



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Division TM

Workers Compensation State Claim Kit

Arkansas



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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.

Arkansas 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 or 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

Report a Claim

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 AR-P – Workers' Compensation Instructions to Employers and Employees Poster

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

To complete the form, please enter the name of your designated insurance carrier and your policy expiration date in the spaces provided. For your convenience, our other contact information has been entered on the Form AR-P.

(Arkansas Code Annotated § 11-9-407, § 11-9-514(g), and Arkansas Workers' Compensation Commission Rule 099.07)

Form AR-P	ARKANSAS WORKERS' COMPENSATION COMMISSION	
Ark. Code Ann. §11-9-403, 407 AWCC Rule 7 Updated: 06-16-14	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 Little Rock Office - 1-800-622-4472 / 501-682-3930 Springdale Office - 1-800-852-5376 / 479-751-2790	

WORKERS' COMPENSATION INSTRUCTIONS TO EMPLOYERS AND EMPLOYEES

All employees of this establishment entitled to benefits under the provisions of the Arkansas workers' compensation laws are hereby notified that their employer has secured the payment of such compensation as may at any time be due employees or their dependents. This employer is required by state law to provide workers' compensation coverage or this employer has waived the exclusion or exemption from the operation of the workers' compensation laws, and the employer certifies by the display of this poster that workers' compensation coverage is now provided by a workers' compensation insurance policy or by enrollment in the Arkansas Self-Insurance Program or by the Public Employee Claims Division of the Arkansas Insurance Department.

(Place label indicating Insurer's Name,
Claims Office Address, Claims Office Phone Number
and Policy Expiration Date)

IN CASE OF JOB-RELATED INJURIES OR OCCUPATIONAL DISEASES

The Employer Shall:

1. Provide all necessary medical, surgical and hospital treatment, as required by law, following the injury and for such additional time as ordered by the Workers' Compensation Commission.
2. Provide compensation payments in accordance with the provisions of the law. The first installment of compensation becomes due on the 15th day after the employer has notice of the injury or death, except in those cases where liability has been denied by the employer.
3. Provide prompt reporting of accidents to appropriate parties.
4. Keep a record of all injuries received by its employees.

The Employee Shall:

The employee shall report the injury to the employer on Form N and to a person or at a place specified by the employer, unless the injury either renders the employee physically or mentally unable to do so, or the injury is made known to the employer immediately after it occurs. The employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's notice of injury. All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements. The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

Failure to give such notice shall not bar any claim (1) if the employer had knowledge of the injury or death, (2) if the employee had no knowledge that the condition or disease arose out of and in the course of employment, or (3) if the Commission excuses such failure on the grounds that for some satisfactory reason such notice could not be given. Objection to failure to give notice must be made at or before the first hearing on the claim.

Statutory Information:

Ark. Code Ann. § 11-9-514(b) states: "Treatment or services furnished or prescribed by any physician other than the ones selected according to the foregoing, except emergency treatment, shall be at the claimant's expense."

Ark. Code Ann. § 11-9-514(f), however, indicates: When compensability is controverted, subsection (b) shall not apply if:

- (1) The employee requests medical assistance in writing prior to seeking the same as a result of an alleged compensable injury; and
- (2) The employer refuses to refer the employee to a medical provider within forty-eight (48) hours after such written request as provided above; and
- (3) The alleged injury is later found to be a compensable injury; and
- (4) The employer has not made a previous offer of medical treatment.

If you have any questions regarding your rights under the Arkansas workers' compensation laws, you may call an Arkansas Workers' Compensation Commission legal advisor at our toll-free number listed above.

All employers who come within the operation of the Arkansas workers' compensation laws and have complied with its provisions must post this notice in a **CONSPICUOUS** place in or about their place or places of business.

AWCC Form P
(Posting Notice)

A posting notice is mentioned in **Ark. Code Ann. §11-9-403**, **Ark. Code Ann. §11-9-407** and **AWCC Rule 7**. **AWCC Form P** satisfies all requirements.

Form P:

1. Is to be on display in a conspicuous place;
2. Tells employers what to do when an employee is injured;
3. Instructs employees to notify the employer immediately (or no later than the close of the next business day) when injured;
4. Lists the claims office that will be handling the insurance aspects of the case;
5. Gives the claims office telephone number;
6. Announces the expiration date of the insurance policy; and
7. Provides telephone numbers for Arkansas Workers' Compensation Commission legal advisors if either party needs assistance.

Employers without **Form P** may lose the use of **Form N** as a defense in litigation. Employees disobeying instructions on **Form P** may delay their benefits or jeopardize the awarding of any benefits in a contested case.

The AWCC furnishes samples, not supplies, of **Form P**. Carriers are to send their insureds an adequate number, and self-insureds must arrange with a printer for the supply they need. Carriers and employers may enlarge **Form P** for posting purposes.

Information about Form P is available from the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): “Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers’ compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers’ Compensation Commission.”

<p>Formulario AR-P</p> <p>Autoridad: Ark. Code Ann., apartado 11-9-403, 407 AWCC, Norma 7 Actualizado: 06-16-2014 En Español: 10-15-2004</p>	<p>COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS</p> <p>324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 Oficina de Little Rock: 1-800-622-4472 / 501-682-3930 Oficina de Springdale: 1-800-852-5376 / 479-751-2790</p>	<p>P</p>
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INSTRUCCIONES SOBRE LA COMPENSACIÓN DE LOS TRABAJADORES PARA EMPLEADORES Y EMPLEADOS

Todos los empleados de este centro que tengan derecho a beneficios en virtud de lo dispuesto en la legislación de compensación de los trabajadores son informados en virtud del presente documento de que su empleador ha organizado el pago de las compensaciones que puedan tener que abonarse a los empleados o sus dependientes. Este empleador debe, en virtud de la legislación estatal, ofrecer a sus empleados cobertura por compensaciones o ha renunciado a la exención o exclusión de la ejecución de la legislación en materia de compensaciones a los trabajadores y certifica mediante la muestra de este cartel que en la actualidad ofrece cobertura a sus trabajadores dentro de una póliza de seguro de compensación de los trabajadores o por su participación en el Programa de Auto-seguros de Arkansas o la División Pública de Reclamaciones de los Empleados del Departamento de Seguros de Arkansas.

