



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Division TM

Workers Compensation State Claim Kit

Virginia



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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 methods listed to the right.

Virginia state law recommends employers report every industrial injury or occupational disease claim to their workers compensation carrier as soon as possible or within 5 days of employer knowledge of injury.

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Contact Information

Online

[bhhcpolicyholder.bhhc.com/
Client/External/Claims](http://bhhcpolicyholder.bhhc.com/Client/External/Claims)

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com





Workers Compensation Posting Requirements

Form VWC-1 – Workers' Compensation Notice Poster

- Post in one or more conspicuous places at all business location
 - Must be readily accessible to employees:
 - Plant
 - Shop
 - Office

(16 Virginia Administrative Code 30-50-80 – Workers' Compensation Commission Rule 7(2))

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.
2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.
4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.
2. Report the injury to the Commission through your carrier or directly to the Commission.
3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. Franklin St
Richmond, Virginia 23219

1-877-664-2566
www.workcomp.virginia.gov

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compesation Act). En caso de lesion por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.
2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete dias despues del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o mas de los dependientes o herederos del difunto o las personas que los representan.
3. Presentar una solicitud a la Comisión para una audiencia dentro de dos años de la fecha de la lesión por accidente or de la primera comunicación del diagnóstico de enfermedad ocupacional, si no llega a un acuerdo con el empleador en relacion al pago de compensación bajo la Ley.
4. Presentar una solicitud a la Comisión dentro de los dos años de la fecha del accidente, si el tratamiento médico es anticipado por mas de dos años de la fecha del accidente y el empleado no ha recibido una orden de la Comisión.

NOTA: El reporte de accidente del empleador no es la presentacion del reclamo del empleado. El pago voluntario sueldos o compensacion durante la incapacidad o de los gastos medicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos anos del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.
2. Reportar las lesiones a la Comision a traves de su representate o directamente a la Comisión.
3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc.

Preguntas pueden ser contestadas llamando a la Comision. Un folleto explicando la Ley de Compensación Para Los Trabajadores esta disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566
vwc.state.va.us

Cada empleador dentro de la operacion de la Ley de Compensacion Para Trabajadores en Virginia, DEBE DE EXPONER ESTE AVISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.

First Report of Injury

Virginia Workers' Compensation Commission
 333 E. Franklin St. Richmond Virginia 23219
 1-877-664-2566



Reason for filing: _____
 VWC Jurisdiction Claim #: _____
 (If assigned) _____
 Claim Administrator File#: _____

SEE INSTRUCTIONS ON REVERSE SIDE

www.vwc.state.va.us

| Employer | | |
|--|---|--|
| Employer's Legal Name | Federal Employer Identification Number (FEIN) | |
| Employer's Mailing Address | | |
| Name/FEIN of Entity on Policy | Nature of Business | |
| Name and Address of Insurer or Self-Insurer for this Claim | Policy Number | |
| Time and Place of Accident | | |
| Location where accident occurred | Date of injury | Hour of injury <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. |
| Date injury or illness reported | If fatal, give date of death | If fatal, give marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced |
| | If fatal, give number of dependent children | <input type="checkbox"/> Married <input type="checkbox"/> Widowed |
| Injured Worker | | |
| Name of Injured Worker | Phone Number | Injured Worker ID Number |
| Injured Worker's mailing address | | Type of ID <input type="checkbox"/> Social Security No. <input type="checkbox"/> Employment Visa <input type="checkbox"/> Green Card <input type="checkbox"/> Passport No. <input type="checkbox"/> Unknown |
| Occupation at time of injury or illness | Date of birth | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Nature and Cause of Accident | | |
| Machine, tool, or object causing injury or illness | | |
| Describe fully how injury or illness occurred | | |
| Describe nature of injury, occupational disease, or illness, including body parts affected | | |
| Signatures | | |
| Submitter (name, signature, title) | Date | Phone number |
| Submitter's Address | | |

First Report of Injury

Filing Instructions

The Virginia Workers' Compensation Act requires that **ALL** injuries occurring in the course of employment be reported to the Commission pursuant to Va. Code §65.2-900.

