



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Division

Workers Compensation State Claim Kit

District of Columbia



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P.O. Box 881236 San Francisco, CA 94188
(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 contact methods listed to the right.

District of Columbia state law recommends employers report every industrial injury or occupational disease claim to their workers compensation carrier as soon as possible or within five 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

Contact Information

Online

[bhhc.com/workers-compensation/
claim-center/report-a-claim.aspx](http://bhhc.com/workers-compensation/claim-center/report-a-claim.aspx)

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com





Workers' Compensation Posting Requirements

FORM DCWC-1 – NOTICE of Compliance Poster

- Post in one or more conspicuous places at all business locations
- Must contain the insurance carrier's name and contact information and the policy expiration date

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

- Name of your designated workers' compensation insurer
- Policy expiration date
- Your company name and federal employer identification number (FEIN)
- The name of the individual completing the form

For your convenience, our other contact information has been entered on the form DCWC-1.

(District of Columbia § 32-1536)

OFFICE OF WORKERS' COMPENSATION

4058 MINNESOTA AVENUE, N.E. • WASHINGTON, DC 20019 • (202) 671-1000 • (202) 671-1929 (Fax)

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law to report promptly to your employer and the Office of Workers' Compensation an occupational injury or disease, even if you deem it to be minor. Form No. 7 DCWC, Notice of Accidental Injury or Occupational Disease, to be obtained from the employer or the Office of Workers' Compensation, must be used for that purpose. After you have completed and signed the form, mail it to the Office of Workers' Compensation at the above address, and to your employer.
2. You are entitled, if required, to the services of a physician or hospital of your choice and lost wages. Call (202) 671-1000 or visit <http://does.dc.gov> for information.
3. You may not sue your employer as a result of a work-related injury or disease by reason of your exclusive remedy under the Workers' Compensation Law.
4. In order to preserve your right to benefits under the DC Workers' Compensation Law, you must file a written claim on Form No. 7A DCWC, Employee's Claim Application, within one (1) year after your injury, or within one (1) year after the last payment of benefits.
5. If you need information regarding your rights and obligations prescribed by law, you may call your employer first. If you require further information, you may call the Office of Workers' Compensation at (202) 671-1000 or visit <http://does.dc.gov>
6. The law gives you the right to legal representation if you so choose.

TO EMPLOYERS

1. You are required to have Workers' Compensation insurance coverage if you have one (1) or more employees.
2. You are required to display this poster at each worksite so that it will be of the greatest possible benefit to your employees.
3. You must file an Employer's First Report of Injury or Occupational Disease, Form No. 8 DCWC, with the Office of Workers' Compensation, send a copy to the nearest claim office of your insurer, for all occupational injuries or disease, as soon as possible, but no later than ten (10) working days after the date of knowledge thereof.
4. Your employee must file Form No. 7 DCWC, Employee's Notice of Accidental Injury or Occupational Disease. Please provide your employee with Form No. 7 DCWC and direct them to complete it and return it to you and the Office of Workers' Compensation. Once you have received notice from the employee, you are required to send the employee a notice of his/her rights and obligations by certified mail, return receipt requested.
5. You are required to report to the Office of Workers' Compensation, and your insurer, any disability of more than three (3) days which was not previously reported, as soon as possible, but no later than ten (10) working days after the date of knowledge thereof.
6. You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee.
7. You are required to obtain from the insurer identified below a supply of all required Workers' Compensation Forms, or you may download the forms and notice mentioned above at our website <http://does.dc.gov>.

NOTICE: Violation of the various provisions of the Workers' Compensation law provides for civil penalties.

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations.

NAME OF INSURANCE COMPANY

Address: _____

Phone: _____

NAME OF EMPLOYER

Address _____ Phone: _____

Employer Representative: _____

Employer ID Number (if number unknown, employer to request from IRS)

**THIS NOTICE IS TO BE POSTED CONSPICUOUSLY IN
AND ABOUT THE EMPLOYER'S PLACE(S) OF BUSINESS**

OFICINA DE COMPENSACIÓN DE TRABAJADORES

4058 MINNESOTA AVENUE, N.E. • WASHINGTON, DC 20019 • (202) 671-1000 • (202) 671-1929 (Fax)

ADVERTENCIA: Es un delito proporcionar información falsa o engañosa a un asegurador con el propósito de defraudar al asegurador o a cualquier otra persona. Las penas incluyen prisión y/o multas. Además, un asegurador puede negar beneficios de compensación si la información falsa materialmente relacionada con una reclamación fue proporcionada por el solicitante.