(Pegar la etiqueta con el nombre de la aseguradora,
la dirección de la oficina de reclamaciones, el número de teléfono de la oficina
de reclamaciones y la fecha en que expira la póliza).

EN CASO DE PRODUCIRSE UNA LESIÓN VINCULADA AL TRABAJO O UNA ENFERMEDAD PROFESIONAL

El empleador deberá:

1. Ofrecer todo el tratamiento médico, quirúrgico y hospitalario que sea preciso en virtud de la legislación, tras la lesión y durante el tiempo adicional que establezca la Comisión de Compensación de los trabajadores.
2. Ofrecer pagos de compensación de acuerdo con lo dispuesto en la legislación. El primer plazo vencerá al cabo de 15 días desde que el empleador sea informado de la lesión o fallecimiento, excepto en los casos en el empleador haya denegado su responsabilidad.
3. Informar inmediatamente de los accidentes a los interesados.
4. Mantener un registro de todas las lesiones de las que sea informado por sus empleados.

El empleado deberá:

El empleado deberá informar de la lesión al empleador en el formulario N y a una persona o en un lugar indicado por este último, a menos que se trate de una lesión que impida mental o físicamente al empleado hacerlo o si la lesión se comunica al empleador inmediatamente después de producirse. El empleador no será responsable de las beneficias de discapacidad, médicas o de otro tipo anteriores a la recepción del informe del accidente. Todos los procedimientos de notificación que especifique el empleador deberán ser razonables y éste deberá notificar razonablemente a todos los empleados los requisitos de notificación. Lo anterior no será de aplicación si el empleado precisa tratamiento médico de urgencia fuera del horario de trabajo habitual del empleador; sin embargo, en ese caso, el empleado deberá hacer que se notifique el accidente al empleador el siguiente día laborable habitual.

La falta de notificación no anulará las reclamaciones si: (1) El empleador tiene conocimiento del fallecimiento o lesión; o (2) El empleado no tenía conocimiento de que la afección o enfermedad se produjo en el transcurso de su empleo; o (3) La Comisión exime esta omisión basándose en que la notificación no pudo realizarse por un motivo justificado.

Las objeciones relativas a la falta de notificación deberán plantearse antes o en el momento de celebrarse la primera vista de la reclamación.

Información legal:

El artículo 11-9-514(b) del Ark. Code Ann. establece que: "El tratamiento o los servicios prestados por un médico distinto de los seleccionados de acuerdo con lo anterior, con excepción de los tratamientos urgentes, correrán a cargo del demandante."

El artículo 11-9-514(f) del Ark. Code Ann., sin embargo, establece que: Cuando la compensación sea causa de controversia, el subapartado (b) no será de aplicación si:

- (1) El empleado solicita asistencia médica por escrito antes de buscarla como consecuencia de una posible lesión compensable; y
- (2) El empleador se niega a remitir al empleado a un proveedor médico en el plazo de cuarenta y ocho (48) horas desde dicha solicitud escrita; y
- (3) Posteriormente se descubre que la supuesta lesión es compensable; y
- (4) El empleador no ha hecho ninguna oferta anterior de tratamiento médico.

Si tiene alguna pregunta relativa a sus derechos en virtud de la legislación en materia de compensaciones de los trabajadores de Arkansas, puede llamar al asesor legal de la Comisión de Compensación de los Trabajadores de Arkansas al número gratuito que se indica más arriba.

Todos los empleadores que se vean afectados por la ejecución de la legislación en materia de compensaciones de los trabajadores de Arkansas y que hayan cumplido estas disposiciones deberán colocar esta notificación en un lugar **PREMINENTE** en su centro de trabajo o las cercanías.

Formulario P de la AWCC
(Notificación)

En los **apartados 11-9-403 y 11-9-407 del Ark. Code Ann. y la Regla 7 de la AWCC** se menciona una notificación. El **formulario P de la AWCC** cumple todos esos requisitos.

Formulario P:

1. Debe mostrarse en un lugar preeminente;
2. Dice a los empleados qué deben hacer cuando un trabajador se lesiona;
3. Instruye a los empleados para que notifiquen las lesiones inmediatamente al empleador (o no más tarde del final del siguiente día laborable);
4. Enumera la oficina de reclamaciones en la que se tratarán los aspectos vinculados a seguros del caso;
5. Anuncia la fecha en que expira la póliza de seguros;
6. Ofrece números de teléfono del asesor legal de la Comisión de Compensaciones de los Trabajadores de Arkansas por si alguien necesita ayuda.

Los empleadores que no cuenten con un **formulario P** podrán perder el derecho a utilizar el **formulario N** como defensa en un litigio. Los empleados que desobedezcan las instrucciones del **formulario P** podrán sufrir retrasos en el beneficio de cualquier prestación en los casos que se impugnen o corren el riesgo de perderlos.

La AWCC ofrece copias de muestra pero no suministra el **formulario P**. Las aseguradoras deben enviar a sus asegurados un número adecuado de copias y los auto-asegurados deben contratar el suministro con una imprenta. Las aseguradoras y los empleadores pueden ampliar el **formulario P** para publicarlo.

Puede obtenerse información sobre el formulario P de la División de Servicios de Soporte (1-800-622-4472 o 501-682-3930).

Ark. Code Ann., apartado 11-9-106(a): “Cualquier persona o entidad que realice consciente y voluntariamente una declaración o afirmación sustancial falsa o que omita u oculte consciente y voluntariamente un dato sustancial, o que utilice consciente y voluntariamente un dispositivo, sistema o artificio para: obtener una prestación o pago, engañar o aumentar o reducir ilegítimamente cualquier reclamación de beneficios o pagos, u obtener o evitar la cobertura de compensación para los empleados o evitar el pago de la prima de seguro correspondiente, o que ayude e induzca a cualquiera de estos fines, será, en virtud del presente capítulo, culpable de un delito de Clase D. El cincuenta por ciento (50%) de cualquier multa penal impuesta y cobrada en virtud de... este artículo se pagará y adjudicará de acuerdo con la legislación aplicable al Fondo de Discapacidad Total Permanente y Fallecimiento administrado por la Comisión de Compensaciones de los Trabajadores.”

