



Berkshire Hathaway  
HOMESTATE COMPANIES

Workers Compensation Division <sup>TM</sup>

# Workers Compensation State Claim Kit

*Maine*



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P.O. Box 881236 San Francisco, CA 94188  
(888) 495-8949  
[bhhc.com](http://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.

Maine 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](mailto:newclaim@bhhc.com)





# Workers Compensation Posting Requirements

## Form WCB-90 – Workers' Compensation Board Notice to Employees

- • Post in one or more conspicuous places at all business locations and work sites
- • Print on 11" x 17" paper

(39-A Maine Revised Statutes § 406)



# WORKERS' COMPENSATION

## WORKERS' COMPENSATION BOARD REGIONAL OFFICES

### AUGUSTA

442 Civic Center Drive, Suite 225  
156 State House Station  
Augusta, ME 04333-0156  
207-287-2308  
1-800-400-6854

### LEWISTON

36 Mollison Way  
Lewiston, ME 04240-5811  
207-753-7700  
1-800-400-6857

### BANGOR

106 Hogan Road, Suite 1  
Bangor, ME 04401  
207-941-4550  
1-800-400-6856

### PORTLAND

1037 Forest Avenue, Suite 11  
Portland, ME 04103  
207-822-0840  
1-800-400-6858

### CARIBOU

43 Hatch Drive, Suite 110  
Caribou, ME 04736-2347  
207-498-6428  
1-800-400-6855

Visit our website at:  
[www.maine.gov/wcb](http://www.maine.gov/wcb)

Statewide TTY: Maine Relay 711

## Notice to Employees:

State law requires your employer to provide workers' compensation insurance for its employees. Workers' compensation insurance provides benefits to employees who are injured at work.

If you are injured at work, NOTIFY YOUR EMPLOYER AT ONCE. You may lose your right to receive benefits unless your employer is notified within 30 days of your injury. Your claim is also subject to a two year statute of limitations. Worker advocates are available at the Workers' Compensation Board to help injured workers.

It is against the law for employers to misclassify employees as independent contractors for the purposes of avoiding workers' compensation insurance, unemployment coverage, or other employer paid taxes and withholdings. For more information on laws pertaining to the hiring of independent contractors, visit the Worker Misclassification Task Force website at [www.maine.gov/labor/misclass](http://www.maine.gov/labor/misclass).

If you have any questions about your rights, please contact one of the regional offices.

## A l'intention des Employés:

D'après les lois de l'Etat du Maine, votre employeur est tenu de souscrire à une assurance indemnisant ses employés victimes d'un accident du travail.

Si vous êtes victime d'un accident du travail, PREVEZ VOTRE EMPLOYEUR IMMEDIATEMENT. Passé un délai de 30 jours, vous risquez de perdre vos droits à l'indemnisation. Au-delà de deux ans, votre déclaration n'est plus recevable. Pour aider les victimes d'un accident du travail, le Workers' Compensation Board met des conseillers juridiques à leur disposition.

La loi interdit aux employeurs de classer fallacieusement leurs salariés comme étant des contractants privés aux fins d'échapper à l'assurance compensatrice-employé, aux

indemnités de chômage, ou aux autres charges et retenues dues par employeur. Pour plus de détails sur la législation relative à l'utilisation des services privés, visitez le site internet de Worker Misclassification Task Force (Unité anti-fraude en matière de classification des salariés) : [www.maine.gov/labor/misclass](http://www.maine.gov/labor/misclass).

Si vous n'êtes pas sûr de vos droits, veuillez contacter l'un des bureaux régionaux.

## Aviso a los Trabajadores:

La ley del estado de Maine requiere que su empresario proporcione el seguro de compensaciones para el trabajador a todos los trabajadores. El seguro de compensaciones para el trabajador proporciona beneficios a los trabajadores accidentados en el trabajo.