NOTIFICACIÓN DE CUMPLIMIENTO

PARA EMPLEADOS

1. Por ley, usted debe informar rápidamente a su empleador y a la Oficina de Compensación de Trabajadores una lesión o enfermedad laboral, incluso si considera que es menor. Para ese fin, deberá usar el Formulario N°. 7 DCWC, Notificación de lesión accidental o enfermedad laboral, que podrá obtener del empleador o de la Oficina de Compensación de Trabajadores. Una vez completado y firmado el formulario, envíelo por correo a la Oficina de Compensación de Trabajadores a la dirección antes mencionada y a su empleador.
2. Usted tiene derecho, si es necesario, a los servicios de un médico u hospital de su elección y a los salarios perdidos. Llame al (202) 671-1000 o visite <http://does.dc.gov> para obtener información.
3. Usted no debe demandar a su empleador como resultado de una lesión o enfermedad relacionada con el trabajo debido a que la Ley de Compensación de Trabajadores es su único recurso.
4. Con el fin de preservar su derecho a los beneficios en el marco de la Ley de Compensación de Trabajadores del D.C., usted debe completar una reclamación por escrito en el Formulario N°. 7A DCWC, Solicitud de reclamación del empleado, en el término de un (1) año después de su lesión, o en el término de un (1) año después del último pago de beneficios.
5. Si necesita información sobre sus derechos y obligaciones prescritas por ley, puede llamar primero a su empleador. Si necesita más información, puede llamar a la Oficina de Compensación de Trabajadores al (202) 671-1000 o visitar <http://does.dc.gov>
6. La ley le concede el derecho a representación legal si elige tenerla.

PARA EMPLEADORES

1. Es obligatorio tener cobertura de seguro de Compensación de trabajadores si tiene uno (1) o más empleados.
2. Debe exhibir este cartel en cada lugar de trabajo para que sea del mayor beneficio posible para sus empleados.
3. Deberá presentar un Formulario N°. 8 DCWC, Primer informe del empleador sobre lesión o enfermedad laboral, ante la Oficina de Compensación de Trabajadores, enviar una copia a la oficina de reclamaciones de su aseguradora más cercana, por cualquier lesión o enfermedad laboral, lo antes posible, pero a más tardar diez (10) días hábiles después de la fecha en que tenga conocimiento del hecho.
4. Su empleado debe presentar el Formulario N°. 7 DCWC, Notificación del empleado de lesión accidental o enfermedad laboral. Por favor provea a su empleado con el Formulario N°. 7 DCWC e indíquele que lo complete y se lo entregue a usted y a la Oficina de Compensación de Trabajadores. Una vez que haya recibido la notificación del empleado, deberá enviar al empleado una notificación de sus derechos y obligaciones por correo certificado, solicitando el acuse de recibo.
5. Deberá informar a la Oficina de Compensación de Trabajadores y a su aseguradora cualquier discapacidad de más de tres (3) días que no haya sido informada previamente, tan pronto como sea posible, pero a más tardar diez (10) días hábiles después de la fecha en que tenga conocimiento del hecho.
6. Deberá proporcionar o hacer que se proporcionen servicios médicos y hospitalarios razonables, otros cuidados curativos o rehabilitación vocacional y diversos tipos de compensación por discapacidad al empleado lesionado o discapacitado.
7. Deberá obtener de la aseguradora identificada a continuación un suministro de todos los Formularios de compensación de trabajadores requeridos, o puede descargar los formularios y la notificación mencionados anteriormente en nuestro sitio web <http://does.dc.gov>.

NOTIFICACIÓN: La violación de las diversas disposiciones de la ley de Compensación de Trabajadores prevé sanciones civiles.

El empleador abajo firmante notifica por la presente el cumplimiento de todas las disposiciones de la Ley de Compensación de Trabajadores y las Normas Administrativas.

NOMBRE DE LA EMPRESA ASEGURADORA

Dirección: _____

Teléfono: _____

NOMBRE DEL EMPLEADOR

Dirección: _____ Teléfono: _____

Representante del Empleador: _____

Número de identificación del empleador (si el número es desconocido, el empleador debe solicitarlo al IRS)

**ESTE AVISO SE PUBLICARÁ NOTORIAMENTE EN
Y SOBRE LOS LUGARES DE NEGOCIO DEL EMPLEADOR**



**District of Columbia Government
Office of Workers' Compensation
4058 Minnesota Avenue, N.E.
Washington, DC 20019
(202) 671-1000**

Warning: *It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.*

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

| Employee Name and Address: | Employer Name and Address: | Insurer Name and Address: |
|----------------------------|----------------------------|---------------------------|
| | | |

IMPORTANT: Every employer shall file this report as soon as possible after knowledge of an occupational injury or disease to one of its employees, but no later than ten (10) days thereafter. Failure to file this form shall be subject to civil penalty not to exceed \$1,000.