Employer

The employer is responsible for accurately completing all sections of this form when an employee is injured. It should be typed or legibly printed, signed, and dated by the preparer. Send the original form to the claim administrator for the insurance company who provided insurance coverage on the date of the occurrence. The claim administrator will report this information to the Commission. Contact your workers' compensation insurance provider for additional information.

Claim Administrator

Claim administrators who are EDI enabled will use the information contained on the paper form and submit electronic data to the Commission.

Claim administrators who are NOT EDI enabled must immediately file the completed form with the Commission. Please note: EDI is mandatory no later than June 30, 2009, after which time paper reports will no longer be accepted. Until you are in EDI production, mail the completed form to the Virginia Workers' Compensation Commission, 333 E. Franklin St., Richmond, VA 23219. At the top of the form, use a numerical code (1-7) to indicate the reason for filing the form for accidents meeting one of the filing criterion.* If none of the criteria apply, you must still report the accident, but may use either Form 45A or this form to do so. (Leave "reason for filing" blank in such a case.)

For questions or assistance in completing the form, please contact the Commission toll-free at 877-664-2566.

*Criteria for filing are: (1) lost time exceeds seven days; (2) medical expenses exceed \$1,000.00; (3) compensability is denied; (4) issues are disputed; (5) accident resulted in death; (6) permanent disability or disfigurement may be involved; and (7) a specific request is made by the Virginia Workers' Compensation Commission.

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE WORKERS' COMPENSATION ACT.



**Commonwealth of Virginia
Virginia Workers' Compensation Commission
1000 DMV Drive, Richmond, Virginia 23220**

VWC Claim No. _____

Case of _____

SUPPLEMENTARY REPORT

If Employer's Accident Report did not show that the injured had returned to work, an Employer's Supplemental Report of injury should be completed and filed immediately after return to work of the employee. In the event of the death of the employee, this report should be filed immediately.

| | | | | | |
|----|--|------|-------------|----------------------|-----------------|
| 1 | Name of Employer | | | | |
| 2 | Office Address: No. and St. | | | City or Town | State |
| 3 | Insured by: Name of Company | | | | |
| 4 | Name of Injured (in full) | | Last | First | Middle Name |
| 5 | Present address: No. and St. | | | City or Town | State |
| 6 | Date of Injury | Date | Day of Week | Hour of Day | AM or PM |
| 7 | Date Disability began | | | Date | AM or PM |
| 8 | Has injured returned to work? | | | IF SO, date and hour | AM or PM |
| 9 | Is injured person earning same wages as before injury? | | | Yes or No | If not, explain |
| 10 | If disability has not terminated, state probable date of termination of disability | | | | |
| 11 | Has injured died? | | | If so, date of death | AM or PM |

NOTE: This form is not an agreement and its filing is not sufficient to terminate an outstanding award.

| | |
|----------------------------|-----------------------|
| Date of this report | Firm Name |
| Signed by | Official Title |

FILING INSTRUCTIONS
(Instructions Updated 09/01/07)

Supplementary Report
VWC Form No. 3A

This form should be completed and filed with the Virginia Workers' Compensation Commission when the Employer's Accident Report (VWC Form No. 3) did not show a date that the injured worker had returned to work as a result of a work-related injury, occupational injury or disease. In the event of the death of the injured worker, this report should be filed immediately.

This form is not an agreement form and its filing is not sufficient to terminate an outstanding award.

Forms: Additional copies of this form are available without cost by writing to the Commission. Address your inquiries to "Forms" at the listed Virginia Workers' Compensation Commission address. This form is also available on the Commission's Website, at www.vwc.state.va.us. If any alternative versions of the form are developed they will require prior approval by the Commission.

For questions or assistance with completing this form, please contact the First Reports Unit at (804) 367-0072 or use the Commission's Toll-free number at (1-877) 644-2566.

