Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation State Claim Kit

Florida

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

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Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

P.O. Box 881236 San Francisco, CA 94188
(888) 495-8949
bhhc.com

Dear Policyholder:

Thank you for placing your workers compensation coverage with Berkshire Hathaway Homestate Companies (BHHC). We look forward to working with you to fulfill all your workers compensation needs.

Enclosed you will find documentation necessary for the processing and administration of a claim in the event of a workplace injury, as well as important information regarding workers compensation requirements for your state (i.e. posting notices, compliance laws, etc). Please utilize the documents included to collect valid information regarding the injured employee and incident, and send the documents in when reporting the claim or upon request. Any completed document should be sent directly to BHHC using mail, e-mail, or fax. The assigned claims professional will forward necessary documentation onto the appropriate state entity.

It is critical that you promptly report all new claims using one of the contact methods listed to the right.

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

bhhcpolicyholder.bhhc.com/Client/External/Claims

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

AM BEST A++ Superior
BHHC has an AM Best Credit Rating of A++ as of February 1, 2023.
For the latest Best Credit Rating, access ambest.com.

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Workers' Compensation Posting Requirements

FORM DFS-F4-1548/20206 – Workers' Comp Works For You Poster

- Post in one or more conspicuous places at all business locations
- Must contain the insurance carrier's name and contact information
- Each page of the Poster must be printed on 11" x 17" paper or cardstock

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

- Your company name and address
- Name of your designated workers' compensation insurer
- Policy Number
- Policy start and end dates

For your convenience, our other contact information has been entered on the Form DFS-F4-1548/2026.

Please note, since this version of the poster contains the mandatory fraud notice language, use of the Anti-Fraud Notice Poster is optional.

(Florida Statute 440.40(1) and Florida Administrative Code FAC 69L-6.007)

Requirements for Florida Anti-Fraud Notice Poster

Post in one or more conspicuous places at all business locations and work sites with Form DFSF4-1548/2026

This poster contains the mandatory fraud notice language; however, use of this poster is optional since the Form DFS-F4-1548/2026 meets the notice requirement. It has been included within the Florida claims kit for your potential use.

(Florida Statute 440.40(2) and Florida Administrative Code FAC 69L-6.007(1))

Workers' Comp Works For You

Workers' compensation pays for all authorized medically necessary care and treatment related to your injury or illness.

If you are unable to work or your earnings are lower because of a work related injury or illness, and you have been disabled for more than seven calendar days, you may be eligible for some wage replacement benefits.

$25,000 Reward

ANTI-FRAUD REWARD PROGRAM

Rewards of up to $25,000 may be paid to persons providing information to the Department of Financial Services leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the department at ***1-800-378-0445*** *or online at* ***https://first.fldfs.com***

A person is not subject to civil liability for furnishing such information, if such person acts without malice, fraud or bad faith.

This notice of compliance must be posted by the employer and maintained conspicuously in and about the employer's place or places of employment.
State of Florida
Division of Workers' Compensation

If you are injured on the job:

1. Notify your employer immediately to get the name of an approved physician. Workers' comp insurance may not pay the medical bills if you don't report your injury promptly to your employer.

2. Notify the doctor and medical staff that you were injured on the job so that bills may be properly filed.

3. If you have any problems with your claim or suffer excessive delays in treatment, contact the State of Florida's Division of Workers' Compensation at 1-800-342-1741.

69L-6.007, F.A.C. Compensation Notice
DFS-F4-1548
Revised March 2010
(Fraud reporting link updated May 2021)

Compensación por accidentes de trabajo labora para usted:

Compensación por accidentes de trabajo paga por todos los gastos médicos y tratamientos autorizados que se relacionen con su lesión u enfermedad y sean médicamente necesarios.

Si usted no puede trabajar o su ingreso es reducido debido a una lesión u enfermedad relacionada con su trabajo, y ha estado incapacitado por más de siete días, puede que sea elegible para recibir compensación por una porción de su sueldo.

Recompensa de $25,000.00

PROGRAMA DE RECOMPENSACIÓN ANTI FRAUDE

*Recompensas de hasta **$25,000.00** pueden ser pagadas a personas que proveen información al Departamento de Servicios Financieros que conduzca al arresto y convicción de aquellos que cometen fraude de seguros, incluyendo empleadores que ilegalmente dejan de obtener un seguro por accidentes de trabajo. Se puede reportar sospechas de fraude al Departamento llamando al **1-800-378-0445** o por correo electrónico al **https://first.fldfs.com***

Nadie es sujeto a responsabilidad civil por someter dicha información si se actúa sin malicia, fraude o mala fe.

Esta notificación debe ser colocada y mantenida a la vista por el empleador en y alrededor del lugar o lugares de empleo. Estado de la Florida, División de Compensación por Accidentes de Trabajo

69L-6.007, F.A.C. Compensation Notice
DFS-F4-2026
Revised March 2010
(Fraud reporting link updated May 2021)

Si usted se lastima en su lugar de empleo:

1. Notifique a su empleador inmediatamente para obtener el nombre de un medico autorizado. Puede que el seguro de compensación por accidentes de trabajo no pague sus cuentas médicas si usted no reporta su accidente lo mas antes posible a su empleador.

2. Notifique al medico y a su personal que usted se lastimó en su lugar de empleo para que las cuentas medicas sean debidamente remitidas.

3. Si usted tiene algún problema con su reclamo o si tiene demasiadas demoras en su tratamiento, comuníquese con la División de Compensación por Accidentes de Trabajo al 1-800-342–1741

$25,000

Anti-Fraud Reward Program

Rewards of up to $25,000 may be paid to persons providing information to the Dept of Financial Services leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the Department at 1-800-378-0445.

A person is not subject to civil liability for furnishing such information, if such person acts without malice, fraud or bad faith.

Workers' Compensation Exemptions

Construction Industry

An employer in the construction industry who employs one or more part-time or full-time employees, including the owner, must obtain workers' compensation coverage.

Corporate officers or members of a limited liability company (LLC) in the construction industry may elect to be exempt if:

- The officer owns at least 10 percent of the stock of the corporation, or in the case of an LLC, a statement attesting to the minimum 10-percent ownership.
- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.

No more than three corporate officers per corporation or limited liability member are allowed to be exempt. A $50 fee is required for each application submitted to obtain an exemption. Construction exemptions are valid for a period of two years or until a voluntary revocation is filed or the exemption is revoked by the Division.

