Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Claim Kit - Rhode Island

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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

Rhode Island 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

Form DWC-8 – Workers' Compensation Act 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
- Your policy effective date

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

(Rhode Island General Law § 28-29-13 and § 28-29-14)

STATE OF RHODE ISLAND
DEPARTMENT OF LABOR & TRAINING

This employer is subject to the provisions of the

WORKERS' COMPENSATION ACT

of the State of Rhode Island

Workers' Compensation Insurance Company: _____

Adjusting Company: Berkshire Hathaway Homestate Companies
PO Box 881716, San Francisco, CA 94188

Telephone: 800-661-6029 Policy Effective Date: _____

In accordance with Rhode Island General Law §28-32-1, the **employer must report** to the Director of Labor and Training **every personal injury sustained by an employee if the injury incapacitates the employee from earning full wages for at least three (3) days or requires medical treatment, regardless of the period of incapacity.** If the injury proves fatal, the report must be filed within forty-eight (48) hours. If not fatal, the report shall be made within ten (10) days of the injury.

An injured employee shall have the freedom to choose medical treatment initially. The employee's first visit to any facility under contract or agreement with the employer or insurer to provide priority care **shall not be considered** the employee's initial choice.

For more information about Workers' Compensation procedures and benefits, call the Education Unit at (401) 462-8100 and press option #1 or TDD (401) 462-8006. If you suspect fraud, contact the Fraud Prevention Unit at (401) 462-8100 and press option #7.

In accordance with Rhode Island General Law §28-29-13, this notice must be posted and maintained in conspicuous places where workers are employed.
Fines may be imposed for noncompliance.

DEPARTAMENTO DE TRABAJO Y ENTRENAMIENTO DEL ESTADO DE RHODE ISLAND

Esta empresa esta sujeta a las estipulaciones del

ACTA DE COMPENSACION DE TRABAJADORES

del Estado de Rhode Island

Seguro de Compensación de Trabajo

Compañía Ajustadora: Berkshire Hathaway Homestate Companies
PO Box 881716, San Francisco, CA 94188

Teléfono: 800-661-6029 Fecha Efectiva de Póliza: _____

De acuerdo con las Leyes Generales de Rhode Island §28-32-1, **las empresas tienen que reportarle** al Director de Trabajo y Entrenamiento **cada lesión personal reportada por un empleado si la lesión incapacita al empleado de ganar un sueldo completo por un mínimo de tres (3) días, o requiere tratamiento médico, sin importar el período de incapacidad.** Si la lesión es fatal, el incidente debe ser reportado dentro de cuarenta y ocho (48) horas. Si no es fatal, el incidente será reportado dentro de diez (10) días de la lesión.

Un empleado lesionado tiene la libertad de escoger al primer proveedor médico. La primera visita del empleado a cualquier centro de atención médico contratado por la empresa o la aseguradora, con la intención de facilitar atencíon inmediata, **no será considerado** el primer proveedor médico.

Para más información referente a la compensación para trabajadores a causa de accidentes de trabajo, procedimientos y beneficios, llame a la Unidad Educacional al (401) 462-8100 y apriete la opción #1 o TDD (401) 462-8006. Si usted sospecha de fraude, póngase en contacto con la Unidad de Prevención de Fraude al (401) 462-8100 y apriete la opción #7.

De acuerdo con las Leyes Generales de Rhode Island §28-29-13, este aviso debe ser colocado y mantenido en lugares visibles para los trabajadores. Las empresas que no cumplan con este requerimiento pueden ser sujetas a multas.

State of Rhode Island

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY, DISEASE OR FATALITY

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942
Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105

DWC No. _____

Insurer File No.

1. EMPLOYER LOCATION:	**2. EMPLOYER NAMED ON WC INSURANCE POLICY:** ☐ **SAME AS BLOCK 1**
FEIN	FEIN
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone Ext. Type of Business	Phone Ext.
RI Unemployment Ins. No. NAICS	WC Policy Number

3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.

