Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division

Workers Compensation State Claim Kit

North Carolina

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

AM BEST A++ Superior

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

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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.

North Carolina 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

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

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Workers Compensation Posting Requirements

Representing Financial Strength & Integrity • Workers Compensation Division

Form 17 – NC Workers' Compensation Notice to Injured Workers and Employers

- Post in one or more conspicuous at all business locations

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

- Your designated insurance company/carrier name
- The insurance policy number
- The start and end dates for the insurance policy

(North Carolina General Statutes § 97-93(e) and North Carolina Workers' Compensation Rule 201 and 301)

FORM 17 Revised 10/2017

N.C. WORKERS' COMPENSATION NOTICE TO INJURED WORKERS AND EMPLOYERS

All employees of this business, except specifically excluded executive officers, suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier.

IF YOU HAVE A WORK-RELATED INJURY OR AN OCCUPATIONAL DISEASE

The Employee Should:

- **Report the injury or occupational disease to the Employer immediately.**
- **Give written notice to the Employer within 30 days.**
- **File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.**
- **If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website www.ic.nc.gov or by calling the Help Line.**
- **Your employer's workers' compensation insurance carrier is _____.**
- **The insurance policy number is _____.**
- **Your employer's workers' compensation insurance policy is valid from _____ until _____.**

For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.

The Employer Should:

- **Provide all necessary medical services to the Employee.**
- **Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed $2,000.00.**
- **Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.**
- **Ensure that compensation is promptly paid as required under the Workers' Compensation Act.**

For assistance with Safety Education Training contact:
Director of Safety Education at (919) 807-2602 or safety@ic.nc.gov

NORTH CAROLINA INDUSTRIAL COMMISSION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235

Website: www.ic.nc.gov

TO EMPLOYER: THIS FORM MUST BE PROMINENTLY POSTED IF YOU HAVE WORKERS' COMPENSATION INSURANCE OR QUALIFY AS SELF-INSURED. (N.C. Gen. Stat. §97-93).

AVISO DE COMPENSACIÓN LABORAL A EMPLEADORES Y EMPLEADOS LESIONADOS

Todo empleado de este negocio que sufre lesiones relacionadas al trabajo puede tener derecho a beneficios de compensación laboral por parte del empleador o el portador de seguro del empleador, excepto oficiales ejecutivos expresamente excluídos.

SI USTED TIENE UNA LESIÓN RELACIONADA CON EL TRABAJO O UNA ENFERMEDAD OCUPACIONAL

El Empleado deberá:

- **Reportar inmediatamente su lesión o enfermedad ocupacional a su empleador.**
- **Notificar por escrito al empleador dentro de treinta (30) días que ocurre la lesión o enfermedad ocupacional.**
- **Hacer inmediatamente un reclamo a la Comisión Industrial usando la Forma 18, no más tarde de (2) años de ocurrir o desarrollar su lesión o enfermedad ocupacional..**
- **Si el tratamiento médico o el pago de compensación no es prontamente suministrado, llame a la compañía de seguros/administrador o requiera una audiencia ante la Comisión Industrial usando la Forma 33 Petición que la Demanda sea Asignada a una Audiencia.**
- **Las formas de la Comisión están disponibles en la página web www.ic.nc.gov o llamando a la Línea de Ayuda.**
- **La compañía de seguros de compensación para trabajadores de su empleador es**
- **El número de la póliza de seguro es**
- **La póliza de seguro de compensación para trabajadores de su empleador es válida desde** hasta

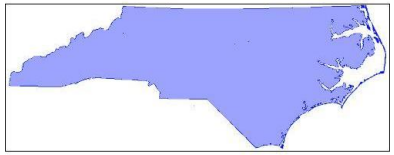
Para asistencia: Llame a la Comisión Industrial LÍNEA DE AYUDA—(800) 688-8349.

El Empleador deberá:

- **Proveer todos los servicios médicos necesarios al empleado.**
- **Reportar la lesión a la compañía de seguros/administrador y a la Comisión Industrial usando la Forma 19 Reporte de Accidente dentro de cinco (5) días, si su empleado falta más de un (1) día de trabajo o si los gastos de tratamientos médicos exceden los $2,000.00.**
- **Proveer a su empleado una copia de la Forma 19 y una copia en blanco de la Forma 18 Aviso de Accidente.**
- **Pagar puntualmente compensación al empleado de acuerdo con el Acta de Compensación Laboral.**

Para asistencia con entrenamiento de seguridad:

Director de Entrenamiento de Seguridad—(919) 807-2602 y safety@ic.nc.gov.