Non-Construction Industry

An employer in the non-construction industry, who employs four or more part-time or full-time employees, must obtain workers' compensation coverage.

Sole proprietors and partners in the non-construction industry are automatically exempt from the law, but can elect to be covered.

Non-construction industry corporate officers may elect to be exempt if:

- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.

There is no limit to the number of corporate officers who can be exempt and there is no application fee. Non-construction exemptions are valid until a voluntary revocation is filed or the exemption is revoked by the Division.

For copies of the exemption form, contact the Division's Bureau of Compliance at (850) 413-1609 or go to http://www.MyFloridaCFO.com/WC/forms.html and click on Rule 69L-6 and Form number DWC-250, Notice of Election to Be Exempt.

What Your Employee Can Expect From the Insurance Carrier

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of the employee's claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of the employee's claim. This information should be provided to the injured worker by mail on either a Notice of Action/Change form (DWC-4) or a Notice of Denial form (DWC-12)

Questions about workers' compensation?

Please visit our Web site at www.MyFloridaCFO.com/wc where you will find extensive information such as publications, databases, rules and forms that will give you a better understanding of workers' compensation.

Employee Assistance and Ombudsman Office Hotline
1-800-342-1741

Injured worker e-mail inquiries
wceao@MyFloridaCFO.com

Customer Service
(850) 413-1601

Employer e-mail inquiries
WorkCompCustServ@MyFloridaCFO.com

Workers' Compensation Fraud Hotline
1-800-378-0445

Frequently Asked Questions

Q) How many days do employees have to report work-related injuries or illnesses?

A) Employers should encourage employees to report accidents as soon as the work related injuries or illnesses occur. By law, however, employees are required to report work related injuries or illnesses within 30 days.

Q To whom should I report the work-related injury?

A) You should report the accident to your insurance company as soon as you have knowledge of the injury.
By law, you have seven days from your first knowledge of the work related injury.

Q) Do I have to report a claim if I do not believe it is a work-related injury or illness?

A) Yes. You should report all claims of work-related injuries or illnesses to your workers' compensation insurance carrier. This includes claims in which there are no witnesses of the injury or illness. It is your workers' compensation insurance carrier's responsibility to investigate all claims and determine if employees are entitled to benefits under Florida's Workers' Compensation Law.

Q) Does the employee pay any part of my workers' compensation insurance premium?

A) No. The law is very specific on this point. It is the employer's responsibility to pay the entire premium for workers' compensation.

Employers who secure workers' compensation coverage can also apply to become a drug-free workplace and may receive a premium discount. To learn more about the Drug-free Workplace Program, please call the Division of Workers' Compensation Customer Service Office at 850-413-1609.

Q) Who should I call if my employees have questions or concerns regarding their workers compensation claims?

A) You should first contact your insurance carrier. If your carrier is unable to answer the question or resolve the problem, you or your employees should call the Employee Assistance and Ombudsman Office at 1-800-342-1741.

Disclaimer:
This publication is being offered as an informational tool only and complies with s. 440.185 (4) F.S., with the understanding that this is not official language of the Florida Statutes. In no event will the Division of Workers' Compensation be liable for direct or consequential damages resulting from the use of this printed material.

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-65
Revised March 2010

EMPLOYER FACTS

IMPORTANT

WORKERS' COMPENSATION INFORMATION FOR FLORIDA'S EMPLOYERS

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

Your workers' compensation insurance policy covers medical and partial wage-replacement benefits for any employee who sustains a work related injury or illness.

This brochure will give you a better understanding of your role and responsibilities under the workers' compensation system.

Workers' Compensation Notice

The law requires that every employer who has secured workers' compensation coverage post in conspicuous place(s) a notice that contains the employer's insurance carrier information, the expiration date of the policy and an anti-fraud statement. The Division of Workers' Compensation has developed this notice, in poster form, for carriers to provide to their policyholders. Your carrier is required by law to provide you with the poster(s).

Even if employers have purchased workers' compensation policies, they shall be deemed to have failed to secure workers' compensation coverage if they have committed any of the following actions:

- materially understated or concealed payroll,
- materially misrepresented or concealed employee duties to avoid proper classification for premium calculations, or
- materially misrepresented or concealed information pertinent to the computation and application of an experience modification factor.

Employers who fail to secure workers' compensation coverage or fail to update information on their workers' compensation insurance application are subject to stop work orders and civil and criminal penalties.

First Report of Injury

As soon as you become aware of a work-related injury or illness, immediately contact your workers' compensation insurance carrier. If you do not report the injury or illness to your insurance carrier within seven days of the date you were informed, you may be subject to an administrative fine not to exceed $2,000 per occurrence. Most insurance companies have a toll-free number to report work-related injuries. If you report the injury or illness to the insurance carrier by telephone, the carrier will complete the form and send a copy to you and the employee within three business days. You can also fill out the First Report of Injury or Illness form (DWC-1) and send it to the insurance carrier. The form contains employer, employee and accident information and can be obtained on the Division of Workers' Compensation Web site at www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1.pdf. You must also provide a copy of the First Report of Injury or Illness form to the employee. The employee's signature on the form is preferred, but if the employee is not able or available to sign it, then write "not available" in the employee signature box.

Workplace Fatalities

Employers must also report deaths resulting from work-related injuries or illnesses to the Division of Workers' Compensation within 24 hours. To report a workplace fatality, call 1-800-219-8953 (in Florida) or 850-413-1611, or fax the First Report of Injury of Illness form containing the fatality information to 850-413-1980. To access the form, go to http://www.MyFloridaCFO.com/WC/forms.html and click on DWC-1.

Medical Benefits

As soon as you notify your carrier about your employee's work-related injury, the carrier will:

- Determine the compensability of the injury
- Provide an authorized doctor
- Pay for all authorized medically necessary care and treatment related to the injury or illness
- Provide a one-time change of physician within five business days of receipt of your written request

Authorized treatment and care may include:

- Doctor's visits
- Hospitalization
- Physical therapy
- Medical tests
- Prescription drugs
- Prostheses
- Travel expenses to and from authorized providers or pharmacies.

Upon reaching maximum medical improvement (MMI), the employee is required to pay a $10 copayment per visit for medical treatment. MMI occurs when the treating physician determines that the employee's injury has healed to the extent that further improvement is not likely.

