Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation State Claim Kit

Connecticut

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

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.

Connecticut 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

bhhcpolicyholder.bhhc.com/Client/External/Claims

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Workers' Compensation Posting Requirements

Notice to Employees Poster

- Post in one or more conspicuous places readily accessible to all employees at all business locations
- Text must be bolded and in at least 10-point font-size

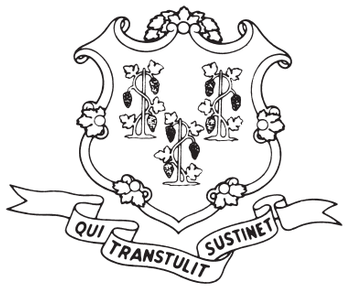
To complete the form, please enter the following information in the spaces provided:

- Your company name
- Your designated insurance company/carrier name
- The address and phone number for the Connecticut Workers' Compensation District Office that is assigned to your area
- Date posted

For your convenience, our other contact information has been entered on the poster and we have attached a copy of a listing of the Commission's District Offices. Please note, the form fields are designed to populate text meeting the statutory font-size requirement.

(Connecticut General Statutes § 31-279(a), § 32-281(f) and Regulations of Connecticut State Agencies § 31-279(B))

NOTICE
TO EMPLOYEES



State of Connecticut Workers' Compensation Commission **Revised 10-01-2021**

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,

_____

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the administrative law judge may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name _____

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

Approved Medical Care Plan ☐ **Yes** ☐ **No**

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.

If your employer has listed a location below, you <u>MUST</u> file your compensation claim there.
When filing your claim, you are also required – by law – to send it by certified mail.

If blank below, ask your employer where to file your claim.

Employer Name _____

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMPLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted: _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).

Connecticut Towns and their Workers' Compensation Districts

Rev. 12-01-2018

Workers' Compensation Commission District Offices and the cities, towns and subdivisions they serve.

First District — Commissioner, 999 Asylum Avenue, Hartford, CT 06105; (860) 566-4154

The Hartford District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Bloomfield
Blue Hills
Broad Brook
Crystal Lake
Dobsonville
East Granby
East Hartford
East Windsor
East Windsor Hill
Ellington
Enfield
Hartford
Hazardville
Melrose
North Somers
North Thompsonville
Poquonock
Rainbow
Rockville
Sadds Mill
Scantic
Scitico
Silver Lane
Somers
Somersville
South Windsor
Suffield
Talcotville
Thompsonville
Tolland
Vernon
Vernon Center
Warehouse Point
West Suffield
Wilson
Windsor
Windsor Locks
Windsorville

Second District — Commissioner, 55 Main Street, Norwich, CT 06360; (860) 823-3900