5. EMPLOYEE INFORMATION:		**6. MEDICAL INFORMATION:**
SSN ☐ Male ☐ Female		Treatment Facility
Name		Address
Address		City, State, Zip
City, State, Zip		Phone Ext.
Phone	Date of Birth	**7. WITNESS INFORMATION:**
Occupation	Date Hired	Name Phone
State of Hire	Preferred Language of Employee: O English O Spanish O Portuguese O Other:	

8. INJURY INFORMATION:	What was person doing when injured?
Injury Date	
Time injury occurred ☐ AM ☐ PM	
Time employee began work ☐ AM ☐ PM	
1. First full day lost from work ☐ NONE LOST	
2. Date returned to work (if appropriate)	List injured body parts and nature of injury:(ex: Broken left finger, lower back strain)
3. Date employer notified of injury	
If fatal - **REPORT WITHIN 48 HOURS** - Date of death	

Place where injury/illness occurred: ☐ At employer location listed in Block 1 **OR** Complete address where accident occurred:

Was this injury previously an incident-only with no medical treatment and no time lost? ☐ Yes ☐ No

If Yes, date employer first notified of medical treatment or time lost

Category(ies) of injury or illness: O Injury O Illness O Occupational Disease O Repetitive Trauma O Occupational Hearing Loss O Unknown

Print Name of Report Preparer	Date Prepared	Phone & Extension
Print Name of Employer Contact Person OR ☐ Same as above		Phone & Extension

DWC:	County	Time A	Time W	OCC	Nature	Part	Source	Type	

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY OR DISEASE (DWC-01)

By law, the employer must complete a First Report of Injury for an employee for any work-related injury, if that injury requires any medical treatment or if the employee loses full wages for at least three (3) days.
The employer must also report any work-related death.

General Instructions:

- Clearly print or type information into all of the areas of the First Report. INCOMPLETE FORMS MAY BE REJECTED.
- The First Report Form is to be completed by the employer.
- The First Report must be filed with Department of Labor and Training (DLT) within 10 days of knowledge of the injury OR within 48 hours of death. If you do not send in the First Report on time or if it is incomplete, you may be subject to a $250 fine.
- Submit the original to Department of Labor and Training to the address on the form. Submit a copy to the Claim Administrator. The employer should keep a copy.
- DO NOT ATTACH MEDICAL REPORTS to the DLT form.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check this box if you are sending in an amended form.

1. Employer Location:
- *FEIN:* Employer's Federal Employer Identification Number.
- *Name:* The name of the business by which the employee was employed at the time of the injury.
- *Address (including city, state, zip):* Employer's mailing address.
- *Phone/Ext:* Phone number of the employer's facility. Include an extension if appropriate.
- *Type of Business:* Briefly describe the employer's purpose. (Ex. Restaurant; Jewelry Manufacturing; etc.)
- *RI Unemployment Ins. No.:* This number (ERN – Employer Record Number) is assigned to employers by the Rhode Island Division of Taxation. Employers use this number on the Quarterly Tax and Wage Report form TX-17 for RI Unemployment Insurance and Temporary Disability Insurance taxes. The Division of Worker's Compensation will use this number for employer identification purposes only.
- *NAICS:* North American Industry Classification System, established by the US Census Bureau to provide common industry classifications based on the type of business. Visit www.census.gov and click on NAICS to locate the industry code. If this code is not available, be sure to complete 'Type of business' on the form.

2. Employer Named on WC Insurance Policy: If this information is the same as the information in Block 1, check the 'Same' box, complete the WC Policy Number, and move onto Block 3. If different, proceed below.
- *FEIN:* Federal Employer Identification Number of the employer listed on the WC Insurance Policy.
- *Name:* Insured named on the policy or the financially responsible self-insured employer, as certified by DLT.
- *Address (including city, state, zip):* Mailing address of the employer named on the WC Insurance Policy.
- *Phone/Ext:* Phone number of the named employer's facility. Include extension if appropriate.
- *WC Policy Number:* Number assigned to the WC contract or policy for that employer.

3. Insurance company named on WC Policy:
- *FEIN:* WC insurance company's Federal Employer Identification Number.
- *Name:* Name of the licensed worker's compensation insurance carrier listed on the insurance policy, not the insurance agent or insurance group. List 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Address (including city, state, zip):* Mailing address of the WC insurance carrier named on the WC Insurance Policy.
- *Phone/Ext:* Phone number of the named WC insurance carrier. Include extension if appropriate.