Wage Replacement Benefits

Workers' compensation benefits for lost wages will start on the eighth day that the injured employee is unable to work. The injured employee will not receive wage replacement benefits for the first seven days of work missed, unless he or she is out of work for more than 21 days due to the work-related injury. In most cases, the wage-replacement benefits will equal two-thirds of the employee's pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. If the employee qualifies for wage replacement benefits, he or she can expect to receive the first benefit check within 21 days after the carrier becomes aware of the injury or illness, and bi-weekly thereafter. The injured employee will be eligible for different types of wage replacement benefits, depending on the progress of the claim and the severity of the injury.

- Temporary Total Benefits: These benefits are provided as a result of an injury that temporarily prevents the employee returning to work and the employee has not reached MMI.
- Temporary Partial Benefits: These benefits are provided when the doctor releases the employee to return to work, and the employee has not reached MMI and earns less than 80 percent of the pre-injury wage. The benefit is equal to 80 percent of the difference between 80 percent of the pre-injury wage and the post-injury wage. The maximum length of time the injured employee can receive temporary benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.
- Permanent Impairment Benefits: These benefits are provided when the injury causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole. If you return to work at or above your pre-injury wage, the permanent impairment benefit is reduced by 50%.
- Permanent Total Benefits: These benefits are provided when the injury causes the employee to be permanently and totally disabled according to the conditions stated in law.
- Death Benefits: Compensation for deaths resulting from work-related injuries or illnesses include payment of funeral expenses and dependency benefits (each are subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

Wage Statement Form

You must complete and provide a wage statement form (DFS-F2-DWC-1a) to your carrier for any employee who is entitled to wage replacement benefits, within 14 days after knowledge of the accident. You must also complete this form upon the termination of the employee or upon termination of fringe benefits for any employee who is collecting wage replacement benefits within seven days of such termination. To access the form go to, http://www.MyFloridaCFO.com/WC/forms.html and click on DWC-1a.

Employee Assistance Office

If you have any questions or concerns about your employees' workers' compensation benefits, call your workers' compensation insurance carrier. If the insurance carrier does not provide the information that you have requested, you can call the Division of Workers' Compensation, Employee Assistance Office (EAO) at 1-800-342-1741. This office helps prevent and resolve disputes between injured workers and employers/carriers.

EAO specialists are knowledgeable about the workers' compensation system and may be able to answer your questions. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at www.MyFloridaCFO.com/WC/organization/eao_offices.html.

In addition, the Division of Workers' Compensation has a Web site section on "Frequently Asked Questions for Employers," which can be accessed at http://www.MyFloridaCFO.com/WC/faq/faqemplyrs.html.

Petition for Benefits

To begin the judicial procedure for obtaining benefits that you believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Office of Judges of Compensation Claims. The form can be accessed at www.jcc.state.fl.us/jcc/forms/.asp.

Anti-Fraud Reward Program

Workers' compensation fraud occurs when any person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program, files false or misleading information. Workers' compensation fraud is a third degree felony that can result in fines, civil liability and jail time. Rewards of up to $25,000 may be paid to individuals who provide information that lead to the arrest and conviction of persons committing insurance fraud.
To report suspected workers' compensation fraud, call 1-800-378-0445.

Certificado de elección para exenciones

Industrias dedicadas a la construcción

Empleadores en las industrias de la construcción con un (1) empleado o más a jornada completa o jornada parcial, incluyendo el dueño, debe obtener la cobertura de seguro por accidentes de trabajo.

Oficiales o miembros de una sociedad de responsabilidad limitada (LLC) de una corporación en la industria de la construcción pueden elegir ser exentos si:

- Poseen un mínimo de diez por ciento (10%) de titularidad de acciones de la corporación o en el caso de un LLC hay una declaración que da testimonio a la propiedad del 10 por ciento mínima.
- El oficial de la compañía aparece como oficial de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación aparece activa en el registro del Departamento del Estado de la Florida, División de Corporaciones.

Solamente tres oficiales de una corporación o sociedades de responsabilidad limitada pueden elige ser exentos. Se requiere pagar $50 por cada aplicación presentada para obtener una exención. Exenciones en las industrias que participan en la construcción son validas por dos años o hasta que se registre una revocación voluntaria o si la exención es revocada por la división.

Industrias que no se dedican a la construcción

Un empleador que no participa en la industria de construcción y tiene cuatro (4) empleados o más de jornada completa o jornada parcial tiene que obtener la cobertura de seguros por accidentes de trabajo.

Propietarios únicos y socios en industrias que no participan en la construcción están automáticamente exentos de la ley, pero pueden elegir ser cubierto.

Oficiales de una corporación que no se dedica a la construcción puede elegir ser exentos si:

- El oficial esta listado como oficial de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación esta listada activa en el registro del Departamento del Estado de la Florida, División de Corporaciones.

No hay límite de oficiales que pueden ser elegibles para ser exentos y no le cobrarán por llenar la aplicación para la exención. Exenciones en las industrias que no se dedican a la construcción son válidas por dos años o hasta que se registre una revocación voluntaria o si la exención es revocada por la división.

Para conseguir copias de la notificación de elección para ser exento [en inglés Notice of Election to Be Exempt] llame al (850) 413-1609 o vaya a nuestro sitio Web en http://www.myfloridacfo.com/WC/forms.html, y haga clic en la regla 69L-6 y número del formulario DWC-250 Elección de ser exento.

Lo que su empleado puede esperar de parte de la compañía de seguros:

- Provisión oportuna de tratamiento médico
- Provisión oportuna de beneficios de reemplazo de salario
- Pago oportuno de cuentas médicas
- Notificación oportuna de su reclamación a la División de Compensación por Accidentes de Trabajo
- Notificación oportuna de cualquier cambio del estado de su reclamación. Esta información se le será proveída por correo en un formulario titulado "Notice of Action/Change (DWC4) [Notificación de Acción o Cambio (DWC4)] o "Notice of Denial (DWC12) [Notificación de Negación (DWC12)]

¿Tiene preguntas sobre el seguro por accidentes de trabajo?

Por favor, visite nuestra página Web en www.MyFloridaCFO.com/wc donde usted encontrará información extensa tal como publicaciones, un número de bases de datos, reglas, y formas que le dará un mejor entendimiento del seguro para accidentes de trabajo.