NORTH CAROLINA INDUSTRIAL COMMISSION
1240 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1240

Página Oficial en Español: www.ic.nc.gov

EMPLEADOR: ESTA FORMA DEBE ESTAR VISIBLEMENTE PUBLICADA SI USTED TIENE SEGURO DE COMPENSACIÓN LABORAL O SI USTED CALIFICA PARA ESTAR AUTOASEGURADO. (N.C. Gen. Stat. § 97-93).

North Carolina Industrial Commission

IC File #_____

Emp. FEIN_____

Carrier FEIN_____

Carrier File #_____

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.
This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 1235 Mail Service Center, Raleigh, NC 27699-1235 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employee's Name		Employer's Name		( ) - Telephone Number
Address		Employer's Address	City State	Zip
City	State Zip	Insurance Carrier	Policy Number	
( ) - Home Telephone	( ) - Work Telephone	Carrier's Address	City State	Zip
- - Social Security Number	☐ M ☐ F Sex / / Date of Birth	( ) - Carrier's Telephone Number	( ) - Fax Number	

Employer	1.	Give nature of employer's business
Time And Place	2.	Location of plant where injury occurred County Department State if employer's premises
	3.	Date of injury / / 4. Day of week Hour of day : ☐ A.M. ☐ P.M.
	5.	Was employee paid for entire day 6. Date disability began / /
	7.	Date you or the supervisor first knew of injury / / 8. Name of supervisor
Person Injured	9.	Occupation when injured
	10.	(a) Date employment began (b) Wages per hour $
	11.	(a) No. hours worked per day (b) Wages per day $ (c) No. of days worked per week (d) Avg. weekly wages w/ overtime $ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. $ per
Cause And Nature Of Injury	12.	Describe fully how injury occurred and what employee was doing when injured: (Statement made without prejudice and without vouching for correctness of information)
	13.	List all injuries and specify body part involved (e.g. right hand or left hand):
	14.	Date & hour returned to work / / at : .M. 15. If so, at what wages $ per
	16.	At what occupation 17. Employee's salary continued in full?
	18.	Was employee treated by a physician
Fatal Cases	19.	Has injured employee died 20. If so, give date of death (Submit Form 29) / /

Employer name _____ Date Completed / /

Signed by _____ Official Title _____

OSHA 301 Information:

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : ☐ A.M. ☐ P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? ☐ Yes ☐ No / Overnight stay? ☐ Yes ☐ No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

FOR IC USE ONLY

RESEARCHER:_____
CC:_____
EC:_____
DATA ENTRY:_____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI: HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML**

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: FORMS@IC.NC.GOV OR MAIL TO: NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235
MAIN TELEPHONE: (919) 807-2500 HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para ceriorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN *[I.C. FILE NUMBER]* (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI:**
HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: **FORMS@IC.NC.GOV** OR MAIL TO: **NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235**
MAIN TELEPHONE: **(919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**

North Carolina Industrial Commission

IC File # _____

STATEMENT OF DAYS WORKED AND EARNINGS OF INJURED EMPLOYEE

Emp. Code # _____

Carrier Code # _____

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Carrier File # _____

Employee's Name

Address

City State Zip

( ) - ( ) -
Home Telephone Work Telephone

XXX-XX- ☐ M ☐ F / /
Last 4 Digits of SSN Sex Date of Birth

Date of Injury: / /

( ) -
Employer's Name Telephone Number

Employer's Address City State Zip

Insurance Carrier

Carrier's Address City State Zip

( ) - ( ) -
Carrier's Telephone Number Fax Number

Year: **20**	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	27	28	29	30	31	Amount Earned
Jan.																																
Feb.																																
Mar.																																
Apr.																																
May																																
June																																
July																																
Aug.																																
Sept.																																
Oct.																																
Nov.																																
Dec.																																
																														Total		

Was this employee given free rent, lodging, or board or other allowances made in lieu of wages? _____

If so, state weekly value thereof: $ _____ .

FORM 22

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

The undersigned employer of _____,
(Name of Employee)

who alleges an injury on the _____ of _____, **20**__
(Day) (Month) (Year)

while in the employment of the undersigned, does hereby certify that the above is a true and correct statement of days worked and earnings of this employee during the 52 weeks immediately preceding the injury (or during the above weeks and parts thereof, if employed for less than 52 weeks) and while engaged in the occupation in which the employee was allegedly injured.

_____
Employer

By _____
Authorized Signature

/ /20__
Date Signed

To Employer: Making a false statement for the purpose of denying workers' compensation benefits may result in civil or criminal penalties.