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)				CARRIER/ADMINISTRATOR CLAIM NUMBER		OSHA LOG CASE #		REPORT PURPOSE CODE	
				JURISDICTION		JURISDICTION CLAIM NUMBER			
				INSURED REPORT NUMBER					
				EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #	
PHONE #									
INDUSTRY CODE		EMPLOYER FEIN							

CARRIER/CLAIMS ADMINISTRATOR									
CARRIER (NAME, ADDRESS, & PHONE #)				POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)			
				TO					
				CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE					
CARRIER FEIN		POLICY/SELF-INSURED NUMBER				ADMINISTRATOR FEIN			

EMPLOYEE/WAGE											
NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE	
ADDRESS (INCL ZIP)				SEX <input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN		MARITAL STATUS <input type="checkbox"/> U UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN		OCCUPATION/JOB TITLE			
								EMPLOYMENT STATUS			
								PHONE			
								# OF DEPENDENTS			
RATE PER:		<input type="checkbox"/> DAY	<input type="checkbox"/> WEEK	<input type="checkbox"/> MONTH	<input type="checkbox"/> OTHER:	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		<input type="checkbox"/> YES	<input type="checkbox"/> NO

OCCURRENCE/TREATMENT													
TIME EMPLOYEE BEGAN WORK		<input type="checkbox"/> AM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE () CANNOT BE DETERMINED		<input type="checkbox"/> AM	LAST WORK DATE		DATE EMPLOYER NOTIFIED		DATE DISABILITY BEGAN	
		<input type="checkbox"/> PM					<input type="checkbox"/> PM						
CONTACT NAME/PHONE NUMBER					TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED				
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO					TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE				
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED							
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED							
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL										CAUSE OF INJURY CODE			
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?				<input type="checkbox"/> YES	<input type="checkbox"/> NO				
				WERE THEY USED?				<input type="checkbox"/> YES	<input type="checkbox"/> NO				
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)					HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)					INITIAL TREATMENT			
										0 NO MEDICAL TREATMENT			
										1 MINOR: BY EMPLOYER			
										2 MINOR CLINIC/HOSP			
										3 EMERGENCY CARE			
										4 HOSPITALIZED > 24 HOURS			
5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED													

OTHER									
WITNESSES (NAME & PHONE #)									
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER	

AWCC Form 1
(Employer's First Report of Injury or Illness)

Ark. Code Ann. § 11-9-529 allows employers 10 days to report injuries. Those involving either more than 7 days of lost time or indemnity payments require **Form 1**. Also, a Form 1 is required for all controversies including a medical-only case. Self-insured employers file **Form 1** with the AWCC; other employers send it to their insurance representatives.

Employers do **NOT** fill in the shaded areas.

On **Form 1**, employers/carriers must:

1. In the **Occurrence Section** list the date the employer first knew of the injury. The 10 days to report begin either on the date of disability **or** the date the employer was notified, whichever date is later.
2. Give the name of the carrier. An insurance agency or third party administrator should be listed in the **Preparer's Section**. A carrier can pre-print its name and address in the **Carrier Section** to help clients properly report.
3. Specify the carrier Federal Employer Identification Number (FEIN) in the **Carrier Section**.
4. Type or print in ink. An illegible, incomplete **Form 1** will be returned.

Neglect of **Form 1**: Late employee benefits, exposing employers to fines.

Lack of **Form 1**: Delays in insurance investigation.

General inquiries on Form 1 can be answered by the AWCC Support Services Division. Questions on a specific Form 1 may be directed to the Research and Statistics Section, which processes the accident reports. (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

ARKANSAS WORKERS' COMPENSATION COMMISSION
324 Spring Street
P.O. Box 950
Little Rock, AR 72203-0950

TO: **Interested Parties**

FROM: **Carl Bayne**
 Operations/Compliance

DATE: **November 20, 2012**

SUBJECT: **Form 1 Required Data, Effective January 1, 2013**

Following this notice you will find a Form 1 clearly marked showing what data is required, effective January 1, 2013.

In the past we have communicated with you that we “require” some data and “request” other. In order to simplify things, we are indicating for you only the data we require. Additionally we are providing for you explanations of what style of information will satisfy our requirements.

Please note that failure to provide any of the data marked on the accompanying Form 1 will cause your submission to be rejected.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

1				CARRIER/ADMINISTRATOR CLAIM NUMBER 3				OSHA CASE NUMBER				REPORT PURPOSE CODE							
				JURISDICTION 4				JURISDICTION CLAIM NUMBER											
				INSURED REPORT NUMBER															
				EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)								LOCATION #							
INDUSTRY CODE				EMPLOYER FEIN 2				5								PHONE #			
CARRIER/CLAIMS ADMINISTRATOR																			
6								POLICY PERIOD 7 TO				CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)							
								CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE 8				9							
CARRIER FEIN				POLICY/SELF-INSURED NUMBER 10								ADMINISTRATOR FEIN							
AGENT NAME & CODE NUMBER																			
EMPLOYEE/WAGE																			
11								DATE OF BIRTH 12				SOCIAL SECURITY NUMBER 13				DATE HIRED 14		STATE OF HIRE	
								15				MARITAL STATUS				OCCUPATION/JOB TITLE 16			
												EMPLOYMENT STATUS				17			
												NCCI CLASS CODE							
PHONE								# OF DEPENDENTS				FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?				YES NO			
RATE		PER		DAY WEEK		MONTH OTHER		DAYS WORKED/WEEK				YES NO							
OCCURRENCE/TREATMENT																			
TIME EMPLOYEE BEGAN WORK		AM PM		DATE OF INJURY/ILLNESS 18				TIME OF OCCURRENCE () CANNOT BE DETERMINED				AM PM		LAST WORK DATE 19		DATE EMPLOYER NOTIFIED 20		DATE DISABILITY BEGAN 21	
CONTACT NAME/PHONE NUMBER								TYPE OF INJURY/ILLNESS 22				PART OF BODY AFFECTED 23							
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?								TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE							
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED								ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED											
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED								WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED											
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL																			
24												CAUSE OF INJURY CODE							
DATE RETURN(ED) TO WORK				IF FATAL, GIVE DATE OF DEATH 25				WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?				YES NO							
								WERE THEY USED?				YES NO							
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)								HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)								INITIAL TREATMENT			
																0 NO MEDICAL TREATMENT			
																1 MINOR: BY EMPLOYER			
																2 MINOR CLINIC/HOSP			
																3 EMERGENCY CARE			
																4 OVERNIGHT HOSPITALIZATION			
				5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED															
OTHER																			
WITNESSES (NAME & PHONE #)																			
DATE ADMINISTRATOR NOTIFIED				DATE PREPARED				PREPARER'S NAME & TITLE 26				PHONE NUMBER 27							