En caso de sufrir accidente o daño laboral, NOTIFIQUELO INMEDIATAMENTE A SU EMPRESARIO. Podría perder el derecho a recibir compensación a menos que su empresario sea notificado de este accidente o daño en el plazo de 30 días. Así mismo esta reclamación debe hacer referencia a un accidente o daño que no haya ocurrido hace más de dos años. Los defensores del trabajador están disponibles para proporcionar ayuda a los trabajadores accidentados en el Consejo de Administración de Compensaciones para el Trabajador (Workers' Compensation Board).

El hecho de no clasificar a los empleados como contratistas independientes, con el propósito de evitar el seguro por compensación al trabajador, cobertura para desempleados, u otros impuestos pagados y retenidos por el empleador; está en contra de la ley del empleador. Para mayor información acerca de las leyes pertenecientes a la contratación de contratistas independientes, visite el Worker Misclassification Task Force en la página web de [www.maine.gov/labor/misclass](http://www.maine.gov/labor/misclass).

En caso de tener cualquier pregunta sobre sus derechos, favor de dirigirse a una de las oficinas regionales de compensaciones para el trabajador.

ENGLISH

Interpreters Available

When calling for assistance, please say the name of your language in English and an interpreter will be called for you. Please stay on the line.

SPANISH

Tenemos intérpretes a su disposición

Si necesita que le atiendan en español por favor diga "Spanish" y le conectaremos con un intérprete. Por favor manténgase en la línea.

PORTUGUESE

Temos intérpretes à sua disposição

Se precisar de atendimento em Português, por favor diga "Portuguese" e um intérprete será prontamente chamado. Por favor, aguarde na linha.

ITALIAN

Abbiamo interpreti disponibili

Se avete bisogno di assistenza in Italiano, Vi preghiamo di dire "Italian" e un interprete sarà messo a Vostra disposizione. Vi preghiamo di rimanere in linea.

FRENCH

Des interprètes sont à votre disposition

Lorsque vous appelez pour demander de l'aide, prononcez le mot "French" et nous mettrons un interprète à votre disposition. Prière de rester en ligne.

POLISH

Tłumacze dostępni na życzenie.

Aby uzyskać pomoc tłumacze, proszę powiedzieć po angielsku "Polish" i czekać na linię.

RUSSIAN

“К вашим услугам имеются переводчики”

“Когда Вы обращаетесь за помощью по телефону, пожалуйста скажите, что Вы говорите по-русски (произнесите “РАШН”), и мы обеспечим Вас переводчиком. После этого, пожалуйста, оставайтесь на линии.”

CHINESE

提供口譯服務

打電話請求幫助時，請用英語說“拼音呢斯”(CHINESE)——我們將為您提供口譯人員。請不要掛斷電話。

JAPANESE

通訳サービスをご利用いただけます

通訳を必要とされる場合は「ジャパニーズ」とおっしゃり、通訳ができるまでそのままお待ちください。

KOREAN

한국어 통역을 이용하실 수 있습니다.

도움이 필요하여 전화를 거실 때 영어로 코리언 (KOREAN)이라고 말씀하시면 통역자를 연결해 드릴 것입니다. 전화를 끊지 마시고 기다리십시오.

VIETNAMESE

“Cố Thông Dịch Viên”

“Khi gọi điện thoại để được giúp đỡ, xin quý vị hãy nói “VIETNAMESE” để chúng tôi cho thông dịch viên giúp quý vị. Xin quý vị chờ trên đường dây.

ARABIC

مترجمون شهيون متيسرون لخدمتكم

عند إتصالكم للمساعدة أو لطلب خدمة معينة نرجو منكم أن تذكروا (أ-ز-ب-ك) ونحن سنقدم لكم مترجماً شهيياً . ابقوا على الخط من فضلكم.

PERSIAN

افراد مترجم در دسترس مي باشند.

را که بدان صحبت مي کنید به انگليسي ذکر کنید تا راجع به امري به ما تلفن مي کنید، لطفاً نام زباني قطع نکنيد. هنگامیکه براي درخواست کمک يا شما تماس گرفته شود. لطفاً روي خط منتظر بمانيد. با يك مترجم براي

SOMALI

Turjunaanno waa la helayaa

Marka aad caawinaad inoogu soo yeeraneysid, fadhlan luqaddaada af Ingiriisi inoogu sheeg turjubaan ayaa Iguugu yeeri doonaaye. Talefoonkana ha dhigin.