The Norwich District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Abington
Almyville
Amston
Andover
Ashford
Attawaugan
Atwoodville
Ballouville
Baltic
Bolton
Bolton Notch
Bozrah
Bozrah Street
Brooklyn
Burnetts Corner
Canterbury
Center Groton
Central Village
Chaplin
Chesterfield
Chestnut Hill *(Lebanon)*
Clark Falls
Clarks Corner
Columbia
Coventry
Danielson
Dayville
Doaneville
Eagleville
East Brooklyn
Eastford
East Killingly
East Putnam
East Thompson
East Willington
East Woodstock
Ekonk
Elmville
Exeter
Fabyan
Fitchville
Franklin
Gales Ferry
Gilead
Gilman
Glasgo
Goshen Hill
Graniteville
Greenville
Griswold
Grosvenordale
Groton
Groton Heights
Groton Long Point
Gurleyville
Hallville
Hampton
Hanover
Harrisville
Hebron
Hopeville
Hop River
Hydeville
Jewett City
Jordan Village
Kenyonville
Killingly
Killingly Center
Laurel Glen
Lebanon
Ledyard
Ledyard Center
Liberty Hill
Lisbon
Long Society
Lords Point
Mansfield
Mansfield Center
Mansfield Depot
Mansfield Hollow
Mashantucket
Mashapaug
Mechanicsville *(Thompson)*
Merrow
Mohegan
Montville
Moosup
Morningside Park
Mystic
Newent
New London
Noank
North Ashford
North Franklin
North Grosvenordale
North Stonington
North Windham
North Woodstock
Norwich
Norwichtown
Oakdale
Occum
Ocean Beach
Old Mystic
Oneco
Orcuttville
Pachaug
Packerville
Pawcatuck
Phoenixville
Plainfield
Pleasure Beach
Pomfret
Pomfret Center
Pomfret Landing
Poquetanuck
Poquonock Bridge
Preston
Putnam
Putnam Heights
Quaddick
Quaker Hill
Quinebaug
Rogers
Scotland
Sodom
South Chaplin
South Killingly
South Willington
South Windham
South Woodstock
Sprague
Spring Hill *(Mansfield)*
Stafford
Stafford Springs
Staffordville
Sterling
Sterling Hill
Stonington
Storrs
Taftville
Thompson
Uncasville
Union
Versailles
Village Hill *(Lebanon)*
Voluntown
Warrenville
Waterford
Wauregan
Wequetequock
Westford
Westminster
West Mystic
West Stafford
West Thompson
West Willington
West Woodstock
Willimantic
Willington
Wilsonville
Windham
Woodstock
Woodstock Valley
Yantic

Third District — Commissioner, 700 State Street, New Haven, CT 06511; (203) 789-7512

The New Haven District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Allingtown
Augerville
Bethany
Branford
Burr Hill
Clinton
Clintonville
Durham
East Haven
East River
Fair Haven
Foxon
Guilford
Hamden
Indian Neck
Killingworth
Madison
Momauguin
Montowese
Morningside
Mount Carmel
New Haven
North Branford
Northford
North Guilford
North Haven
North Madison
Orange
Pine Orchard *(Branford)*
Pond Meadow *(Killingworth)*
Quinnipiac
Rivercliff
Rockland
Sachem Head
Short Beach
Spring Glen
Stony Creek
West Haven
Westville
Whitneyville
Woodbridge

Fourth District — Commissioner, 350 Fairfield Avenue, Bridgeport, CT 06604; (203) 382-5600

The Bridgeport District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Ansonia
Berkshire
Botsford
Bridgeport
Derby
Devon
Dodgingtown
Easton
East Village
Fairfield
Greenfield Hill
Greens Farms
Hattertown
Hawleyville
Huntington
Huntingtontown
Long Hill District
Lordship
Milford
Monroe
Newtown
Nichols
Riverside *(Newtown)*
Sandy Hook
Saugatuck
Shelton
Southport
Stepney
Stevenson
Stratford
Trumbull
Upper Stepney
Westport
Woodmont

Fifth District — Commissioner, 55 West Main Street, Waterbury, CT 06702; (203) 596-4207

The Waterbury District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Amesville
Bantam
Beacon Falls
Bethlehem
Burrville
Campville
(Litchfield)
Canaan
Canaan Valley
Cornwall
Cornwall Bridge
Cornwall Center
Cornwall Hollow
Drakeville
East Canaan
East Litchfield
East Morris
East Plymouth
Ellsworth
Falls Village
Flanders
Goshen
Greystone
Harwinton
Hotchkissville
Huntsville
Kent
Kent Furnace
Lakeside
Lakeville
Lime Rock
Litchfield
Lower City
Macedonia
Middlebury
Millville
Milton
Minortown
Morris
Naugatuck
Newfield
(Torrington)
Norfolk
North Canaan
Northfield
North Kent
North Woodbury
Oakville
Oxford
Pequabuck
Plymouth
Pomperaug
Prospect
Quaker Farms
Salisbury
Seymour
Sharon
South Britain
Southbury
South Canaan
Southford
South Kent
Straitsville
Taconic
Terryville
Thomaston
Torringford
Torrington
Twin Lakes
Union City
Warren
Waterbury
Watertown
West Cornwall
West Goshen
West Torrington
White Oak
Woodbury
Wrightville