REQUIRED FORM 1 DATA

1. EMPLOYER NAME AND ADDRESS: Providing the name and address shown on the policy is helpful, but do not hesitate to include a DBA if it's appropriate. And, if it is a national employer, you will have an opportunity to, in box 5 (Employer's Location Address if Different) give us the local name and physical address of the employer.

2. EMPLOYER FEIN: Double check this for accuracy.

3. CARRIER/ADMINISTRATOR CLAIM NUMBER: Provide the claim number assigned by the Carrier or TPA actually handling this claim.

4. JURISDICTION: This is required only on EDI submission of your Form 1. For all claims other than by EDI submissions, we will accept it and enter it as an AR claim, unless some other state code is entered here, at which time we will reject your Form 1 filing.

5. EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT): We require a physical location for where in injury/illness occurred. If you provide in Employer Name and Address (box 1) a P.O. Box, or if the injury/illness occurred at a location separate from the address listed in Employer Name and Address, you are required to provide this data, making sure it is a physical address.

6. CARRIER (NAME & ADDRESS): Provide the Carrier Name and Address as it is registered with the Arkansas Workers' Compensation Commission.

7. POLICY PERIOD: While self-insureds do not have a policy expiration date, if self-insurance is not marked in box 8, and this data is not provided, this Form 1 will be rejected.

Everyone else provide us the policy period for the policy in effect on the date of injury/illness.

8. SELF-INSURANCE: If a self-insured fails to properly identify themselves as self-insured, we will reject the Form 1 without a policy period.

9. CLAIMS ADMINISTRATOR (NAME & ADDRESS): Provide this information, in this block, even if the previously identified Carrier is handling the claim. We want the name and address in which the adjuster handling this claim is housed.

10. POLICY/SELF-INSURED NUMBER: Provide us the policy number which existed on the date of the injury/illness.

11. EMPLOYEE NAME: Double check the spelling. Provide at minimum the legal last and first names (unless the claimant's given name is "Bubba", do not send in a Form 1 indicating that his name is "Bubba").

12. DATE OF BIRTH: An accurate date of birth is required. Several have filed their Form 1 with dates that meet the format standard required to make it through the EDI screening, sometimes entering something such as 01/01/1901. If the date of birth is obviously fabricated, we will reject your Form 1.

13. SOCIAL SECURITY NUMBER: The full 9-digit Social Security Number is required on the Form 1.

14. DATE HIRED: This information is required only in Death cases. If, after filing your Form 1, the claimant dies, file an Amended Form 1 (clearly write "Amended" on the top of the Form and circle any data that is being added or changed), reporting the Date of Death and Date Hired.

15. SEX: This means gender: Male or Female. The Form 1 has a little box for Unknown, but we will not accept your Form 1 if you enter Unknown.

16. OCCUPATION/JOB TITLE: Please enter the primary occupation of the claimant at the time of his/her accident/incident/exposure.

17. EMPLOYMENT STATUS: The valid choices for Employment Status are:

Full-Time	On Strike	Volunteer	Seasonal
Part-Time	Disabled	Apprenticeship Full-Time	Piece Worker
Not Employed	Retired	Apprenticeship Part-Time	

18. DATE OF INJURY/ILLNESS: This is an absolute requirement, and is used on virtually all of the AWCC Forms that you will file on this claim. Please be sure that you're accurate on this date, as any form(s) that come in after your Form 1 with a different date of injury/illness are liable to be rejected.

19. LAST WORK DATE: It is not necessary that this be a complete work day. If an employee is injured and has to leave work, that day is his/her last work date. Without this date, we will reject your Form 1.

20. DATE EMPLOYER NOTIFIED: This is required only to the point that if you don't provide it for us, I will provide it on your behalf. If you leave this blank, I will not reject your Form 1, but I will use the Date of Injury/Illness as the Date Employer Notified.

21. DATE DISABILITY BEGAN: This is required only to the point that if you don't provide it for us, I will enter it on your behalf. If you leave this blank, I will not reject your Form 1, but our system is set up to default to the day after the Date of Injury/Illness as the Date Disability Began, if you don't give us a different date.

22. TYPE OF INJURY/ILLNESS: Ladies and gentlemen, following this instruction sheet, you will find the complete listing of injury/illnesses and the code for each.

23. PART OF BODY AFFECTED: Ladies and gentlemen, following this instruction sheet, you will find the complete listing of body parts and the code for each body part.

24. HOW INJURY OR ILLNESS OCCURRED: A short narrative, please. We want more than "tripped" or "crushed his finger". What we would like is more "carrying a box, stepped on a loose pipe, fell, dropping the box on his foot, breaking his foot".

25. IF FATAL, DATE OF DEATH: If this claim is a Death claim, we require the date of death to be reported on the Form 1. Additionally, you must report the Date of Hire (box 14).