Oficina de Ayuda al Trabajador (Oficina de asistencia para el trabajador) 1-800-342-1741

Empleados lesionados pueden hacer preguntas por correo electrónico wceao@myfloridaCFO.com

Servicio al cliente (850) 413-1601

Empleadores pueden hacer preguntas por correo electrónico
WorkCompCustServ@MyFloridaCFO.com

Preguntas sobre el programa contra el fraude
1-800-378-0445

Preguntas hechas con frecuencia

P) ¿Cuántos días tienen los empleados para reportar lesiones u enfermedades relacionadas con el trabajo?

R) Los patrones deben aconsejar a sus empleados que reporten accidentes tan pronto como ocurran lesiones o enfermedades relacionadas con el trabajo. Por ley, sin embargo, se requiere que empleados reporten lesiones o las enfermedades relacionadas con el trabajo en el plazo de 30 días.

P) ¿A quién le debo reportar la lesión relacionada con el trabajo?

R) Usted debe reportar el accidente a su compañía de seguros tan pronto usted tenga conocimiento de la lesión. Por ley, usted tiene siete días desde su primer conocimiento de la lesión relacionada con el trabajo.

P) ¿Tengo que reportar un reclamo si no creo que la lesión o enfermedad es relacionada con el trabajo?

R) Sí. Usted debe reportar todas las demandas de lesiones o de enfermedad relacionadas con el trabajo a su compañía de seguros. Esto incluye las demandas de las cuales no hay testigos de las lesiones u de las enfermedades. Es responsabilidad de la compañía de seguros por accidentes de trabajo investigar todas las demandas y determinar si el empleado tiene derecho a recibir beneficios de acuerdo a la ley de seguros por accidentes de trabajo.

P) ¿El empleado paga parte de la prima de seguro por accidentes de trabajo?

R) No. La ley es muy específica en este punto. Es la responsabilidad del empleador pagar la prima entera del seguro por accidentes de trabajo.

P) ¿A quién debo llamar si mis empleados tienen preguntas o preocupaciones con respecto a sus reclamaciónes?

R) Usted debe primero contactar a su compañía de seguro. Si la aseguradora no puede contestar la pregunta o resolver el problema, usted o sus empleados deben llamar la oficina de la ayuda al Trabajador en 1-800-342-1741.

Empleadores que adquieran una póliza de seguros por accidentes de trabajo pueden también aplicar para ser un lugar de trabajo libre de drogas y pueden recibir un descuento de prima. Para aprender más sobre el programa, llame por favor a la División de Compensación por Accidentes, la oficina del servicio de atención al cliente al 850-413-1609.

Limitación de responsabilidad
Esta publicación esta siendo ofrecida sólo como una herramienta de información, acata s.440.185 (4) F.S. con el entendimiento que esto no es lenguaje oficial de los Estatutos de la Florida. Bajo ningunas circunstancias será la División de Compensación por accidentes de trabajo responsable de daños directos o resultantes del uso de ese material.

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-66
Revised March 2010

Información Para Empleadores

INFORMACIÓN IMPORTANTE

DEL SEGURO DE INDEMNIZACION POR ACCIDENTES DE TRABAJO PARA LOS EMPLEADORES DE LA FLORIDA

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

Su póliza de seguro por accidentes de trabajo cubre beneficios médicos y reemplazo parcial del salario para cualquier empleado que sostenga lesión o una enfermedad relacionada con su trabajo.

Este folleto le dará una mejor comprensión de su papel y responsabilidades bajo el sistema de seguro por accidentes de trabajo.

Aviso de seguro por accidentes de trabajo

La ley requiere que cada empleador que ha adquirido una póliza de seguro por accidentes de trabajo coloque en un lugar o lugares conspicuo(s) un aviso que contenga información sobre la compañía de seguros, la fecha de vencimiento de la póliza, y una declaración en contra de fraude. La División de Compensación por Accidentes de Trabajo ha desarrollado este aviso en forma de cartel, para que las compañías de seguro se las proporcionen a sus asegurados. Su compañía de seguros tiene obligación legal de proveerle los carteles.

Aunque el empleador adquiera una póliza de seguros por accidentes de trabajo, se consideran no haberlo hecho si han cometido cualquiera de las siguiente acciones:

- subestimar u ocultar nómina de pago,
- falsificar u ocultara las responsabilidades del empleado para evitar la clasificación apropiada para los cálculos de la prima de seguro
- falsificar u ocultar información pertinente al cálculo y aplicación de un factor de modificación de experiencia.

Los empleadores que tienen obligación de proveer seguro por accidentes de trabajo pero no lo hacen o no actualizan la información reportada en la solicitud de seguro por accidentes de trabajo, son sujetos a recibir una orden de suspensión de trabajo y penas civiles y criminales.

Primer reporte de la lesión o enfermedad

Tan pronto usted se entere de una lesión o enfermedad relacionada con un accidente en el lugar de trabajo, contacte inmediatamente a su compañía de seguro por accidentes de trabajo. Si usted no reporta la lesión o la enfermedad a la compañía de seguro en un plazo de siete días después de la fecha que usted fue informado, usted puede estar sujeto a una multa administrativa que no exceda $2.000 por ocurrencia. La mayoría de las compañías de seguros tienen un número gratis para reportar lesiones relacionadas con el trabajo. Si usted reporta la lesión o la enfermedad a la compañía de seguros por teléfono, la compañía de seguros llenará el formulario y le enviará una copia al empleado dentro de tres días laborales. Usted también puede completar el primer reporte de la lesión o enfermedad (DWC-1) y enviarlo a la compañía de seguros. El formulario contiene información sobre el empleador, el empleado, y el accidente y se puede obtener en la página Web de la División de Compensación por Accidentes de Trabajo en www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1a.pdf. Usted debe también proveer una copia del primer reporte del accidente o enfermedad al empleado. Se prefiere la firma del empleado en el formulario, pero si el empleado no puede o no esta disponible para firmarlo, escriba “no disponible” en la caja donde se pide la firma del empleado.

Fallecimientos relacionados con el trabajo

Empleadores también tienen que reportar muertes que resulten por lesiones o enfermedades relacionadas con el trabajo a la División de Compensación por Accidentes de Trabajo en un plazo de 24 horas. Para reportar una una fatalidad en el lugar de trabajo, llame al 1-800-219-8953 (en la Florida) o al 850-413-1611, o envíe el primer reporte de la lesión o enfermedad con la información sobre la muerte por fax a 850-413-1980. Para tener acceso al formulario,vaya a la página web http://www.MyFloridaCFO.com/WC/forms.html.Haga clic en DWC-1.