Sixth District — Commissioner, 233 Main Street, New Britain, CT 06051; (860) 827-7180

The New Britain District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Avon
Bakersville
Barkhamsted
Berlin
Bristol
Burlington
Canton
Canton Center
Colebrook
Collinsville
East Berlin
East Hartland
Edgewood
Elmwood
Farmington
Forestville
Granby
Hartland
Kensington
Marion
Mechanicsville
(Granby)
Milldale
Nepaug
New Britain
New Hartford
Newington
North Canton
North Colebrook
North Granby
Pine Meadow
Plainville
Plantsville
Pleasant Valley
Riverton
Robertsville
Simsbury
Southington
Tariffville
Unionville
Weatogue
West Avon
West Granby
West Hartford
West Hartland
West Simsbury
Wethersfield
Whigville
Winchester
Winchester Center
Winsted
Wolcott

Seventh District — Commissioner, 111 High Ridge Road, Stamford, CT 06905; (203) 325-3881

The Stamford District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Banksville
Belltown
Bethel
Boardmans Bridge
Branchville
Bridgewater
Brookfield
Brookfield Center
Byram
Cannondale
Church Hill
Cos Cob
Cranbury
Danbury
Darien
East Norwalk
Gaylordsville
Georgetown
Germantown
Glenbrook
Glenville
Greenwich
High Ridge
Long Ridge
(Stamford)
Lower Merryall
Lyons Plains
Marble Dale
Merryall
Mianus
Mill Plain
New Canaan
New Fairfield
New Milford
New Preston
Noroton
Noroton Heights
North Stamford
Northville
North Wilton
Norwalk
Old Greenwich
Park Lane
Redding
Redding Ridge
Ridgebury
(Ridgefield)
Ridgefield
Riverside
(Greenwich)
Romford
Round Hill
(Greenwich)
Rowayton
Roxbury
Roxbury Falls
Roxbury Station
Sherman
Silvermine
(Norwalk)
South Norwalk
South Wilton
Springdale
Stamford
Titicus
Topstone
Turn Of River
Upper Merryall
Washington
Washington Depot
West Norwalk
Weston
West Redding
Wilton
Winnipauk
Woodville

Eighth District — Commissioner, 90 Court Street, Middletown, CT 06457; (860) 344-7453

The Middletown District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Addison
Baileyville
Bashan
Black Hall
Black Point
Buckingham
Buckland
Centerbrook
Cheshire
Chester
Cobalt
Colchester
Cornfield Point
Crescent Beach
Cromwell
Deep River
East Glastonbury
East Haddam
East Hampton
East Lyme
Essex
Fenwick
Flanders Village
Gildersleeve
Glastonbury
Grove Beach
(Westbrook)
Haddam
Haddam Neck
Hadlyme
Hamburg
Higganum
Highland
Highland Park
Hopewell
Ivoryton
Knollwood Beach
Laysville
Leesville
Little Haddam
Lyme
Manchester
Manchester Green
Marlborough
Meriden
Middlefield
Middlefield Center
Middle Haddam
Middletown
Millington
Mixville
Moodus
Niantic
North Lyme
North Plains
North Westchester
Old Lyme
Old Saybrook
Pond Meadow
(Westbrook)
Ponset
Portland
Rockfall
Rocky Hill
Salem
Salem Four Corners
Saybrook Manor
Saybrook Point
Shailerville
Sound View
South Glastonbury
South Lyme
South Meriden
Tylerville
Wallingford
Westbrook
Westfield
Winthrop
Yalesville

State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Date filed in Chairman's Office

(for WCC use only)

Employer *(Name, Address & Zip)* | Phone #

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

SIC Code | FEIN

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ☐ Check, if Self-Insured | Policy Period *(MM/DD/YY)* FROM: TO:

Employee: Last Name First Name Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender ☐ Male ☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ _____ . _____ per ☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ☐ a.m. ☐ p.m.