Wage Chart

Employer's Statement of Wage Earnings

Virginia Workers' Compensation Commission
333 E. Franklin St., Richmond, Virginia 23219

| | | |
|--|----------------------|-----------------|
| The boxes to the right are for the use of the insurer. | Reserved | VWC File Number |
| | | |
| | Insurer Claim Number | |

| | | | | | | |
|------------------|-----------------|--|----------------|------------------|--------------|--|
| | Employee | | Address | | | |
| Name of Employee | | | | Date of Accident | Date of Hire | |
| | Employer | | Address | | | |
| Name of Employer | | | | | | |

PLEASE REFER TO THE FILING INSTRUCTIONS PRINTED ON THE BACK OF THIS FORM

| Week No. | Week Ending Date | Days Worked | Gross amount paid, including overtime | Week No. | Week Ending Date | Days Worked | Gross amount paid, including overtime | Week No. | Week Ending Date | Days Worked | Gross amount paid, including overtime |
|----------|------------------|-------------|---------------------------------------|----------|------------------|-------------|---------------------------------------|----------|------------------|-------------|---------------------------------------|
| 1 | | | | 19 | | | | 37 | | | |
| 2 | | | | 20 | | | | 38 | | | |
| 3 | | | | 21 | | | | 39 | | | |
| 4 | | | | 22 | | | | 40 | | | |
| 5 | | | | 23 | | | | 41 | | | |
| 6 | | | | 24 | | | | 42 | | | |
| 7 | | | | 25 | | | | 43 | | | |
| 8 | | | | 26 | | | | 44 | | | |
| 9 | | | | 27 | | | | 45 | | | |
| 10 | | | | 28 | | | | 46 | | | |
| 11 | | | | 29 | | | | 47 | | | |
| 12 | | | | 30 | | | | 48 | | | |
| 13 | | | | 31 | | | | 49 | | | |
| 14 | | | | 32 | | | | 50 | | | |
| 15 | | | | 33 | | | | 51 | | | |
| 16 | | | | 34 | | | | 52 | | | |
| 17 | | | | 35 | | | | | | | |
| 18 | | | | 36 | | | | | | | |

Value of perquisites for entire year: _____ Total gross earning \$ _____ Total weeks worked _____

| | | |
|----------------------------|----------------------|---------------------------------------|
| Bonuses \$ _____ | Electricity \$ _____ | Total value of perquisites \$ _____ |
| Meals/Lodging \$ _____ | Water \$ _____ | |
| Meals Only \$ _____ | Telephone \$ _____ | Total earnings & perquisites \$ _____ |
| Temporary Lodging \$ _____ | Uniforms \$ _____ | |
| House Rent \$ _____ | Laundry \$ _____ | |
| Tip Income \$ _____ | | |

VWC use only:

AWW: _____

CR: _____

| | | |
|--|------|------------------|
| INSURER OR EMPLOYER (include name & signature) | Date | Telephone number |
|--|------|------------------|

FILING INSTRUCTIONS

Wage Chart VWC Form No. 7A

How to complete the Wage Chart:

- Indicate gross weekly earnings for the 52 weekly periods immediately **preceding** the date of accident.
- Note that these earnings are GROSS earnings and include overtime and tips, before any deductions are made for taxes or Social Security. If there were any perquisites, please list the TOTAL value separately at the bottom of the chart.
- If an injured employee lost more than seven consecutive calendar days, although not in the same week, these periods should be noted on the Wage Chart (VWC Form No. 7-A) using an asterisk in the Week No. column and are not to be counted in the calculations. Va. Code § 65.2-101.
- If injured employee has worked less than 12 months, the earnings for the time worked should be used. The earnings for a similar employee may be used if the employee has worked less than 60 days.