Beneficios médicos

Tan pronto usted le notifique a la compañía de seguro sobre la lesión que sufrió su empleado en el trabajo, la compañía:

- Determinará si la lesión es compensable
- Proveerá un medico autorizado
- Pagará para todo el cuidado autorizado que sea médicamente necesario y este relacionado con la lesión u enfermedad.
- Proporcionará un solo cambio de médico dentro de cinco jornadas laborales del recibo de la petición de su empleado por escrito.

Atención médica y tratamientos autorizados pueden incluir:

- Consultas médicas
- Hospitalización
- Terapia física
- Exámenes médicos
- Medicamentos recetados
- Prótesis
- Gastos de ida y vuelta por viajes a consultas médicas o farmacias autorizadas.

En cuanto usted alcance la máxima mejoría médica (MMI por su sigla en inglés) usted tendrá que pagar un copago de $10.00 por cada consulta para tratamiento médico. La máxima mejoría médica ocurre cuando el médico que lo (a) atiende determina que la lesión o enfermedad del empleado se ha curado al grado que mejoría adicional no es probable.

Beneficios de reemplazo de salario

Los beneficios de reemplazo de salario comenzarán al octavo día que el empleado no pueda trabajar. El empleado lesionado no recibirá beneficio de reemplazo de salario por los primeros siete días que no pudo trabajar a menos que ha estado incapacitado por más de 21 días debido a su lesión o enfermedad relacionada con su empleo. En la mayoría de los casos, los beneficios de reemplazo de salario igualaran a dos tercios (2/3) del salario semanal regular del empleado antes de sufrir la lesión o enfermedad, pero el beneficio no excederá el promedio de los salarios semanales en la Florida. Si el empleado califica para los beneficios de reemplazo de salario, él o ella puede esperar recibir el primer cheque dentro de 21 días después de que la compañía de seguros se entere de la lesión o enfermedad. Los siguientes cheques se le enviaran cada dos semanas. El empleado lesionado será elegible para diversos tipos de beneficios de reemplazo de salario dependiendo del progreso del reclamo y de la severidad de la lesión.

- Beneficios Por incapacidad total temporal (TTD por su sigla en inglés)*: Estos beneficios son proveídos como resultado de una lesión o enfermedad que temporalmente prohíbe que el empleado vuelva a trabajar, y el empleado no ha alcanzado la máxima mejoría médica.
- Beneficios Por incapacidad parcial temporal (TPD por su sigla en inglés): Estos beneficios son proveídos cuando el médico le permite al empleado volver a trabajar, el empleado no ha alcanzado la máxima mejoría médica, y gana menos del 80% del salario que ganaba antes de sufrir la lesión o enfermedad. El beneficio es igual al 80% de la diferencia entre el 80% del salario de antes de la lesión y del salario después de la lesión.El periodo máximo que el empleado lesionado puede recibir beneficios temporales es 104 semanas o hasta que la fecha del MMI sea determinada, lo que ocurra primero.
- Beneficios por daños permanente (IB por su sigla en ingles): Estos beneficios son proveídos cuando la lesión o enfermedad causa cualquier pérdida física, psicológica o funcional y el impedimento existe después de la fecha de la máxima mejoría médica. [MMI] Un médico asignará una valoración de incapacidad permanente a la lesión que será expresada como un porcentaje.
- Beneficios por incapacidad total permanente(PTD por su sigla en inglés) Estos beneficios son proveídos cuando la lesión causa que el empleado sea permanente y totalmente incapacitado(a) según las estipulaciones de la ley.
- Indemnizaciones por fallecimiento: Compensación por accidentes de trabajo que resulten en la muerte del trabajador incluye pago de gastos para el funeral y beneficios para los dependientes del fallecido (estos son sujetos a límites definidos por ley). Un cónyuge dependiente puede ser elegible para entrenamiento vocacional.

Formulario de la declaración del salario

Usted debe llenar el formulario de la declaración del salario (DFS-F2-DWC-1a) para cualquier empleado que tenga derecho a recibir beneficios de reemplazo de salario y proveérselo a su compañía de seguros dentro de 14 días después del conocimiento del accidente. Usted también debe llenar el formulario al despedir o al dejar de proveer beneficios a cualquier empleado que esté recibiendo beneficios de reemplazo del salario. Esto se debe hacer en un plazo de 7 días de tal terminación. Para tener acceso a la forma vaya a la página web (http://www.MyFloridaCFOS.com/WC/forms.html) y haga clic en DWC-1a.

Oficina de ayuda al trabajador

Si usted tiene algunas preguntas o preocupaciones sobre los beneficios que ofrece el seguro por accidentes de trabajo, llame a su compañía de seguros. Si la compañía de seguros no ofrece la información que usted ha pedido, usted puede llamar la División de Compensación por Accidentes de Trabajo, oficina de Ayuda al Empleado (EAO) al 1-800-342-1741. Esta oficina ayuda a prevenir y a resolver disputas entre los trabajadores y los empleadores/las compañías de seguros.

Los especialistas de la EAO poseen conocimiento sobre el sistema de seguro por accidentes de trabajo(y pueden contestar sus preguntas. EAO tiene oficinas por todo el estado que puede llamar o visitar. Usted puede localizar el lugar donde están estas oficinas visitando el sitio: www.MyFloridaCFO.com/WC/organization/eao_offices.html.

Además, la División de Compensación por Accidentes de Trabajo tiene una sección en el Web, “Preguntas hechas con frecuencia por empleadores,” que puede alcanzar en http://www.MyFloridaCFO.com/WC/faq/faqemplyrs.html.

Petición para beneficios

Para comenzar el proceso judicial para solicitar beneficios que se le deben según la ley pero la compañía de seguros no lo ha proveído, se debe presentar el formulario “Petition for Benefits” [Petición para beneficios] a la Oficina de los Jueces de las reclamaciones de compensación. Se puede conseguir el formulario visitando el sitio Web: www.jcc.state.fl.us/jcc/forms/.asp.

Programa de recompensación contra fraude

El fraude en el seguro por accidentes de trabajo ocurre cuando cualquier persona a sabiendas y con intención de hacer daño, defrauda o engaña a cualquier empleador o trabajador, compañía de seguros, o auto compañía de seguros, presenta información falsa o engañosa. El fraude del seguro por accidentes de trabajo es un delito mayor de tercer grado que puede resultar en multas, responsabilidad civil, o encarcelamiento. Recompensas de hasta $25,000.00 se les puede pagar a personas quienes proveen información que resulte en la detención y la condena de personas que han cometido fraude de seguros. Llame al 1-800-378-0445 para reportar sospechas de fraude de seguros por accidentes de trabajo.