Time of Occurrence ☐ cannot be determined ☐ a.m. ☐ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Contact Name

Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ☐ Yes ☐ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

If provided, were they used? ☐ Yes ☐ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

☐ No Medical Treatment ☐ Emergency Care

☐ Minor — by Employer ☐ Hospitalized More Than 24 Hours

☐ Minor — by Clinic / Hospital ☐ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

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
Workers Compensation Division

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 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:

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
Workers Compensation Division

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

STATE OF CONNECTICUT
WORKERS' COMPENSATION COMMISSION

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS BY A HOSPITAL/PROVIDER FOR THE PURPOSE OF ADMINISTERING A CONNECTICUT WORKERS' COMPENSATION CLAIM FOR BENEFITS

PATIENT NAME: _____ DATE OF BIRTH: _____
(PLEASE PRINT NAME) (REQUIRED)

BODY PART(S): _____

I, the undersigned, authorize: _____
(HOSPITAL/PROVIDER)

to disclose, in writing, protected health information [PHI] to:

_____
(PERSON OR ENTITY TO WHOM INFORMATION IS TO BE DISCLOSED)

and its attorneys and/or representatives. The PHI to be disclosed is relevant medical records and reports relating to my medical treatment/consultation/examination and/or diagnostic procedures performed at the above-named medical facility and which pertain to an injury/occupational disease for which I am claiming benefits under the Connecticut Workers' Compensation Act. I understand the information disclosed based on this authorization may include mental health treatment records and information regarding HIV/AIDS status, treatment or testing. **INFORMATION RELATING TO TREATMENT FOR ALCOHOL AND DRUG ABUSE WILL NOT BE RELEASED WITHOUT MY SPECIFIC CONSENT in accordance with state and federal law**.[1] I understand I have the right to inspect or copy the PHI to be disclosed as permitted under federal HIPAA law and state law.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION. In order to revoke this authorization I may, at any time, send written notification to the above-named HOSPITAL/PROVIDER. I understand that my revocation of this authorization is ineffective to the extent that the above-named HOSPITAL/PROVIDER has relied on this authorization to disclose PHI relating to me.

I UNDERSTAND THAT PHI DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE PERSON OR ENTITY I HAVE IDENTIFIED ABOVE AND MAY NO LONGER BE PROTECTED FROM DISCLOSURE TO OTHERS BY FEDERAL OR STATE LAW. I understand that the above-named HOSPITAL/PROVIDER may not condition my treatment on whether I provide authorization for the requested use or disclosure.

I UNDERSTAND THAT I HAVE THE RIGHT TO DETERMINE A DATE OR EVENT AT WHICH TIME THIS AUTHORIZATION EXPIRES. I am identifying the expiration date of this authorization to be COMPLETION OF WORKERS' COMPENSATION LITIGATION AS EVIDENCED BY A STIPULATION OR FINDING AND AWARD/DISMISSAL, OR IN THE EVENT OF APPELLATE REVIEW, A FINAL DETERMINATION BY THE HIGHEST APPELLATE AUTHORITY TO WHOM AN APPEAL IS MADE.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this authorization relates to a Workers' Compensation matter. However, I understand that as a practical matter, my authorization in this form may facilitate the processing and administration of my claim for Workers' Compensation benefits.

My signature below indicates that I have read and understand this Authorization and its terms.

_____ _____

Signature of Patient Date

[1] Any consent to release information pertaining to treatment for drug and alcohol abuse must conform to the requirements of state law and the federal regulations, e.g., Part 2 of Title 42 of the Code of Federal Regulations.

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

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

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 7-13-2009

1A

Filing Status and Exemption

This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER October 1, 1991, and must be completed in its entirety.