**To the employer:** This notice must be posted in a conspicuous place upon your premises accessible to employees. 39-A MRSA §406. The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services or activities.

This poster is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone: (888) 801-9087 or TTY (877) 832-5525.

# EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

**REASON FOR REPORT (check all that apply)**

- 2a.  LOST TIME - ONE OR MORE DAYS    2b. WAS EMPLOYEE PAID FOR IJ DAY OR MORE ON DAY OF INJURY?     YES     NO  
3.  LOST EARNINGS BUT NO LOST TIME    4.  MEDICAL/HEALTH CARE    5.  FATALITY DATE OF DEATH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY  
6a.  OCCUPATIONAL DISEASE    6b. DATE OF LAST EXPOSURE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY    6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY  
7a.  CORRECT PRIOR REPORT    7b. DATE OF CORRECTION: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY    7c. DATE CORRECTION SENT TO WCB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

**EMPLOYER**

|   |  |  |            |  |                              |
|---|--|--|------------|--|------------------------------|
| 8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):   |  | 9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):        |            | 10. EMPLOYER NAME:   |                              |
| 11. STREET/P.O. BOX MAILING ADDRESS:                              |  | 12. CITY:  | 13. STATE: | 14. ZIP:   | 15. TELEPHONE NUMBER:<br>( ) |
| 16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED: |  | 17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS: |            | 18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED: |                              |

**(check one)**  INSURER     THIRD PARTY ADMINISTRATOR (TPA)     SELF-ADMINISTERED EMPLOYER

|                                      |  |                    |            |                          |                              |
|--------------------------------------|--|--------------------|------------|--------------------------|------------------------------|
| 19. INSURANCE / TPA COMPANY NAME:    |  | 20. POLICY NUMBER: |            | 21. INSURER FILE NUMBER: |                              |
| 22. STREET/P.O. BOX MAILING ADDRESS: |  | 23. CITY:          | 24. STATE: | 25. ZIP:                 | 26. TELEPHONE NUMBER:<br>( ) |

**EMPLOYEE**

|                                      |  |   |  |            |   |                             |  |
|--------------------------------------|--|---|--|------------|---|-----------------------------|--|
| 27. LAST NAME:                       |  | 28. FIRST NAME:                                   |  | 29. MI:    | 30. TELEPHONE NUMBER:<br>( )  | 31. SOCIAL SECURITY NUMBER: | 32. GENDER:<br><input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| 33. STREET/P.O. BOX MAILING ADDRESS: |  | 34. CITY:   |  | 35. STATE: |   | 36. ZIP:                    | 37. DATE OF BIRTH:<br>____/____/____<br>MM DD YYYY                           |
| 38. OCCUPATION/JOB TITLE:            |  | 39. DATE OF HIRE:<br>____/____/____<br>MM DD YYYY | 40. WEEKLY WAGE AT TIME OF INJURY:<br>\$ |            | 41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME AND ADDRESS: |                             |  |

**CLAIM INFORMATION**

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 42. DATE OF INJURY OR ILLNESS:<br>____/____/____<br>MM DD YYYY                  | 43. DATE OF INCAPACITY:<br>____/____/____<br>MM DD YYYY | 44. TIME EMPLOYEE BEGAN WORK<br>(e.g. 7:30 a.m.):     | 45. DATE EMPLOYER NOTIFIED INSURER/TPA:<br>____/____/____<br>MM DD YYYY  |  |  |
| DATE EMPLOYER NOTIFIED:<br>____/____/____<br>MM DD YYYY                         | DATE EMPLOYER NOTIFIED:<br>____/____/____<br>MM DD YYYY | 46. TIME OF INJURY (e.g. 1:10 p.m.):                  | 47. HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE DATE: ____/____/____<br>MM DD YYYY |  |  |
| 48. SPECIFIC INJURY OR ILLNESS<br>(e.g. second degree burn or toxic hepatitis): |   | 49. BODY PART(S) AFFECTED (e.g. lower right forearm): |  | 50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate): |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.):<br><br>WAS ACTIVITY PART OF NORMAL JOB DUTIES? <input type="checkbox"/> YES <input type="checkbox"/> NO | 52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.): |  |  |  |  |
|--|--|--|--|--|--|

