rehabilitation to workers injured on the job. Severe penalties can be assessed against an uninsured employer. Neither general liability nor health and accident insurance policies are substitutes for workers' compensation insurance.

The worker and employer may complete this form together or they may each submit a separate form.

Injured Worker's Instructions

Workers have two reporting requirements: 1) Notify your employer of an on-the-job injury within 30 days of its occurrence and 2) Complete this form as a claim for compensation. The form must be signed and submitted to the employer's insurer or the Department of Labor and Industry within 12 months of the accident. The form must be submitted for all injuries in order to protect your right to benefits in the event a seemingly minor injury develops into a more serious condition.

Complete a report of the injury

Be thorough in completing all areas except the gray shaded areas. It is important to you that we have complete information. You must provide your Social Security Number (SSN). This is a mandatory requirement that is permitted under Section 7(a) the Privacy Act of 1974 because the Montana Department of Labor and Industry's forms, prescribed by department rules in existence prior to January 1, 1975, have required disclosure of the SSN. The SSN is used as a key identifier of the claimant, and is needed because of the number of persons who have similar names and birth dates, and whose identities can only be distinguished by the SSN. Use extra sheets of paper if needed. Type or print with a ballpoint pen.

To ensure that workers' compensation systems will not be disrupted, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, 42 USC 1301, et. seq., **permits the disclosure of protected health care information pursuant to the provisions of state laws regarding workers' compensation.** 45 CFR 164.512(l) states:

"Standard: Disclosures for workers' compensation: A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault."

Employer's Instructions

Montana law requires employers to complete this form within six days after notice of every on-the-job accident, injury and/or occupational disease (OD) by a worker. Ensure all areas are completed except the gray shaded areas, which your insurer will complete. **It is important that we have complete information.**

Type or print with a ballpoint pen. If you are completing with WORD software, you may tab through the fields. If the injured worker is available to do so, they may file a claim for workers' compensation by completing and signing their portions of this form. You may then complete the employer section.

Send the original immediately to your workers' compensation insurer. If you don't know whom your insurer is, contact the Montana Department of Labor and Industry (see below). **SEND THIS FORM WITHIN THE 6-DAY LIMIT EVEN IF THE WORKER IS NOT AVAILABLE TO SIGN.** This form must be submitted even if the employer questions whether or not the reported injury and/or OD are job-related. Additional sheets of paper may be attached, if needed to fully explain all conditions concerning the injury and/or OD.

The United States Department of Labor, OSHA, requires employers to maintain a record of occupational injuries in the employer's office. Please copy the completed form for your records.

Insurer/Adjuster (not submitting electronically)

Please complete all gray shaded areas, and mail a completed copy immediately to the Montana Department of Labor and Industry at the address shown below. Boxes that have been **BOLDED** are mandatory in order to file this report. If you wish to file First Report information electronically, please contact the Employment Relations Division.

Further Information

Department of Labor & Industry
Employment Relations Division
Workers' Compensation Claims Assistance Bureau
PO Box 8011
Helena MT 59604-8011
(406) 444-6543
<http://erd.dli.mt.gov>

The United States Department of Labor, OSHA, requires employers to maintain a record of occupational injuries in the employer's office.



AUTHORIZATION FOR THE RELEASE OF INFORMATION
AUTORIZACIÓN PARA LA LIBERACIÓN DE INFORMACIÓN

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

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

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

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

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

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

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

The released information is required for the following reasons:
La información liberada es requerida por las siguientes razones:

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

A copy or fax is as valid as the original.

Una copia o fax es tan válida como el original.

-

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

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

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

Signed /
Firma _____

Date /
Fecha _____

MEDICAL HISTORY REQUEST

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

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

Thank you for your cooperation.

Past Injuries, Disabilities, or Other Medical Conditions

--

Hospitalizations

HOSPITAL NAME, ADDRESS AND PHONE	DATES ADMITTED

Treating Physicians or Groups

DOCTOR OR GROUP NAME, ADDRESS AND PHONE	DATES OF TREATMENT



EMPLOYEE'S ACCIDENT REPORT

To be completed by the injured worker

Employee name	
Employer name	

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

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

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

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

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

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

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

What did you do after the accident occurred?

The above report is true and correct:

SIGNATURE:	DATE FORM COMPLETED:

SUPERVISOR'S REPORT OF EMPLOYEE ACCIDENT

Employee name	
Employer name	

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

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

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

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

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

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

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

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

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

The above report is true and correct:

Prepared by:	Title:	Date prepared:

WITNESS' REPORT/STATEMENT OF EMPLOYEE ACCIDENT

Employee name	
Witness name & phone number	
Witness Address	

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

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

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

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

What did the employee do after the accident occurred?

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

The above report is true and correct:

Signature of witness:	Date signed:

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

»» To the Injured Worker:

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

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

Atención Trabajador Lesionado:

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

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

»» To the Pharmacist:

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

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

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

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

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

Express Scripts

ID#: _____

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

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

G3YA

Group #: _____

Employee Date of Birth: ____/____/____

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

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

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

Employee Information

First M Last

Street Address or PO Box

City State ZIP

Employer Name

Participating Retail Network Pharmacies



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



Berkshire Hathaway
HOMESTATE COMPANIES

\$1000 Reward!

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

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

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

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



1 (800) 300-JAIL



BHHC Workers Compensation Division • Representing Financial Strength & Integrity

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



Berkshire Hathaway
HOMESTATE COMPANIES

\$1000 RECOMPENSA!

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

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

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

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



(800) 300-JAIL



BHHC Workers Compensation Division • Representing Financial Strength & Integrity

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