4. Claim Administrator: Identify the entity who will handle the claim, the insurer or a third party administrator. If this information is the same as the insurer information in Block 3, check the 'Same' box, and move to Block 5. If different, proceed below.
- *FEIN:* Federal Employer Identification Number of the company administering the claim.
- *Name:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Address (including city, state, zip):* Mailing address of the claim administrator.
- *Phone/Ext:* Phone number of the claim administrator. Include extension if appropriate.

5. Employee:

- *SSN:* Employee's Social Security Number.
- *Male/Female:* Check one.
- *Name:* Employee's full name as shown on social security card.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.
- *Date of Birth:* Date the employee was born.
- *Occupation:* Primary occupation of the employee at the time of the accident.
- *Date Hired:* Date the employee began his or her employment with the employer.
- *State of Hire:* State in which the employee was actually hired.
- *Preferred Language of Employee:* Primary language spoken or understood by the employee.

6. Medical Information:

- *Treatment Facility:* Name of the facility where employee received treatment for injury or illness.
- *Address (including city, state, zip):* Treatment facility address.
- *Phone/Ext:* Phone number of the treatment facility. Include extension if appropriate.

7. Witness Information:

- *Name:* Name of person or persons who witnessed injury.
- *Phone:* Phone number(s) of witness(es)

8. Injury Information:

- *Injury Date:* Date that the accident happened.
- *Time injury occurred:* Time that the injury happened.
- *Time employee began work:* Time that the employee began work on the day the injury happened.
- *First full day lost from work:* First full day that the employee lost from work (include scheduled days off, weekends and holidays). This is referred to as the Incapacity Date throughout the claim. Check *NONE LOST* if the employee lost no time due to the injury.
- *Date returned to work (if appropriate):* If employee has returned to work, enter the date.
- *Date employer notified of injury:* Date that the injury was reported to a representative of the employer.
- *If fatal, REPORT WITHIN 48 HOURS – Date of Death:* If employee died, enter the date of death.
- *What was person doing when injured?:* Describe how the accident happened. List any objects that caused the injury.
- *List injured body parts and nature of injury:* Description of what body part or parts were injured and what type of injury it is. (EX. Heat burn to right index finger and right middle finger, fractured left ankle)
- *Place where injury/illness occurred:* Check this box if the injury happened at the address of the employer listed in Block 1 OR enter the complete address (including city and state) where injury actually took place.
- *Was this injury previously an incident-only with no medical treatment and no time lost?* Check *No* if that is the appropriate answer. Checking *Yes* refers to injuries which were originally not reportable to the State—meaning that the employee lost no time or received no medical treatment for the injury (incident only). If the injury later becomes reportable because the employee now has lost full wages for at least three (3) days or received any medical treatment due to the work-related injury, then check *Yes*.
- *If Yes, date employer first notified of medical treatment or time lost:* If *Yes* was checked on the previous question, enter appropriate date.
- *Category(ies) of injury or illness:* Check the appropriate item(s).
- *Print Name of Report Preparer/Date Prepared/Phone & Extension:* Clearly enter the name of the person who filled out the form, the date that the form was prepared, and the complete phone number of the preparer.
- *Print Name of Employer Contact Person OR Same as above /Phone & Extension:* Clearly enter the name and complete phone number of the employer contact person OR check the SAME box if the employer contact person also prepared the report.

Employee's Certificate of Dependency Status

☐ Check if this is a corrected report

State of Rhode Island
Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100

Claim Administrator File Number:

1. Employee information:		2. Claim information:	
SSN:	XXX - XX -	Employer name	
Name		Claim Administrator	
Address		Address	
City, St, Zip		City, St, Zip	
Phone		Injury Date	
Date of Birth		Incapacity Date	

Employee: complete this form and return it to the Claim Administrator.
This information is needed to calculate your compensation rate.

3. Marital Status At the time of the injury the employee was ☐ Single ☐ Married

☐ Spouse works ☐ Spouse does not work Spouse's name

4. Number of Exemptions ☐

Enter the maximum number of personal exemptions you are allowed to claim for workers' compensation purposes. Include yourself, your spouse, your dependents, and any other exemptions.