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)

Social Security Number

Date of Accident (Month-Day-Year)

Time of Accident ☐ AM ☐ PM

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION

DATE OF BIRTH _____ / _____ / _____

SEX ☐ M ☐ F

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

EMPLOYER INFORMATION

COMPANY NAME: _____

D. B. A.: _____

Street: _____

City: _____ State: _____ Zip: _____

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

TELEPHONE Area Code Number

DATE EMPLOYED _____ / _____ / _____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED _____ / _____ / _____

RETURNED TO WORK ☐ YES ☐ NO
IF YES, GIVE DATE _____ / _____ / _____

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP _____ / _____ / _____

PLACE OF ACCIDENT (Street, City, State, Zip)

Street: _____

City: _____ State: _____ Zip: _____

COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable) _____ / _____ / _____

AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK

$ _____ PER ☐ DAY ☐ MO

Number of hours per day _____

Number of hours per week _____

Number of days per week _____

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.

I have reviewed, understand and acknowledge the above statement.

_____ EMPLOYEE SIGNATURE (If available to sign) _____ DATE

_____ EMPLOYER SIGNATURE _____ DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case - DWC-12, Notice of Denial Attached

☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)

Employee's 8TH Day of Disability _____ / _____ / _____

Entity's Knowledge of 8TH Day of Disability _____ / _____ / _____

☐ 3. Lost Time Case - 1st day of disability _____ / _____ / _____ Full Salary in lieu of comp? ☐ YES Full Salary End Date _____ / _____ / _____

Date First Payment Mailed _____ / _____ / _____ AWW _____ Comp Rate _____

☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH ☐ SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:

INSURER CODE #

EMPLOYEE'S CLASS CODE

EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #

CLAIMS-HANDLING ENTITY FILE #

INSURER NAME

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Authorization for the Release of Information
Autorización Para La Liberación De Información

Claim Number/Número de Reclamo

Date of Injury / Fecha de la Lesión

Employee/Empleado

Date of Birth / Fecha de Nacimiento

I hereby authorize the divisions of Berkshire Hathaway Homestate Companies, their representative or bearer, to review, inspect, copy, and/or photograph any and all of the following documents:

Por este medio autorizo las divisiónes de Berkshire Hathaway Homestate Companies, su representante o portador, a revisar, inspeccionar, copiar, y/o fotografiar cualquier y todo de los siguientes documentos:

1 Any and all medical records, including but not limited to office and hospital records, laboratory results, diagnostic reports and films, psychiatric records, medical correspondences, doctor's and nurse's notes, and medical histories relevant to my workers' compensation claim. I also hereby give permission to Berkshire Hathaway Homestate Company representatives to contact the attending physicians involved in the treatment of all related conditions.

Cualquier y todo expediente médico, incluyendo pero no limitado, a los expedientes de la oficina y hospitales, resultados de laboratorios y filminas, expedientes psiquiátricos, correspondencia médica, notas de los doctores y enfermeros(as), e historiales médicos relevantes a mi reclamo de compensación de trabajadores. También, por este medio le doy permiso a los representantes de Berkshire Hathaway Homestate Company para comunicarse con el médico tratante envuelto en el tratamiento de todas las condiciones relacionadas.

2 All employment and human resource information including but not limited to: hiring and employment records, payroll and income statements, documentation related to this or any other relevant injury and any other information pertinent to providing benefits and services necessary for the completion of this claim.

Toda información del empleo y de recursos humanos, incluyendo pero no limitado a: expedientes de contratación y empleo, declaraciones de nómina e ingresos, documentación relacionada a esta o cualquier otra lesión relevante, y cualquier otra información pertinente que provea los beneficios y servicios necesarios para completar este reclamo.

The released information is required for the following reasons:

La información liberada es requerida por las siguientes razones:

1 To provide for adequate preparation, investigation, evaluation, review, and discovery of a claim for workers compensation benefits. Specifically, to determine the causation and the nature and extent of any possible pre-existing, concurrent or aggravating medical conditions with potential medical, legal, or factual implications in the this work-related injury or injuries.

Para proporcionar una preparación, investigación, evaluación, revisión, y descubrimiento adecuado del reclamo de beneficios de compensación de trabajadores. Específicamente, para determinar la causa y la naturaleza y extensión de cualquier posible condición médica pre-existente, concurrente o agravante con potencial médico, legal, o implicaciones fácticas en esta lesión o lesiones relacionadas al trabajo.

2 To provide the treating physician, consultant or evaluator with medical information necessary to provide you with the best possible medical care and medical advice.

Para proporcionar al médico tratante, consultor, o evaluador con la información médica necesaria para proporcionarle el mejor cuidado médico posible y consejería médica.

3 To facilitate recovery of all benefits paid toward your workers' compensation claim from any third party responsible for this injury.

Para facilitar la recuperación de todos los beneficios pagados por su reclamo de compensación de trabajadores de cualquier tercer parte responsable de esta lesión.

4 To ensure that you are accurately compensated for any amount of lost wages, time or resources while undergoing evaluation, treatment and recovery for this injury.

Para asegurar que usted se encuentra compensado correctamente por cualquier cantidad de salarios, tiempo, o recursos perdidos mientras se somete a la evaluación, tratamiento, y recuperación de esta lesión.

5 To obtain any information necessary to appropriately determine further actions as a result of the injury or condition and to prevent further issues for you and other employees.

Para obtener cualquier información necesaria para determinar apropiadamente acciones adicionales como resultado de la lesión o condición, y para prevenir problemas adicionales para usted y otros empleados.

6 This consent and authorization is effective immediately, and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate on conclusion of the claim without express revocation.

Este consentimiento y autorización es efectivo inmediatamente, y está sujeto a la revocación del abajo firmante en cualquier momento excepto a la extensión en que se hayan tomado acciones en dependencia con esto de aquí en adelante, y si no es revocado anteriormente, terminará con la conclusión del reclamo si no se presenta una revocación expresa.

A copy or fax is as valid as the original.

Una copia o fax es tan válida como el original.

Names, Addresses, and Phone Numbers of Providers/Nombres, direcciones, y números de teléfonos de los proveedores

I have read this authorization and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

He leído esta autorización y entendido completamente su contenido en su totalidad. He hecho preguntas sobre todo lo que no estaba claro para mí y estoy satisfecho con las contestaciones que he recibido. Yo entiendo que tengo derecho a recibir una copia de esta autorización una vez lo solicite.