|  |   |                                |                      |  |                              |
|--|---|--------------------------------|----------------------|--|------------------------------|
| 53. HOSPITALIZED OVERNIGHT AS INPATIENT?<br><input type="checkbox"/> YES <input type="checkbox"/> NO | 54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM?<br><input type="checkbox"/> YES <input type="checkbox"/> NO: | 55. HEALTH CARE PROVIDER NAME: | 56. MAILING ADDRESS: |  | 57. TELEPHONE NUMBER:<br>( ) |
|--|---|--------------------------------|----------------------|--|------------------------------|

**PREPARER INFORMATION**

|  |  |                              |  |   |  |
|--|--|------------------------------|--|---|--|
| 58. PREPARER NAME AND TITLE (TYPE OR PRINT): |  | 59. TELEPHONE NUMBER:<br>( ) |  | 60. DATE SENT TO WCB:<br>____/____/____<br>MM DD YYYY |  |
|--|--|------------------------------|--|---|--|

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY Maine Relay 711.  
WCB-1 (eff. 1/1/13)

**WAGE STATEMENT**  
**STATE OF MAINE**  
**WORKERS' COMPENSATION BOARD**  
**27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027**

|  |  |   |                              |                             |   |  |
|--|--|---|------------------------------|-----------------------------|---|--|
| 1. INSURER FILE NUMBER:  |  | 6. SOCIAL SECURITY NUMBER (LAST 4 DIGITS):<br><b>XXX -XX-</b> |                              | 7. WCB FILE NUMBER:         |   |  |
| 2. EMPLOYER NAME:  |  | 8. EMPLOYEE LAST NAME:  |                              | 9. FIRST NAME:              | 10. M.I.:   |  |
| 3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:  |  | 11. ADDRESS-NUMBER AND STREET:                                |                              |                             |   |  |
| 4. INSURER NAME:   |  | 12. CITY:   | 13. STATE:                   | 14. ZIP:                    | 15. HOME PHONE:   |  |
| 5. INSURER MAILING ADDRESS:  |  | 16. DATE OF INJURY:   | 17. DESCRIPTION OF INJURY:   |                             |   |  |
| 18. DOES EMPLOYEE WORK CONCURRENTLY FOR ANOTHER EMPLOYER?<br>IF YES, GIVE NAME(S): _____<br>NOTE: THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FOR EACH ADDITIONAL EMPLOYER. |  |   | YES <input type="checkbox"/> | NO <input type="checkbox"/> | 19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS' COMPENSATION?<br>NOTE: THE EMPLOYER SHALL RECALCULATE THE AVERAGE WEEKLY WAGE IF/WHEN FRINGE BENEFITS CEASE (SEE RULE 1.5(2)) |  |
|  |  |   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |   |  |