If the claim did not begin as a Death claim, but becomes one, you are required to file an Amended Form 1 (clearly write "Amended" on the top of the Form and circle any data that is being added or changed), reporting the Date of Death and Date of Hire.

Too, when a Fatality occurs, you are required to file a Form D within 30-days of the Date of Death.

26. PREPARER'S NAME AND TITLE: We require the name and title of the adjuster handling this particular claim. So many have the employer's staff person who actually filled out the Form 1 to put their name and title here, but doing this is incorrect!

The proper place for the name and phone number of the employer's staff person who may actually fill out this Form 1 is the "Contact Name/Phone Number" box immediately below box number 18, in the Occurrence/Treatment section.

While we require the name and title of the adjuster handling this particular claim, we will not reject your Form 1 submission, even though the employer's staff person's name and title are written in here, IF you print your information on the bottom of the Form.

27. PHONE NUMBER: Similar to the note above, we want the phone number of the adjuster handling this claim. We do not ask for the phone number of the employer's staff person filling out this form, as we will never be contacting them. We do, however, want to be able to quickly contact you, so we require your direct phone number, or your main office phone number and your extension.


FINAL NOTE: "UNKNOWN" is never an acceptable entry on a Form 1. If it's a required data element, find the answer before submitting the Form 1. If it's not a required data element, and you don't know the answer, don't put anything in that box.

FORM 1, TYPE OF INJURY/ILLNESS AND CODES (Box 22 on Form 1)

Code	Type of Injury/Illness	Code	Type of Injury/Illness
01	NO PHYSICAL INJURY	80	ALL OTHER CUMULATIVE INJURIES
02	AMPUTATION	90	MULTIPLE PHYSICAL INJURIES
53	SYNCOPE (SWOONING, FAINTING)	91	MULTIPLE INJURIES
54	ASPHYXIATION	03	ANGINA PECTORIS (CHEST PAIN)
55	VASCULAR LOSS	04	BURN
58	VISION LOSS	07	CONCUSSION
59	ALL OTHER	10	CONTUSION
60	DUST DISEASE NOC	13	CRUSHING
61	ASBESTOSIS	16	DISLOCATION
62	BLACK LUNG	19	ELECTRIC SHOCK
63	BYSSINOSIS	22	ENUCLEATION (REMOVE TUMOR)
64	SILICOSIS	25	FOREIGN BODY
65	RESPIRATORY DISORDERS (GASES,FUMES,ETC.)	28	FRACTURE
66	POISONING - CHEMICAL	30	FREEZING
67	POISONING - METAL	31	HEARING LOSS (TRAUMATIC ONLY)
68	DERMATITIS	32	HEAT PROSTRATION
69	MENTAL DISORDER	34	HERNIA
70	RADIATION	36	INFECTION
71	ALL OTHER OCCUPATIONAL DISEASE	37	INFLAMMATION
72	LOSS OF HEARING	40	LACERATION
73	CONTAGIOUS DISEASE	41	MYOCARDIAL INFARCTION (HEART ATTACK)
74	CANCER	42	POISONING GENERAL
75	AIDS	43	PUNCTURE
76	VDT-RELATED DISEASE	46	RUPTURE
77	MENTAL STRESS	47	SEVERANCE
78	CARPAL TUNNEL SYNDROME	49	SPRAIN
79	HEPATITIS C	52	STRAIN

FORM 1, BODY PART AFFECTED AND CODES (Box 23 on Form 1)

Code	Body Part	Code	Body Part
00	UNDEFINED	66	NO PHYSICAL INJURY
10	MULTIPLE HEAD INJURY	90	MULTIPLE BODY PARTS INJURY
38	SHOULDER(S)	91	MULT SYSTEMS AND MULT BODY SYSTEMS
39	WRIST(S) & HAND(S)	99	UNSPEC
40	MULTIPLE TRUNK INJURY	11	SKULL
41	UPPER BACK AREA (THORACIC AREA)	12	BRAIN
42	LOW BACK AREA INC:LUMBAR & LUMBO-SACRAL	13	EAR(S)
43	DISC (TRUNK AREA)	14	EYE(S)
44	CHEST INC: RIBS,STERNUM,AND SOFT TISSUE	15	NOSE
45	SACRUM AND COCCYX	16	TEETH
46	PELVIS	17	MOUTH
47	SPINAL CORD	18	OTHER FACIAL SOFT TISSUE
48	INTERNAL ORGANS	19	FACIAL BONES
49	HEART	20	MULTIPLE NECK INJURY
50	MULTIPLE LOWER EXTREMITIES INJURY	21	VERTEBRAE
51	HIP	22	DISC (NECK AREA)
52	THIGH	23	SPINAL CORD
53	KNEE	24	LARYNX
54	LOWER LEG	25	SOFT TISSUE
55	ANKLE	26	TRACHEA
56	FOOT	30	MULTIPLE UPPER EXTREMITIES
57	TOE(S)	31	UPPER ARM (INC: CLAVICLE AND SCAPULA)
58	GREAT TOE	32	ELBOW
60	LUNGS	33	LOWER ARM
61	ABDOMEN (INCLUDING GROIN)	34	WRIST
62	BUTTOCKS	35	HAND
63	LUMBAR AND/OR SACRAL VERTEBRA	36	FINGER(S)
64	ARTIFICIAL APPLIANCE	37	THUMB
65	UNKNOWN - INSUFFICIENT INFORMATION		

Form AR-S Authority: Ark. Code Ann. § 11-9-529 Revised: 1-1-2001	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

SUPPLEMENTAL REPORT

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)			Employee SS Number	
Employer Name		FEIN No.	City	State	Zip Code	
Carrier Or Self-Insured Name		NAIC No.	Claims Office Address			

1. Date of injury: _____ 2. Date employee began losing time from work: _____ 3. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date _____ 4. If employee has returned to work, is he/she earning the same wages as before the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, please explain: 5. Has employee died? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date of death: _____
--

ADDITIONAL INFORMATION

--

CERTIFICATION

I certify that the information above is accurate according to the employer's/carrier's records.			
Signature	Printed or Typewritten Name	Title	Date

AWCC Form S
(Supplemental Report)

This form reports any change-in-status, including, but not limited to:

1. The injured employee is back at work and drawing wages;
2. The injured employee is losing time again;
3. The injured employee has died;

Employers need to file **Form S** promptly.