How to calculate the Wage Chart:

- If a full year's wage information **has been** provided covering the 52 week period prior to the date of accident:
 - determine the total wages earned, including yearly perquisites;
 - divide the total wages earned for this period by 52;
 - the sum will be the average weekly wage.
- If a full year's wage information **has not been** provided covering the 52 week period prior to the date of accident:
 - determine the total wages earned, including yearly perquisites;
 - divide the total wages earned by the number of weeks wages were earned (Note: if warranted, the weeks can be converted into days and calculated on that basis);
 - the sum will be the average weekly wage.
- If the form is completed on a **bi-weekly basis**:
 - determine the total wages earned, including yearly perquisites;
 - divide the total wages earned by the number of weeks worked (employee paid 26 times a year represents 52 weeks of wages);
 - the sum will be the average weekly wage.
- Samples of properly completed wage chart(s) are available through the Commission's website at workcomp.virginia.gov under the forms menu.
- Have questions about the Virginia Workers' Compensation Commission and no lawyer? Call the Ombuds Department at 833-448-1681, or email at ombuds@workcomp.virginia.gov. We cannot give legal advice, but all conversations will be kept confidential.

Virginia Medical Provider Panels

Employees who have suffered a compensable injury are entitled to receive medical treatment at no cost to the employee for as long as required by the authorized treating physician. As medical treatment is the most costly item in the life of a claim, it is important to insure that a reputable doctor is treating the injured employee from the onset of injury. Since the authorized treating physician directs the course of treatment, selection of the authorized treating physician is arguably the most important first step in the life of a claim.

As the employer, you are able to maintain medical control by providing the injured employee, upon notice of injury, with an initial panel of at least three physicians. For your convenience we have provided a blank Panel and Claimant's Choice of Physician Form for your company.

Creating Your Panel

It is recommended that your panel be comprised of urgent care physicians for initial treatment and that your panel is in place prior to any injury. When creating your panel, it is important to list actual physicians, not merely clinics, and to confirm that the physicians listed accept workers' compensation patients and are still in practice otherwise the panel could be defective. Failure to provide the injured employee with a valid panel permits the injured worker to have their choice of any physician. Upon reporting the claim to the carrier, the assigned adjuster will evaluate the need for any further panels and subsequently create any additional panels.

When To Provide The Panel

Upon the report of an injury you should provide the injured employee with a complete panel of physicians so they may select one doctor from the panel. It is recommended that the injured employee sign the panel document indicating which physician was selected by the injured employee. The doctor chosen by the employee will become the authorized treating physician and will provide medical treatment.

Providing a panel assures the employer that the authorized treating physician is one that is reputable and trusted. In emergency situations it is recommended to send the injured worker to the emergency room and provide the panel when the employee is stabilized.

Panel Creation Tips

- Have your panel in place prior to any injury.
- List urgent care physicians for initial treatment.
- List actual physicians, not merely clinics.
- Confirm that the physicians listed accept workers' compensation patients.
- Confirm that the physicians listed are still in practice.
- Assigned adjuster will provide any necessary additional panels.

Panel Utilization Tips

- Provide the panel immediately upon report of injury
- Have the Employee sign the panel document indicating which physician was selected



Claimant's Choice of Physician

Employee Name

Employer Name

Section 65.2-603 of the Code of Virginia requires that the employer provide the claimant with a panel of physicians from which to choose. The physician chosen by the claimant becomes the authorized treating physician.

Please select a physician from the following:

| Physician Name | Physician Name | Physician Name |
|----------------|----------------|----------------|
| Clinic | Clinic | Clinic |
| Address | Address | Address |
| Phone | Phone | Phone |

Initial Treating Physician Selection

I hereby select the following physician to provide medical services and treatment for my work injury or illness:

Physician's Name Clinic

Address Phone

Date of Selection

Employer's Name Employee's Name

Address Address

Phone Phone

Signature Signature



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





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



Employee Accident Report

This form 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)

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

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 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

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 demanda 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 información presentará a la agencia judicial correspondiente. El proceso de crímenes es la responsabilidad exclusiva de las autoridades, que pueden decidir si el proceso debe entablarse 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.