**&S" @GH; FCGG95FB-B; G: CF'957< 'K 99?.** .....

| WK | WEEK ENDING | GROSS EARNINGS | WK | WEEK ENDING | GROSS EARNINGS | WK                   | WEEK ENDING | GROSS EARNINGS |
|----|-------------|----------------|----|-------------|----------------|----------------------|-------------|----------------|
| 1  |             |                | 19 |             |                | 37                   |             |                |
| 2  |             |                | 20 |             |                | 38                   |             |                |
| 3  |             |                | 21 |             |                | 39                   |             |                |
| 4  |             |                | 22 |             |                | 40                   |             |                |
| 5  |             |                | 23 |             |                | 41                   |             |                |
| 6  |             |                | 24 |             |                | 42                   |             |                |
| 7  |             |                | 25 |             |                | 43                   |             |                |
| 8  |             |                | 26 |             |                | 44                   |             |                |
| 9  |             |                | 27 |             |                | 45                   |             |                |
| 10 |             |                | 28 |             |                | 46                   |             |                |
| 11 |             |                | 29 |             |                | 47                   |             |                |
| 12 |             |                | 30 |             |                | 48                   |             |                |
| 13 |             |                | 31 |             |                | 49                   |             |                |
| 14 |             |                | 32 |             |                | 50                   |             |                |
| 15 |             |                | 33 |             |                | 51                   |             |                |
| 16 |             |                | 34 |             |                | K ? 'C: '            |             |                |
| 17 |             |                | 35 |             |                | -B>I FM              |             |                |
| 18 |             |                | 36 |             |                | &S" HCH5 @           |             |                |
|    |             |                |    |             |                | .....95FB-B; G       |             |                |
|    |             |                |    |             |                | &S"; FCGG5J9F5; 9'   |             |                |
|    |             |                |    |             |                | .....'K 99? @MK 5; 9 |             |                |

23. COMMENTS:

|                                    |  |                              |  |                  |  |
|------------------------------------|--|------------------------------|--|------------------|--|
| 24. PREPARER NAME (TYPE OR PRINT): |  | 25. TELEPHONE NUMBER:<br>( ) |  | 26. DATE MAILED: |  |
| E-MAIL ADDRESS:                    |  | TOLL-FREE NUMBER:<br>( )     |  | MM / DD / YYYY   |  |

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.  
WCB-2 (eff. 1/1/13)

**FRINGE BENEFITS WORKSHEET**  
**STATE OF MAINE**  
**WORKERS' COMPENSATION BOARD**  
**27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027**

|   |   |                            |           |
|---|---|----------------------------|-----------|
| 1. INSURER FILE NUMBER:                       | 6. SOCIAL SECURITY NUMBER (last 4 digits):<br>XXX-XX- | 7. WCB FILE NUMBER:        |           |
| 2. EMPLOYER NAME:                             | 8. EMPLOYEE LAST NAME:                                | 9. FIRST NAME:             | 10. M.I.: |
| 3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER: | 11. EMPLOYEE ADDRESS-NUMBER AND STREET:               |                            |           |
| 4. INSURER NAME:                              | 12. CITY:   | 13. STATE:                 | 14. ZIP:  |
| 5. INSURER MAILING ADDRESS:                   | 16. DATE OF INJURY:                                   | 17. DESCRIPTION OF INJURY: |           |

**PROVIDE THE COST OF THE FRINGE BENEFIT PAID BY THE EMPLOYER AS OF THE EMPLOYEE'S DATE OF INJURY IF THE EMPLOYEE WAS RECEIVING THE BENEFIT ON HIS/HER DATE OF INJURY (SEE RULE CHAPTER 1(5)(1)).**

**NOTE: THE AMOUNTS REPORTED ARE SUBJECT TO VERIFICATION BY THE EMPLOYEE AND HIS/HER REPRESENTATIVE AND DOCUMENTATION MUST BE PROVIDED UPON REQUEST.**

| 18. Fringe Benefit                              | Provided   | Continues while Employee is out of work                  | Date Benefits End | Weekly Cost of Benefits to Employer |
|---|--|--|-------------------|-------------------------------------|
| Health Benefits (inc. insurance)                | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |                   | \$                                  |
| Dental Insurance                                | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |                   | \$                                  |
| Disability Insurance (inc. short and long term) | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |                   | \$                                  |
| 401K  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |                   | \$                                  |
| Life Insurance                                  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |                   | \$                                  |
| Education/Training                              | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |                   | \$                                  |
| Pension   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |                   | \$                                  |
| Other (please list):                            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |                   | \$                                  |
| Other (please list):                            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |                   | \$                                  |

|                                    |                              |                  |
|------------------------------------|------------------------------|------------------|
| 19. PREPARER NAME (TYPE OR PRINT): | 20. TELEPHONE NUMBER:<br>( ) | 21. DATE MAILED: |
| E-MAIL ADDRESS:                    | TOLL-FREE NUMBER:<br>( )     | MM / DD / YYYY   |