Signature/Firma

Date/Fecha

PRINT THIS FORM/ IMPRIMIR FORMULARIO

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Medical History Request

Employee Name

Date of Injury

Employer Name

Completion Date

Please complete this form by providing your medical history for the past 5 years. This will help ensure that we are able to provide all of your medical records to your current treating physician for you to receive the proper care for your work injury.

Thank you for your cooperation.

Past Injuries, Disabilities, or Other Medical Conditions

Hospitalizations

Hospital Name & Address	Phone	Date(s) Adimitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

RESET FORM

PRINT THIS FORM

WAGE STATEMENT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

RECEIVED BY CLAIMS-HANDLING ENITY

NOTICE TO EMPLOYEE: If you have any questions about the information contained on this form, please contact your employer or claim-handling entity. If further assistance is needed, contact the Division's Employee Assistance Office at 1-800-342-1741.

PLEASE PRINT OR TYPE

	EMPLOYEE NAME (First, Middle, Last)	DATE OF ACCIDENT (Month-Day-Year)
EMPLOYER NAME & ADDRESS	CONCURRENT EMPLOYER NAME & ADDRESS (If applicable)	ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? ___ YES ___ NO SIMILAR EMPLOYEE'S NAME
TELEPHONE	TELEPHONE	OCCUPATION OF SIMILAR EMPLOYEE

EMPLOYEE'S CUSTOMARY WORK WEEK	EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK	EMPLOYER'S CUSTOMARY WORK WEEK
(ex. Saturday thru Friday - Use 7 calendar day period)	(ex. 5 days / week)	(ex. 40 hours / week)	(ex. Saturday thru Friday - Use 7 calendar day period)

NOTICE TO EMPLOYER: Please read all instructions on the back of this form carefully. Complete the form as fully as possible and submit it to your claims-handling entity within 14 days after knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Wage Statement with your claims-handling entity within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.

Please list wages earned for the 13 calendar weeks (Sunday through Saturday) immediately preceding the accident.

Do Not Report Any Wages Earned During The Week of the Accident – Use The 13 Calendar Weeks Immediately Preceding The Accident

WEEK NO.	WEEK FROM	WEEK TO	# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY	GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (employee rec'd) **EMPLOYER COST ONLY** HEALTH INSURANCE	RENT/ HOUSING
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
**								
				TOTAL			WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS?	
							___YES___NO	___YES___NO
							TOTAL FRINGE BENEFITS	$
							TOTAL OF GROSS PAY, GRATUITIES AND FRINGES	$
							(FOR CLAIMS-HANDLING ENTITY **USE ONLY)** **AWW**	**COMP RATE**

RETURN THIS FORM TO:
(Claims-handling entity Name, Address & Telephone #)

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.

PREPARER'S NAME	TELEPHONE #	DATE

WAGE STATEMENT REPORTING INSTRUCTIONS

General: Florida law requires disabled employees to be compensated at a certain percentage of their average weekly wage. If the injured employee worked during "substantially the whole of 13 calendar weeks" immediately preceding the accident, the employee's average weekly wage is one-thirteenth of the total amount of wages earned during the 13 calendar weeks. The term "substantially the whole of 13 calendar weeks" means not less than 75% of the total customary full-time hours of employment during that period.

NOTICE TO EMPLOYER: Please read all instructions on this form carefully. Complete the form as fully as possible and submit it to your claims-handling entity within 14 days after your knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Form DWC-1a (Wage Statement) with your claims-handling entity within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.

- **DO NOT combine wages of two or more employees.**
- **Calendar Week**: means a seven-day period of time, which starts on Sunday and continues through Saturday.

Week of Accident – **DO NOT** report any wages earned during the week of the accident. Use the 13 calendar weeks immediately preceding the week of the accident and start with the most recent full calendar week before the week of the accident. For example, if the accident occurred on a Wednesday, then week No. 1 should begin the preceding Sunday and end the preceding Saturday.

Reporting Gross Pay: Complete **all** columns as applicable. Report the actual **gross** earnings of the injured employee for the consecutive 13 calendar week period immediately preceding the accident. The 13 calendar week period includes Saturdays, Sundays, holidays, and other non-working days. Remember to include all overtime and any bonuses paid during the 13 calendar week period. If the injured employee was not employed for you for approximately 68 days during that period, enter the wages of a similar employee in the same employment who was employed for approximately 68 days of the 13 calendar week period. **DO NOT** combine wages for two or more employees to yield wages for the 13 calendar weeks. The spaces immediately following week #13 are to be used for reporting the wages earned in a partial week when requested.

Reporting Gratuities & Fringe Benefits: Gratuities reported should include only those gratuities reported to the employer in writing as taxable income received in the course of employment from others than the employer. The reportable value of a fringe benefit is the actual cost to the employer for the benefit furnished. The only fringe benefits that can be included for dates of accident occurring on or after 07/01/1990 are employer contributions for health insurance for the employee or the employee's dependents, and the reasonable value of housing furnished to the employee by the employer which is intended as the permanent year-round housing of the employee.

If you have questions or need assistance in the completion of this required form, please contact the claims-handling entity listed on the front of this form.

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

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)

Yes or No

How did the injury occur? What job duties were you performing? Please describe in your own words.

What part(s) of your body was injured (indicating right and/or left)?

Have you sought any medical treatment for these injuries? If so, specify where and when.

Have you ever injured this part of your body before (yes or no)? If so, please describe how and when the previous injury(s) occurred.

What witnesses were present when the 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

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

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)

Si/No

¿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

RESTABLECER FORMULARIO

IMPRIMIR FORMULARIO

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

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? Yes or No

Address of Incident

City, State

Zip

Offsite? (Y/N) Yes or No

How did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were reported as injured?

Has the employee sought any medical treatment for these injuries? If so, specify where and when.

What witnesses were present when the 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
- ☐ Unused/unavailable PPE (gloves, hardhat, goggles, etc.)
- ☐ Unused/unavailable sharps container
- ☐ Unguarded or improperly guarded equipment
- ☐ Electrical exposure
- ☐ Obstructed view
- ☐ Lack of training
- ☐ Wet/slippery floor
- ☐ Poor housekeeping
- ☐ Interaction with co-worker
- ☐ Interaction with patient or resident
- ☐ Interaction with customer
- ☐ Chemical exposure
- ☐ Motor vehicle incident
- ☐ Other:

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

The above form is true and correct.