WCC File #

Date filed in District

(for WCC use only)

EMPLOYEE

Name _____ Date of Birth *(required)* _____

Address _____

City/Town _____ State _____ Zip Code _____

DATE OF INJURY:

_____

FILING STATUS AND EXEMPTIONS — In order to determine your weekly benefit rate, as per Sec. 31-310 C.G.S.,we need the following information:

1. Select your Federal tax filing status based upon your **ACTUAL filing status as of the date of injury**, listed at right: *(Must match your tax return, as if you were filing with the IRS on the date of your injury.)*

   ❑ Single ❑ Head of Household ❑ Married filing jointly ❑ Married filing separately

2. Number of exemptions *(including yourself)* as of the date of injury listed at right = _____

3. FICA withheld for the above-named employee? ..... ❑ YES ..... ❑ NO — ***If NO, insurer must manually calculate weekly benefit rate.***

4. Check all appropriate boxes:

   ❑ Employee 65 years of age or older ❑ Employee legally blind ❑ Spouse 65 years of age or older ❑ Spouse legally blind

5. List name *(yourself first)*, date of birth, and relationship to you for all exemptions included in question #2, above:

Name	*Date of Birth*	*Relationship*
		SELF

CONCURRENT EMPLOYMENT — To be certain you receive all the benefits to which you are entitled, provide the following information *if you were working for more than one employer on the date of injury indicated above*:

Name of Employer	*Address*	*Date of Hire*

NOTE: Wage information for each concurrent employer must be supplied by the claimant.

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

I hereby attest that the above information is correct to the best of my knowledge.

Employee's Signature _____ Date _____

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 ™

$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.

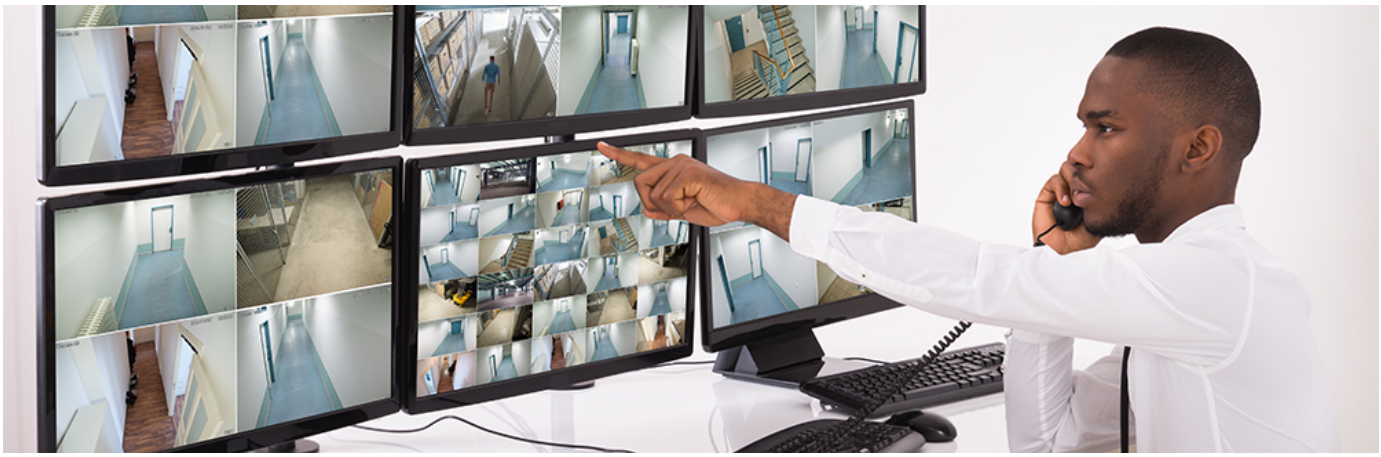
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

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.

Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™



$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.