# State of Maine Workers' Compensation Board Limited Release of Medical/Health Care Information

Name: \_\_\_\_\_ SSN (last 4 digits): XXX-XX-

Date Birth: \_\_\_\_\_ Date of Injury/Illness: \_\_\_\_\_

**Notice to employer/insurer/employee representative:** You may only use forms adopted by the State of Maine Workers' Compensation Board for the release of protected medical/health care information to an employer or its insurer. The Board's forms may NOT be altered. Abuses may result in penalties.

**Notice to employee:** The employer/insurer contends your health care provider's medical records, regardless of the date of injury, meaning all records relating to the diagnosis, treatment and care, including X-rays, related to the following body part(s) and/or condition(s):

\_\_\_\_\_ are needed to determine whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

This release authorizes any and all health care providers to release the records, regardless of the date of injury, they have related to the diagnosis, treatment and care, including X-rays, of the body part(s) and/or condition(s) listed above. This release authorizes the release of records dating from \_\_\_\_\_ until thirty (30) months after the date I sign this form. This release authorizes my health care provider(s) to release records pursuant to a later request after this release is signed through the termination date of this release.

You have 14 days from receipt of this certificate to complete and return it to the employer/insurer. If you do not understand this form, talk with your legal representative. If you do not have a legal representative, a Workers' Compensation Board Claims Resolution Specialist can help you.

**Voluntary:** I understand I may choose not to complete this form. If I choose not to complete this form, my claim for benefits may be denied.

**Limited:** I understand this form gives my health care providers permission to release only those health records related to the body part(s) and/or condition(s) listed above. This form does NOT authorize oral communication with or by any health care provider with anyone other than me or my representative.

**Redisclosure:** I understand the information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.

**Revocable:** I understand I may revoke this authorization at any time in writing, but doing so may result in a loss of, or reduction in, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. Note: You may not cancel this release with respect to medical records already provided.

**This authorization does NOT authorize the release of information regarding testing, treatment or counseling related to: Psychological matters; substance abuse; HIV/Aids and sexually transmitted diseases.**

I authorize release of my medical records to: \_\_\_\_\_  
(Name of Recipient)

Address of Recipient: \_\_\_\_\_  
\_\_\_\_\_

Format Requested (circle one): **Electronically (if available):** \_\_\_\_\_ Fax to: \_\_\_\_\_

Mail to : \_\_\_\_\_

I hereby authorize the above named recipient to obtain from my health care provider(s) subject to the terms of this release.

Employee or Authorized Representative Signature \_\_\_\_\_ Date: \_\_\_\_\_

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).



# Medical History Request

Employee Name

Date of Injury

Employer Name

Completion Date

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

Thank you for your cooperation.

## Past Injuries, Disabilities, or Other Medical Conditions

### Hospitalizations

| Hospital Name & Address | Phone | Date(s) Admitted |
|-------------------------|-------|------------------|
|                         |       |                  |
|                         |       |                  |
|                         |       |                  |
|                         |       |                  |

### Treating Physicians or Groups

| Doctor or Group Name, Address | Phone | Dates of Treatment |
|-------------------------------|-------|--------------------|
|                               |       |                    |
|                               |       |                    |
|                               |       |                    |
|                               |       |                    |

# Employee 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

Electrical exposure

Interaction with co-worker

Other:

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

The above form is true and correct.

Prepared by

Signature

Date Completed

# 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

Exposición eléctrica

Mala limpieza

Other:

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

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

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

\_\_\_\_\_

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



# \$1000 REWARD

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

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

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

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

# 1 (800) 300-JAIL

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



# \$1000 RECOMPENSA

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

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

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

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

# 1 (800) 300-JAIL

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