Prepared by

Signature

Date Completed

RESET FORM

PRINT THIS FORM

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Informe de Incidente del Supevisor

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? Si/No

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N) Si/No

¿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 Supevisor

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

- ☐ Equipo para levantar no usado/no disponible
- ☐ PPE (guantes, casco, gafas, etc.) no usado/no disponible
- ☐ Contenedor de objetos punzantes no usado/no disponible
- ☐ Equipo no resguardado o incorrectamente resguardado
- ☐ Exposición eléctrica
- ☐ Vista obstruida
- ☐ Falta de capacitación
- ☐ Herramientas o equipo defectuosos
- ☐ Piso mojado/resbaloso
- ☐ Mala limpieza
- ☐ Interacción con compañero de trabajo
- ☐ Interacción con paciente o residente
- ☐ Interacción con cliente
- ☐ Exposición a producto químico
- ☐ Incidente de vehículo motorizado
- ☐ Other: _____

¿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: _____

RESTABLECER FORMULARIO

IMPRIMIR FORMULARIO

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

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

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

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

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

Dirección del incidente

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/ No)

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

RESTABLECER FORMULARIO

IMPRIMIR FORMULARIO

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____/ _____/ _____
MM/DD/YYYY

G3YA

Group #: _____

Employee Date of Birth: _____/ _____/ _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

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Participating Retail Network Pharmacies

myMatrixx
An Express Scripts Company

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Walmart
Wegmans
Weis
Winn Dixie

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Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

$1000 REWARD

For information leading to the arrest and conviction of any co-worker, health care professional, or the attorney representing a fraudulent workers compensation claim to Berkshire Hathaway Homestate Companies (BHHC)*.

In most states, it is a felony to make or cause to be made a knowingly false or fraudulent material statement in order to obtain workers compensation benefits. BHHC believes that any party engaging in such fraud should be prosecuted to the fullest extent of the law, including jail sentences.

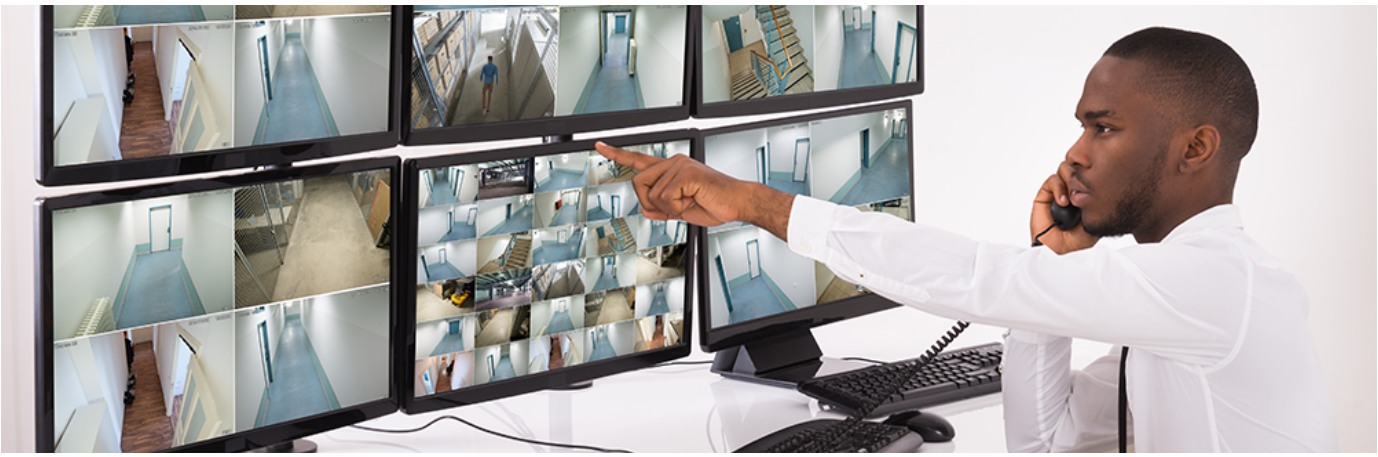
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

Call our toll-free fraud hotline immediately if you have information on a fraudulent claim.

1 (800) 300-JAIL

*Maximum reward of $1,000 per conviction. In the event that more than one individual submits information regarding the same fraudulent claim, BHHC will equally divide the reward among those providing information used in obtaining the conviction. BHHC reserves the right to determine what information, if any, will be provided to the appropriate law enforcement agency. Criminal prosecutions are the sole responsibility of the authorities and may or may not be pursued at their discretion. Any issues regarding the interpretation of this policy shall be resolved by BHHC at their sole discretion. Program subject to change or termination without prior notice.

Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™



$1000 RECOMPENSA

Información que lleva al arresto y a la condena de cualquier compañero de trabajo, profesional de cuidado medico, o abogado que represente un reclamo fraudulento en contra de Berkshire Hathaway Homestate Companies*.

En la mayoría de los estados es un delito grave hacer que haga una declaración de material fraudulento para obtener beneficios de Compensación al Trabajador. Berkshire Hathaway Homestate Companies cree que cualquier persona que se involucre en tal fraude debe ser procesado con todo el rigor de la ley, incluyendo SER SENTENCIADO A LA CARCEL.

Ayúdenos de su parte. El poner a estos delincuentes fuera de op eraciones nos beneficia a todos, incluso esto ayuda a mantener los réditos bajos de la as eguranza de su empleador.

Si usted tiene información sobre un reclamo fraudulento por favor llame de inmediato a nuestra LINEA GRATUITA DE FRAUDE.

1 (800) 300-JAIL

*La recompensa máxima es de $1,000 por convicción. En caso de que más de una persona presente informaciones sobre la misma demando fraudulenta. BerkshireHathaway dividirá la recompensa por partes iguales entre aquellas persones que aportaron informaciones para obtener la convicción. Berkshire Hathaway se reserva el derecho de determinar qué informacion presentará a la agencia judicial correspondiente. El proceso de crímenes es la responsibilidad exclusiva de las autoridades, que pueden decidir si el proceso debe entablarse or no. Cualquier disputa que pudiera surgir en la interpretación de esta ofreta será resuelta por la propia Compañia de Seguros Berkshire Hathaway. Este programa está sujeto a cambios a cancelación sin aviso previo.