5. Dependents

A dependent for workers' compensation includes children you support who are:

- Under age 18, or age 18 to 23 and a full time student
- Mentally or physically incapacitated from earning at any age

Dependent's Name	Date of Birth	Relationship	Full time student?	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

Employee's Signature Date

DWC-04 (4/19)

FULL-TIME/PART-TIME WAGE STATEMENTS
(DWC-03F/DWC-03P)

General Instructions:

- Full-time: Hired for 20 hours or more per week. (13 weeks of wages)
- Part-time: Hired for less than 20 hours per week. (26 weeks of wages)
- Completed by: Employer.
- Time Frame: No set time frame. However, the wage statement should be completed as soon as the employee has been out of work for four consecutive days due to his or her work-related injury.
- Distribution: Original from employer to claim administrator. Claim administrator must attach to appropriate documentation when filing with DLT.
- Attachments: None.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Hired for:* Number of hours that the employee was hired to work per week. Check box if hours are not regularly scheduled but approximated.
- *Are these supplemental wages? Yes/No:* Check No if the wages are from the employer where the employee was injured. Check Yes if the employee has more than one employer and the wage statement is from the employer where the injury did not occur.
- *If Yes, supplemental employer name:* Name of the supplemental employer.
- *Maximum no. of exemptions/Single or Married:* Total exemptions the employee is able to claim; **not** necessarily what is on the employee's W-4 form. Check appropriate marital status.

2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).
- *Hire Date:* Date the employee began his or her employment with the employer.

3. Employed Less Than 2 Weeks: Use this section **only** if the employee was employed for less than two full weeks.

- *List agreed upon hourly wage:* Hourly rate of pay agreed to between employer and employee.
- *Number of hrs. per week for full-time (part-time) employees:* Enter number of hours full-time (part-time) employees are generally scheduled for the employer.
- *Multiply #1 by #2:* Multiply the hourly rate by the number of scheduled hours for the average weekly wage (AWW).
- *OR Give average weekly for same or similar employment:* If no hourly rate was agreed upon, put the AWW for the same or similar job.

4. Employed More Than 2 Weeks: Follow the instructions.

- *LIST 13 (26)* ***CONSECUTIVE*** *WEEKS:*
  - *Week Ending Date:* Ending date of the weekly earnings period.
  - *No. of standard hours worked:* Number of hours worked for the week listed.
  - *Gross Wages (No Overtime):* Gross wage for the week listed. Include Sunday and Holiday pay. Do not include overtime.
  - *Total number usable weeks:* Total the number of weeks listed that have wages entered.
  - *Total Earnings:* Total of wages entered.
- *BONUS AND OVERTIME CALCULATION:*
  - *Number of weeks employed(up to 52):* Number of weeks the employee had been employed prior incapacity date. If more than 52, enter 52.
  - *Total BONUS amount paid in past 52 weeks:* Total of all bonus monies paid to employee in 52 weeks prior to incapacity date.
  - *Divide Block 2 by Block 1 for average bonus:* Divide total bonus monies by number of weeks employed (up to 52).
  - *Total OVERTIME amount paid in past 52 weeks:* Total of all overtime monies paid to employee in 52 weeks prior to incapacity date.
  - *Divide Block 4 by Block 1 for average overtime:* Divide total overtime monies by number of weeks employed (up to 52).
- *CALCULATION OF AVERAGE WEEKLY WAGE(AWW):*
  - *1. Total earnings from 13 (26) weeks:* Enter the total earnings from the left side of the wage statement.
  - *2. Total number usable weeks:* Enter the total the number of usable weeks from the left side of the wage statement.
  - *3. Divide total earnings by number of usable weeks:* Enter calculation.
  - *4. Average bonus:* Enter the calculation from Block 3 above.
  - *5. Add 3 and 4 for AWW excluding Overtime:* Enter calculation.
  - *6. Average overtime:* Enter calculation from Block 5 above.
  - *7. Add 5 and 6 for Total Average Weekly Wage:* Enter calculation.
- *Print Preparer Name/Date:* Clearly enter the name of the person who filled out the form and the date that the form was prepared.
- *Print Adjuster Name/Date:* Clearly enter the name of the adjuster who checked the calculations on the form and the date signed.
- More wage calculation tips.