Carriers file the form to fill in any "gaps" in time on **AWCC Form 4** when the case is being closed.

Contact the AWCC Office Services Section for help with the Form S. General information is available from the Support Services Division (1-800-622-4472 or 501-682-3930) .

Ark. Code Ann. §11-9-106(a): “Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers’ compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers’ Compensation Commission.”

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 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

WAGE STATEMENT IMMEDIATELY PRECEDING INJURY DATE

Weeks	Straight Time Worked		Wages Paid For Straight Time	Overtime Hours Worked		Wages Paid for Overtime
	Days	Hours		Days	Hours	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
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50						
51						
52						
Total						

AWCC No.

Carrier Claim No.

Employee Name:

Employee S.S.No.:

Employer Name:

Employer FEIN No.:

Carrier or Self-Insured Name:

Carrier NAIC No.:

INSTRUCTIONS FOR
COMPLETING WAGE STATEMENT
(To be completed only if claimant
receives less than maximum benefits)

In completing the Wage Statement, in week
one give information for the week prior to
the injury and follow with preceding weeks.
Days and hours of straight time work should
be given in all cases.

Explanation of time lost by employee: _____

W

AWCC Form W
(Wage Statement)

1. The **AWCC Advisory 88-1** requires respondents to file **Form W** (with the AWCC file number for the case, obtained from **AWCC Form A-110**) if the claimant receives less than the maximum compensation rate.
2. The average weekly wage of the injured worker shall "[I]n no case...be computed on less than a full-time workweek in the employment." [Ark . Code Ann. § 11-9-518(a)(1)]

Information on Form W is available from the Office Services Section. General Information is available from the Support Services Division. (1-800-622-4472 or 501-682-3930)

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	N
<small>Ark. Code Ann. §§11-9-701, 508, 514 AWCC Rule 099.33 Revised: 1-1-2001 Updated: 8-1-2006</small>		

EMPLOYEE'S NOTICE OF INJURY

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	M I	Social Security Number	Home Phone No.
Street Address or P.O. Box	City		State	Zip Code
Child Support Obligation: <input type="checkbox"/> Current <input type="checkbox"/> Past Due Payable to:				

EMPLOYER INFORMATION (Please Print)

Employer's Name	Supervisor's Name
Employer's Street Address or P.O. Box	Employer's City
State	Zip Code

ACCIDENT INFORMATION (Please Print)

			Date /Time
Place of Accident	Date of Accident	Time of Accident	Employer Notified of Accident
What part of your body was injured? _____ _____ _____			
Briefly discuss the cause of injury: _____ _____ _____			


Name/address of witness(es): _____ _____ _____ _____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, written or oral, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change-of-physician. (See additional information on back side of form)

Date _____ Signature _____

Assistance with AWCC Form N is available from the AWCC Legal Advisor Division (1-800-250-2511 or 501-682-3930). Information is supplied by the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	
Ark. Code Ann. §§ 11-9-701, 508, 514 AWCC Rule 33 Revised: 1-1-2001 Updated: 8-1-2006		

EMPLOYER'S NOTICE TO EMPLOYEE

NOTICE TO EMPLOYEE - Fill out this form to give to your employer immediately. Employer: Be sure the employee receives a copy of this form [Ark. Code Ann. § 11-9--514 (c)]

Ark. Code Ann. § 11-9-701. Notice of injury or death.

- (a)(1) Unless an injury either renders the employee physically or mentally unable to do so, or is made known to the employer immediately after it occurs, the employee shall report the injury to the employer on a form prescribed or approved by the Workers' Compensation Commission and to a person or at a place specified by the employer, and the employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's report of injury.
- (2) All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements.
- (3) The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.
- (b)(1) Failure to give the notice shall not bar any claim:
 - (A) If the employer had knowledge of the injury or death;
 - (B) If the employee had no knowledge that the condition or disease arose out of and in the course of the employment; or
 - (C) If the commission excuses the failure on the grounds that for some satisfactory reason the notice could not be given.
- (2) Objection to failure to give notice must be made at or before the first hearing on the claim.

CHOICE/CHANGE OF PHYSICIAN

Rights and responsibilities. Treatment or services furnished or prescribed by any physician other than the ones selected according to the provisions below, except emergency treatment, shall be at the claimant's/employee's expense.

Ark. Code Ann. § 11-9-508. Medical services and supplies.

"(e) . . . [T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions."

1. Your employer shall have the right to select the initial primary care physician from among those associated with certified MCOs.
2. You may request a change-of-physician. You should initially request a change from the insurance carrier or employer. Within five business days of your initial request for a change-of-physician, the insurance carrier or employer should notify you of its decision to grant or deny the change-of-physician.
3. If your request for change of physician is denied you may send a petition to the Clerk of the Arkansas Workers' Compensation Commission for a one (1) time only change-of-physician.
4. **If your employer has contracted with a certified MCO**, you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must also either be associated with the certified MCO chosen by your employer or who is your regular treating physician. (Your "regular treating physician" is one who maintains your medical records and with whom you have a history of regular treatment before the onset of your compensable injury.) The health care provider to whom you change must agree to refer you to the certified MCO chosen by your employer for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by the MCO initially chosen by your employer.
5. **If your employer does not have a contract with a certified MCO**, you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must either be associated with any certified MCO or who is your regular treating physician. (See definition above.) The health care provider to whom you change must agree to refer you to a physician associated with any certified MCO for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by any certified MCO.