INSTRUCTIONS

This form must be completed and filed with the Commission in all cases resulting in death unless maximum compensation rate is stipulated. It must also be filed in any other case if there is a disagreement about earnings or if the Commission requests it.

In preparing this form, place an X in the proper squares to indicate days paid in full. Days the employee is on paid vacation leave and/or paid sick leave should be marked with an X. Leave blank squares to indicate days not paid in full for any reason. Total earnings for each pay period should be placed in the proper column. If the employee's job or pay rate was changed during the reported period, this should be noted, with an indication as to the nature of the change.

The employer code number and the carrier code number, if any, must be inserted in the proper place at the upper right-hand corner of the form.

Berkshire Hathaway HOMESTATE COMPANIES

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.

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

Print This Form/ Imprimir Formulario

Berkshire Hathaway HOMESTATE COMPANIES

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) Adimitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

Reset Form

Print This Form

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Employee Accident Report

This for should be filled out by the injured employee.

Name

Employer Name

Date of Accident

Time of accident

Time you began work on day of accident

Address of Accident

City, State

Zip

Offsite? (Y/N)

Yes or No

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 form is true and correct.

Signature

Date Completed

Reset Form

Print This Form

Berkshire Hathaway HOMESTATE COMPANIES

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? Yes or No

Address of Accident | City, State | Zip | Offsite? (Y/N) Yes or No

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:

Berkshire Hathaway HOMESTATE COMPANIES

Supervisor's Report of Employment Accident

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
- ☐ 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 form is true and correct.

Prepared by

Signature

Date Completed

Reset Form

Print This Form

Berkshire Hathaway HOMESTATE COMPANIES

Witness' Report/Statement of Employee Accident

Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)
Yes or No

Date of Accident

Time of accident

Time you began work on day of accident

Address of Accident

City, State

Zip

Offsite? (Y/N)
Yes or No

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

Reset Form

Print This Form

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
Workers Compensation Division

AM BEST A++ Superior

$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.

Representing Financial Strength & Integrity • Workers Compensation Division

F.ENG.21.1.7.2

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

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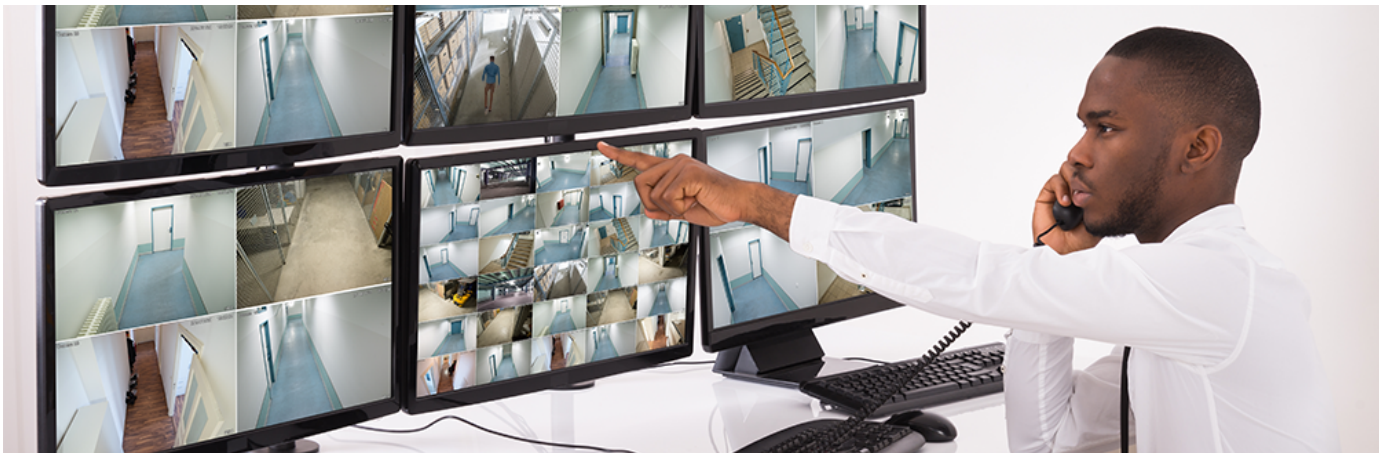

$1000 RECOMPENSA

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 op eraciones nos beneficia a todos, incluso esto ayuda a mantener los réditos bajos de la as eguranza 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 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.

Representing Financial Strength & Integrity • Workers Compensation Division

FSP.21.1.7.4