WAGE CALCULATION TIPS

When a wage statement arrives at DLT, Division of Workers' Compensation from the claim administrator, each one is calculated separately to ensure accuracy. If incorrect, a letter is sent to the claim administrator who must contact the employer to get the corrections; the corrections go back to the claim administrator and again are sent to DLT. To avoid this lengthy process and promote prompt payment to the injured worker, please review these tips.

- Be ready to prepare a wage statement as soon as the employee has been out of work for 4 calendar days. A delay in completing the wage statement can lead to problems with a claim.
- Know which wage statement to use and have it available. Do not wait for the claim administrator to send you the wage statement. Use the…
  - Full-time for a person hired for 20 hours or more per week.
  - Part-time for a person hired for less than 20 hours per week.
  - Seasonal for a person hired to work for 16 weeks or less.
- The same rules for completion apply to the full-time and the part-time wage statements. The seasonal wage statement is different (see Seasonal Wage Statement instructions).
- Complete all areas of the wage statement – you may not realize the many uses for a single number or date.
- Be sure to include the number of hours per week the employee was hired to work.
- Injury date and Incapacity date are very important. Incapacity date is the first full calendar day that the employee was out of work due to their injury.
- Hire date must be provided – it is used for several reasons.
- Use the correct section depending on whether the employee worked less or more than 2 weeks.
- USE CONSECUTIVE WEEKS ALWAYS – whether the employee earned money or not.
- COMPLETE ALL COLUMNS. Skipping weeks and incomplete columns are two troublesome errors.
- Weeks go backwards from the incapacity date – not the injury date.
  - EX: Injury date: 5/10/2003; Incapacity date: 8/13/2003. Wages would go from 8/13/2003 back 13 or 26 weeks (depending on the statement used).
- In this same example, you would not use the week of incapacity unless it was a full week worked.
  - EX: If the employee was hired for 40 hours and worked 40 hours during the week of the incapacity, that week could be used on the wage statement. If the employee worked less than the 40 hours, you would not list the week, but would start with the week previous (no matter how many hours worked that week).
  - The same rule applies for the week of hire if it appears on the wage statement, only use it if a full week was worked.
- No overtime or bonus monies or hours should be listed in the 13 (26) weeks. They are calculated separately on the right side of the form.
- Since overtime is generally paid after 40 hours, if an employee worked more than 40 hours without earning any overtime, use the total hours and put *NO OT* next to the hours. This will let others know that, although more than 40 hours are listed, no overtime is included.
- Common examples of what <u>will be</u> included in the 13 (26) weeks:
  - Commissions
  - Holiday Pay - except during an unpaid plant shutdown week
  - Shift Differential
  - Sick Pay or put "UNPAID"
  - Sunday Pay
  - Vacation Pay or put "UNPAID"
- Sick and vacation pay are included, but if the employee did not receive payment for any of those weeks which might appear, put the word "UNPAID" in the Gross Wages column instead of a zero. This will let others know that it was, in fact, unpaid. Otherwise, one might think that the preparer did not know that those monies are used.
- When determining *Total number of usable weeks*, add up only the weeks where wages are listed. Zero weeks are not used in the mathematical computation when getting the average weekly wage (AWW).
- Although only 13 or 26 weeks of wages are used, you must go back 52 weeks from the incapacity date to collect bonus and overtime monies.
- In *Block 1*of the Bonus and Overtime Calculation, remember to only use the number of weeks employed up to 52. If the employee worked for less than 52, list the actual number – if greater than 52, list 52.
- Following the step-by step instructions on the remainder on the wage statement should result in an accurate computation of the AWW.
- Many unique circumstances may develop when completing a wage statement, contact your WC claim administrator or call a DLT Claims Analyst at (401) 462-8120 for help.
- All wage statements are available in an Excel format, which will do the final calculations for you!