Back side / Two-sided form

N

Formulario AR-N	COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS	N
Autoridad: Ark. Code Ann., apartado 11-9-702, 508, 514 AWCC Norma 33 Revisado: 1-1-2001 En Español: 10-15-2004 Actualizada: 8-1-2006	324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

NOTIFICACIÓN DE ACCIDENTE DEL EMPLEADO

DATOS DEL EMPLEADO (utilizar tinta y mayúsculas)

Apellido	Nombre	Inicial del 2 nd nombre	# de la Seguridad Soc.	Fecha de nacimiento	(Prefijo), número de teléfono particular
Dirección o apartado de correos		Ciudad	Estado	Código postal	
¿Tiene obligación de pagar manutención de sus hijos? <input type="checkbox"/> Estoy al corriente <input type="checkbox"/> Estoy atrasado/a <input type="checkbox"/> Pagaderos a:					

DATOS DEL EMPLEADOR (utilizar mayúsculas)

Nombre del empleador (denominación con la que opera)			(Prefijo), número de teléfono del empleador
Dirección del empleador	Ciudad del empleador	Estado	Código postal

INFORMACIÓN SOBRE EL ACCIDENTE (utilizar mayúsculas)

Lugar del accidente	Fecha del accidente	Hora del accidente	Día / Hora
¿Qué parte del cuerpo se ha lesionado? _____			
Describa brevemente las causas del accidente: _____			

TESTIGOS

Nombre y dirección de los testigos, si procede: _____

Por la presente autorizo a cualquier hospital, médico, psicoterapeuta o profesional sanitario a suministrar al portador cualquier dato, oral o escrito, incluidos, entre otros, copias de los registros médicos relativos a mi estado físico, mental o emocional pasado, presente o futuro. Por la presente renuncio a mi privilegio médico (y psicoterapeuta o profesional sanitario)-paciente. Una copia fotostática de la presente autorización será tan válida como y efectiva como el original. Mi firma a continuación también indica que se me ha ofrecido el ejercicio de mis derechos relativos al cambio de médico. (Véase la información adicional al dorso.)
Fecha: _____ Firma: _____

Puede obtenerse ayuda con respecto al formulario N de la AWCC de la División del Asesor Legal (1-800-520-2511 o 501-682-3930). Puede obtenerse información de la División de Servicios de Soporte (1-800-622-4472 o 501-682-3930).

Ark. Code Ann., apartado 11-9-106(a): “Cualquier persona o entidad que realice consciente y voluntariamente una declaración o afirmación sustancial falsa o que omita u oculte consciente y voluntariamente un dato sustancial, o que utilice consciente y voluntariamente un dispositivo, sistema o artificio para: obtener una prestación o pago, engañar o aumentar o reducir ilegítimamente cualquier reclamación de prestaciones o pagos, u obtener o evitar la cobertura de compensación para los empleados o evitar el pago de la prima de seguro correspondiente, o que ayude e induzca a cualquiera de estos fines, será, en virtud del presente capítulo, culpable de un delito de Clase D. El cincuenta por ciento (50%) de cualquier multa penal impuesta y cobrada en virtud de... este artículo se pagará y adjudicará de acuerdo con la legislación aplicable al Fondo de Discapacidad Total Permanente y Fallecimiento administrado por la Comisión de Compensaciones de los Trabajadores.”

Formulario AR-N	COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS	N
Autoridad: Ark. Code Ann., apartado 11-9-702 Revisado: 1-1-2001 En Español: 10-15-2004	324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

NOTIFICACIÓN DE ACCIDENTE DEL EMPLEADO

NOTIFICACIÓN AL EMPLEADO - Cumplimente este formulario para entregarlo a su empleador inmediatamente.

Ark. Code Ann., apartado 11-9-701. Notificación de fallecimiento o lesión.
(a) (1) A menos que se trate de una lesión que impida mental o físicamente al empleado hacerlo, o si se comunica al empleador inmediatamente después de producirse, el empleado deberá informar del accidente a su empleador en una forma establecida o aprobada por la Comisión de Compensación de los trabajadores y a una persona y en un lugar especificado por el empleador, y el empleador no será responsable de las beneficias de discapacidad, médicas o de otro tipo anteriores a la recepción del informe del accidente.
(2) Todos los procedimientos de notificación que especifique el empleador deberán ser razonables y éste deberá notificar razonablemente a todos los empleados los requisitos de notificación.
(3) Lo anterior no será de aplicación si el empleado precisa tratamiento médico de urgencia fuera del horario de trabajo habitual del empleador; sin embargo, en ese caso, el empleado deberá hacer que se notifique el accidente al empleador el siguiente día laborable habitual.
(b) (1) La falta de notificación no anulará las reclamaciones si:
(A) El empleador tiene conocimiento del fallecimiento o lesión; o
(B) El empleado no tenía conocimiento de que la afección o enfermedad se produjo en el transcurso de su empleo; o
(C) La Comisión exime esta omisión basándose en que la notificación no pudo realizarse por un motivo justificado.
(2) Las objeciones relativas a la falta de notificación deberán plantearse antes o en el momento de celebrarse la primera vista de la reclamación.