Date and time of Injury: _____ am/pm? Day of the week? _____

Normal starting time: _____ am/pm? If employee back to work, give date and time: _____ am/pm?

At what wage? _____ If fatal, give date of death _____ (file supplement report)

Date/time disability began? _____ am/pm? Was the injured paid in full for this day? _____

Was the injured given Form No. 7 DCWC? Yes No Foreman/Supervisor _____

When did you or the foreman first learn of the injury? _____

Male Female DOB: _____ Employee's Telephone No.: _____

Occupation when injured? _____ Was this his/her regular occupation? _____

(Department or branch regularly employed): _____

Was the injured hired in DC? _____ How long employed by you? _____

Piece or time worker? _____ Hourly wage? _____ Hours worked/day? _____

Daily wages: _____ Days worked per week: _____ Average weekly earnings: _____

If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week, or month: _____

Employer's principal business function in DC: _____

Employer's Telephone No.: _____ Insurance Policy No.: _____

Location of plant or place where accident occurred: _____

On employer's premises? _____

Describe fully the events which resulted in injury or disease, what the employee was doing when injured and type of injury including parts of the body affected: _____

Name of Witnesses: _____

Nature and location of injury (Describe fully): _____

Attending Physician and Address (If Hospital Involved – Indicate): _____

Name (Please Print or Type)

Name of Person Completing Form

Signature

Official Position

**DISTRICT OF COLUMBIA GOVERNMENT
 OFFICE OF WORKERS' COMPENSATION
 4058 MINNESOTA AVENUE, N.E.
 WASHINGTON, D.C. 20019**

(202) 671-1000

 Date of This Report

 Employee Social Security No.

 Employer Identification No.

 Insurer No.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**EMPLOYEE'S
 NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE**

| Employee Name and Address: | Employer Name and Address: | Insurer Name and Address: |
|-------------------------------|-------------------------------|------------------------------|
| | | |

NOTICE TO EMPLOYEE

YOU MUST FILE THIS REPORT WITHIN 30 DAYS AFTER YOU BECOME AWARE OF AN ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE AND ITS RELATIONSHIP TO YOUR JOB. PART 1 SHOULD BE MAILED TO THE D.C. GOVERNMENT, OFFICE OF WORKERS' COMPENSATION AT THE ABOVE ADDRESS. PART 2 SHOULD BE MAILED OR DELIVERED TO YOUR EMPLOYER, AND PART 3 RETAINED FOR YOUR RECORDS. IN ORDER TO PRESERVE YOUR RIGHTS UNDER THE LAW, YOU MUST FILE A CLAIM FORM NO. 7a DCWC, A COPY OF WHICH CAN BE OBTAINED FROM YOUR EMPLOYER OR THE OFFICE OF WORKERS' COMPENSATION.

Date and Time of Injury: _____ am/pm?

Place where injury occurred: _____

Description of Injury: _____

THIS IS TO NOTIFY YOU _____
 (Employer)

THAT I _____ while in your
 employ, sustained an injury or contracted an occupational disease as described above, caused by:

Treating Physician's Name and Address: _____

Employee's Rights and Obligations

District of Columbia Workers Compensation Law

- You are required by law to promptly report your injury by filing DCWC Form 7, employee's Notice of Accidental Injury or Occupational Disease, with your employer and the Office of Workers' Compensation within 30 days of the date of injury or the date you have knowledge that the injury is related to your job.
- In order to preserve your right to workers' compensation benefits under the law, you must file a written claim on DCWC Form 7a, Employee's Claim Application, within 1 year after your injury, or within 1 year after the last payment of benefits. Benefits include indemnity payments for lost wages, medical services and treatment, and vocational rehabilitation.
- Failure to properly file the Notice of Accidental Injury or Occupational Disease, DCWC Form 7 or the Employee's Claim Application DCWC, Form 7a, may bar your right to future compensation. Copies of these forms and other pertinent information are available on the Department of Employment Services, Office of Workers' Compensation's web site. The web site address is listed below.
- You may not sue your employer as a result of a work-related injury or disease, the Workers' Compensation law is your exclusive remedy.
- You have the right to choose a treating physician. Once you choose a treating physician you may not change physicians unless you get approval from your employer's insurance company or the Office of Worker's Compensation. The medical treatment includes medical services, supplies, prosthetic devices, and prescriptions. The medical services include treatment by a dentist, osteopath, podiatrist and chiropractor.
- Compensation is not paid for the first 3 days of disability unless the disability exceeds 14 days. Compensation is paid at the rate of 66^{2/3}% of your average weekly wage. Unless your employer controverts your right to compensation within 14 days after he has knowledge of the injury, the 1st installment of compensation becomes due on the 14th day and must be paid within 14 days after it is due.
- You have the right to request an informal conference or a formal hearing on disputes arising on matters regarding your claim and you have the right to be represented by an attorney or other representative if you so desire.
- You may be entitled to vocational rehabilitation services if you are unable to return to the job you had prior to the injury.
- For injuries occurring on or after 4/16/99, temporary partial or permanent partial or permanent partial disability benefits will be limited to 500 weeks. Within 60 days of the expiration date, the claimant may petition for an extension of benefits up to 167 weeks beyond the 500-week cap.
- Your employer is required to advise you of your rights and obligations under the Workers' Compensation law and if you need further information, you may call the Office of Workers' Compensation on (202) 671-1000 or fax (202) 671-1929. The web address is <http://does.dc.gov>