State of Rhode Island
FULL-TIME WAGE STATEMENT (Hired for 20 hours or more per week)

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Hired for_____ hours each week (☐ Approximate)
Are these supplemental wages? ☐ Yes ☐ No
If yes, supplemental employer name: _____
Maximum no. of exemptions_____ ☐ Single ☐ Married

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____
Hire date _____

3. EMPLOYED LESS THAN 2 WEEKS:

If Yes:	**OR:**
1. List agreed upon hourly wage _____	
2. Number of hrs. per week for full-time employees _____	Give average weekly for same or similar employment: _____
3. Multiply #1 by #2 for average weekly wage	

4. EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS.** Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 13 **CONSECUTIVE** WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
Total number usable weeks:		Total earnings:	

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
Total **BONUS amount paid** in past **52 weeks**	Block 2
Divide Block 2 by Block 1 for average bonus	Block 3
Total **OVERTIME amount paid** in past **52 weeks**	Block 4
Divide Block 4 by Block 1 for average overtime	Block 5

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):

1. Total earnings from 13 weeks	
2. Total number usable weeks	
3. Divide total earnings by number of usable weeks	
4. Average bonus (Block 3 in BONUS AND OT)	
5. Add 3 and 4 for AWW excluding Overtime	$
6. Average overtime (Block 5 in BONUS AND OT)	
7. Add 5 and 6 for Total Average Weekly Wage	$

Print Preparer Name: Date:	Print Adjuster Name: Date:

State of Rhode Island
PART-TIME WAGE STATEMENT (Hired for less than 20 hours per week)

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____

Name _____

Hired for_____ hours each week (☐ Approximate)

Are these supplemental wages? ☐ Yes ☐ No

If yes, name of supplemental employer _____

Maximum no. of exemptions_____ ☐ Single ☐ Married

2. CLAIM INFORMATION:

Employer _____

Insurance Co. _____

Claim Administrator _____

Injury date _____

Incapacity date _____

Hire date _____

3. EMPLOYED LESS THAN 2 WEEKS:

If Yes:	**OR:**
1. List agreed upon hourly wage _____	
2. Number of hrs. per week for part-time employees _____	Give average weekly for same or similar employment: _____
3. Multiply #1 by #2 for average weekly wage	

4. EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS**. Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 26 **CONSECUTIVE** WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
Total number usable weeks:		Total earnings:	

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
Total **BONUS amount paid** in past **52 weeks**	Block 2
Divide Block 2 by Block 1 for average bonus	Block 3
Total **OVERTIME amount paid** in past **52 weeks**	Block 4
Divide Block 4 by Block 1 for average overtime	Block 5

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):

1. Total earnings from 26 weeks	
2. Total number usable weeks	
3. Divide total earnings by number of usable weeks	
4. Average bonus (Block 3 in BONUS AND OT)	
5. Add 3 and 4 for AWW excluding Overtime	$
6. Average overtime (Block 5 in BONUS AND OT)	
7. Add 5 and 6 for Total Average Weekly Wage	$

Print Preparer Name:	Date:	Print Adjuster Name:	Date:

State of Rhode Island
SEASONAL WAGE STATEMENT (Hired for 16 weeks or less)

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____

Name _____

Maximum no. of exemptions_____ ☐ Single ☐ Married

Wages for how many employers are listed below? _____

2. CLAIM INFORMATION:

Employer _____

Insurance Co. _____

Claim Administrator _____

Injury date _____

Incapacity date _____

Hire date _____

List 52 CONSECUTIVE weeks of gross wages for *any* employment held by this person within the 52 week period.

Week Number	Week Ending Date	Gross Wages	Week Number	Week Ending Date	Gross Wages
1			27		
2			28		
3			29		
4			30		
5			31		
6			32		
7			33		
8			34		
9			35		
10			36		
11			37		
12			38		
13			39		
14			40		
15			41		
16			42		
17			43		
18			44		
19			45		
20			46		
21			47		
22			48		
23			49		
24			50		
25			51		
26			52		
		Total earnings:			Total earnings:

1. Combine total earnings listed _____
2. Divide total earnings by 52 ÷ 52
3. Average Weekly Wage $ _____

Print Preparer Name: Date:	Print Adjuster Name: Date:

For instructions visit our web site: www.dlt.ri.gov/wc

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.