ELECCIÓN/CAMBIO DE MÉDICO

Derechos y responsabilidades. El tratamiento o los servicios suministrados o prescritos por un médico distinto del seleccionado de acuerdo con las siguientes disposiciones, excepto el tratamiento de urgencia, correrán a cargo del solicitante/empleado.
Ark. Code Ann., apartado 11-9-508. Servicios y suministros médicos.
“(e) ...[E]l empleado lesionado podrá tener acceso directo a cualquier proveedor de servicios oftalmológicos u optométricos que acepte suministrar servicios de acuerdo con las normas y condiciones relativas a los servicios prestados por la entidad de atención gestionada inicialmente elegida por el empleador para el tratamiento y control de lesiones o afecciones de los ojos.”
1. Su empleador podrá seleccionar al médico de atención primaria inicial de entre los asociados con MCOs certificadas.
2. Podrá solicitar un cambio de médico. Inicialmente debería solicitar un cambio a la aseguradora o el empleador. En el plazo de cinco días laborables desde su solicitud inicial de cambio de médico, la aseguradora o el empleador deberían notificarle su decisión de concederle o denegarle el cambio de médico.
3. Si su solicitud de cambio de médico es denegada podrá enviar una petición al Secretario de la Comisión de Compensación de los trabajadores para un (1) único cambio de médico.
4. Si su empleador tiene un contrato con una MCO certificada , podrá cambiar de médico solicitando a la Comisión un (1) único cambio de médico por un facultativo que también deberá estar asociado a la MCO certificada elegida por su empleador o que sea el médico que le atiende regularmente (Por “médico que le atiende regularmente” se entiende el facultativo que mantiene sus registros médicos y con el que cuente con un historial de tratamiento habitual anterior a la lesión para la que se puede solicitar la compensación”). El proveedor de atención sanitaria por el que cambie deberá aceptar remitirlo a la MCO certificada elegida por el empleador para cualquier tratamiento especializado, incluida la terapia física, y deberá aceptar cumplir todas las normas y condiciones relativas a los servicios prestados por la MCO certificada inicialmente elegida por su empleador.
5. Si su empleador no tiene un contrato con una MCO certificada , podrá cambiar de médico solicitando a la Comisión un (1) único cambio de médico por un facultativo que también deberá estar asociado a una MCO certificada o que sea el médico que le atiende regularmente (véase la definición anterior). El proveedor de atención sanitaria por el que cambie deberá aceptar remitirlo a una MCO certificada para cualquier tratamiento especializado, incluida la terapia física, y deberá aceptar cumplir todas las normas y condiciones relativas a los servicios prestados por cualquier MCO certificada.

Employee Incident Report

This form should be filled out by the injured employee.

Name

Employer Name

Date of Incident

Time of incident

Time you began work on day of incident

Address of Incident

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 incident 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 incident occurred?

The above form is true and correct.

Signature

Date Completed

Informe de Incidente del Empleado

A ser completado por el trabajador lesionado.



Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Hora en que usted empezó a trabajar el día del incidente

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

¿Cómo ocurrió la lesión? ¿Qué deberes del trabajo estaba desempeñando? Por favor, describa en sus propias palabras.

¿Qué parte(s) de su cuerpo resultó(aron) lesionada(s) (indicando derecha y/o izquierda)?

¿Ha buscado algún tratamiento médico para estas lesiones? Si es así, especifique dónde y cuándo.

¿Se ha lesionado anteriormente alguna vez esta parte de su cuerpo (sí o no)? Si es así, por favor, describa cómo y dónde ocurrió(eron) la(s) lesión(es) anterior(es).

¿Qué testigos estuvieron presentes cuando ocurrió el incidente? Por favor, proporcione nombres si es aplicable.

¿A quién informó la lesión? ¿Cuándo fue informada la lesión? Por favor, proporcione nombre(s) y puesto(s).

¿Qué hizo después de ocurrido el incidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario

Supervisor's Report of Employment Incident



Employee Name

Employer Name

Date of Incident

Time of incident

Time the employee began work on day of incident

Did the employee report the incident immediately?

Address of Incident

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 incident occurred (including self)?

Do you have any reason to question the legitimacy of the incident? If so, please explain:



Supervisor's Report of Employment Incident

Indicate working conditions present that led to incident (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 incident

Interaction with co-worker

Other:

Electrical exposure

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

Informe de Incidente del Supervisor



Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente?

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

¿Cómo ocurrió la lesión? ¿Qué deberes del trabajo estaba desempeñando el empleado?

¿Qué parte(s) del cuerpo del empleado se informaron como lesionadas?

¿Ha buscado el empleado algún tratamiento médico para estas lesiones? Si es así, especifique dónde y cuándo.

¿Qué testigos estuvieron presentes cuando ocurrió el incidente (incluyendo él mismo)?

¿Tiene usted alguna razón para dudar de la legitimidad del incidente? Si es así, por favor, explique:



Informe de Incidente del Supervisor

Indique las condiciones de trabajo presentes que conllevaron al incidente (por favor, marque todas las que apliquen).

Equipo para levantar no usado/no disponible

Vista obstruida

Interacción con paciente o residente

PPE (guantes, casco, gafas, etc.) no usado/no disponible

Falta de capacitación

Interacción con cliente

Contenedor de objetos punzantes no usado/no disponible

Herramientas o equipo defectuosos

Exposición a producto químico

Equipo no resguardado o incorrectamente resguardado

Piso mojado/resbaloso

Incidente de vehículo motorizado

Mala limpieza

Other:

Exposición eléctrica

Interacción con compañero de trabajo

¿Qué cambios se pueden realizar para eliminar o reducir el(los) peligro(s) identificado(s) anteriormente?

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración:

Witness' Report/Statement of Employee Incident



Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)

Date of Incident

Time of incident

Time you began work on day of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)

Did you witness the above-reported incident? 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 incident occurred?

Were any other witnesses present at the time of the incident? If so, please list them below.

The above form is true and correct.

Witness' Signature

Date Completed

Informe de Incidente del Testigo



Nombre del Empleado

Nombre del Testigo

Teléfono del Testigo

Dirección del Testigo

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/No)

Fecha Del Incidente

Hora del incidente

Hora en que comenzó a trabajar el día del incidente

Dirección del incidente

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/ No)

¿Presenció el incidente? Si es así, ¿cómo ocurrió? ¿Qué deberes laborales estaba realizando el empleado?

¿Qué parte(s) del cuerpo del empleado resultaron lesionadas? Describa el tipo de lesión (tensión, moretón, etc.)

¿Qué dijo el empleado lesionado en el momento de la lesión? ¿El empleado lesionado se quejó de dolor en el momento de la lesión? Si se quejaron de dolor, especifique la(s) parte(s) del cuerpo(s).

¿Qué hizo el empleado después de que ocurrió el incidente?

¿Había otros testigos presentes en el momento del incidente? Si es así, por favor escríbalos aquí.

La forma anterior es verdadera y correcta.

Firma del Testigo

Fecha

»» 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



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 o 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.