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.



- 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.

- 6 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.

Signature/Firma

Date/Fecha





**District of Columbia Government
Office of Workers' Compensation
4058 Minnesota Avenue, N.E.
Washington, DC 20019
(202) 671-1000**

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Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

Wage Schedule

| Employee Name and Address: | Employer Name and Address: | Insurer Name and Address: |
|----------------------------|----------------------------|---------------------------|
| | | |

Employer must forward to insurer copies of this schedule no later than employee's tenth (10th) day of loss of wages.

This wage schedule is for 26 weeks prior to date of injury, for wages fixed by week, month, or year, and must be filed with Office of Workers' Compensation by insurer, together with Form No. 9 DCWC, except when maximum compensation is paid. (Wages: In addition to money payments, wages mean reasonable value of board, rent, and housing that were received from employer as well as gratuities declared for tax purposes.)

Date of Hire: _____ Date of Injury: _____

Hourly Wages: _____ Average Weekly Earnings: _____

| Week Ending | 1 Gross Earnings | 2 Other Advantages <small>(see wages definition above)</small> | Week Ending | 3 Gross Earnings | 4 Other Advantages <small>(see wages definition above)</small> |
|-------------|---------------------|--|-------------|---------------------|--|
| 1 | | | 14 | | |
| 2 | | | 15 | | |
| 3 | | | 16 | | |
| 4 | | | 17 | | |
| 5 | | | 18 | | |
| 6 | | | 19 | | |
| 7 | | | 20 | | |
| 8 | | | 21 | | |
| 9 | | | 22 | | |
| 10 | | | 23 | | |
| 11 | | | 24 | | |
| 12 | | | 25 | | |
| 13 | | | 26 | | |

Total of columns 1,2,3 and 4 _____

If wages fixed by week, month, or year, state amount _____ **per** _____

Representatives Name

Signature



THE GOVERNMENT OF THE DISTRICT OF COLUMBIA
 DEPARTMENT OF EMPLOYMENT SERVICES
 OFFICE OF WORKERS' COMPENSATION
 4058 Minnesota, Avenue, N.E.
 WASHINGTON, DC 20019
 (202) 671-1000

Date of This Report: _____

Employee Social Security No. _____

Employer Identification No. _____

Insurer No. _____

MEDICAL REPORT

IMPORTANT – THIS REPORT SHALL BE FILED IMMEDIATELY. FAILURE TO COMPLY WITHIN TWENTY (20) DAYS CAN RESULT IN UNNECESSARY DELAY IN PAYMENT OF BENEFITS TO THE INJURED WORKER AND PAYMENT FOR SERVICES RENDERED. (sec. 8, d)

EMPLOYEE _____
 (Name) (Age) (Sex) (Soc. Sec. No.)

EMPLOYER _____
 (Name) (Address) (Identification No.)

CARRIER _____
 (Name) (Address) (Policy No.)

PHYSICIAN _____
 (Name) (Address) (Specialty) (Tel. No.)

FOR USE OF PHYSICIAN

| | |
|-------------------|--|
| Accident | 1. Date of accident: _____ 2. Time : _____ AM/PM 3. Date disability began: _____ 4. State where and how the accident occurred as described by patient: _____ _____ _____ |
| Injury | 5. Give diagnosis of injury or disease: _____ _____ _____ 6. Will the injury result in a permanent defect? _____ 7. If so, what? _____ _____ 8. Has the patient any physical impairment due to previous injury or disease? _____ If so, what? _____ _____ 9. State physical limitations, if any: _____ 10. In your opinion is the injury and disability as a result of the accident described in (4) above? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Treatment | 11. Date of your first treatment: _____ 12. Describe: _____ _____ 13. Who engaged your services? _____ 14. Were X-Rays taken? <input type="checkbox"/> Yes <input type="checkbox"/> No 15. When? _____ 16. Where? _____ 17. X-Ray diagnosis: _____ 18. Did anyone else treat the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No 19. If so, who? _____ 20. When? _____ 21. Hospital, if any? _____ 22. Admission Date: _____ 23. Discharge Date: _____ 24. If further treatment needed? <input type="checkbox"/> Yes <input type="checkbox"/> No 25. How long? _____ |
| Disability | 26. Will the patient ever be able to resume their regular occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No 27. Expected length of disability? <input type="checkbox"/> 2 weeks <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months or longer <input type="checkbox"/> Unknown 28. Patient was or will be able to resume regular work on: _____ 30. Date of death, if any? _____ |

Physician's IRS Number

Physician's Signature

Date

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 | Phone | Date(s) Admitted |
|-------------------------|-------|------------------|
| | | |
| | | |
| | | |
| | | |

Treating Physicians or Groups

| Doctor or Group Name, Address | Phone | Dates of Treatment |
|-------------------------------|-------|--------------------|
| | | |
| | | |
| | | |
| | | |

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKERS' COMPENSATION
4058 MINNESOTA AVENUE, N.E.
WASHINGTON, D.C. 20019

(202) 671-1000

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

EMPLOYEE'S CLAIM APPLICATION

| Employee Name and Address: | Employer Name and Address: | Insurer Name and Address: |
|----------------------------|----------------------------|---------------------------|
| | | |

NOTICE TO EMPLOYEE

A CLAIM FOR WORKERS' COMPENSATION BENEFITS HAS BEEN FILED WITH THIS OFFICE. YOU HAVE 14 DAYS FROM THE RECEIPT OF THIS NOTICE IF YOU HAVE NO PREVIOUS KNOWLEDGE OF INJURY OR ITS RELATIONSHIP TO EMPLOYMENT, TO BEGIN VOLUNTARY PAYMENTS OF WORKERS' COMPENSATION BENEFITS TO THE ABOVE NAMED EMPLOYEE, OR YOU MUST FILE A NOTICE OF CONTROVERSION, MEMO OF DENIAL OF BENEFITS, FORM NO. 11 DCWC WITH THIS OFFICE. FAILURE TO PAY BENEFITS, UNLESS YOU CONTROVERT THE EMPLOYEE'S RIGHT TO BENEFITS, WILL SUBJECT YOU TO PENALTIES UNDER THE ACT. YOU SHOULD CONTACT YOU INSURER IMMEDIATELY.

Date and Time of Injury: _____ am/pm? **Office Representative** _____

Place where injury occurred: _____

Description of Injury: _____

THIS IS TO NOTIFY YOU _____

That while in the employ of the above named employer I sustained a disabling injury or contracted an occupational disease as described above. The disability was caused by: _____

Treating Physician's Name and Address: _____

YOU SHOULD HAVE ALREADY FILED OR SHOULD FILE EMPLOYEE'S NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE, FORM NO. 7 DCWC.

I HAVE FILED THE CLAIM WITH THE OFFICE OF WORKERS' COMPENSATION.

Supervisor's Report of Employment Accident



Employee Name

Employer Name

Date of Accident

Time of accident

Time you began work on day of accident

Did the employee report the accident immediately?

Address of Accident

City, State

Zip

Offsite? (Y/N)

How did the injury occur? What job duties were you 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

Obstructed view

Interaction with patient or resident

Unused/unavailable PPE (gloves, hardhat, goggles, etc.)

Lack of training

Interaction with customer

Unused/unavailable sharps container

Wet/slippery floor

Chemical exposure

Unguarded or improperly guarded equipment

Poor housekeeping

Motor vehicle accident

Electrical exposure

Interaction with co-worker

Other:

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

The above form is true and correct.

Prepared by

Signature

Date Completed

Witness' Report/Statement of Employee Accident



Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)

Date of Accident

Time of accident

Time you began work on day of accident

Address of Accident

City, State

Zip

Offsite? (Y/N)

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 form is true and correct.

Witness' Signature

Date Completed

»» 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

| | | | |
|---------------------|--------------------|--------------------|---------------------|
| 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 |



\$1000 REWARD

For information leading to the arrest and conviction of any co-worker, health care professional, or the 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

*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.



\$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.

1 (800) 300-JAIL

*La recompensa máxima es de \$1,000 por convicción. En caso de que más de una persona presente informaciones sobre la misma demando fraudulenta. BerkshireHathaway 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 informacion 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 or 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.