



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Division TM

Workers Compensation State Claim Kit

Massachusetts



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

Dear Policyholder:

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

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

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

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

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

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com





Workers Compensation Posting Requirements

Notice to Employees Poster

- Post in one or more conspicuous places at all business locations

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

- Name of your designated insurance company
- Policy number and effective dates (start and end)
- Name, address, and phone number of your insurance agent
- Your company name and address
- Name of your company workers' compensation officer (if any)
- Date
- Name and address of a local hospital to provide emergency medical treatment

For your convenience, our other contact information has been entered on the Poster.

(Annotated Laws of Massachusetts 152 § 21 and § 22)

NOTICE
TO
EMPLOYEES



NOTICE
TO
EMPLOYEES

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

LAFAYETTE CITY CENTER, 2 AVENUE DE LAFAYETTE, BOSTON, MA 02111

(617) 727-4900 - www.mass.gov/dia

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above-mentioned chapter by insuring with:

NAME OF INSURANCE COMPANY

ADDRESS OF INSURANCE COMPANY

POLICY NUMBER

EFFECTIVE DATES

NAME OF INSURANCE AGENT

ADDRESS

PHONE #

EMPLOYER

ADDRESS

EMPLOYER'S WORKERS' COMPENSATION OFFICER (IF ANY)

DATE

MEDICAL TREATMENT

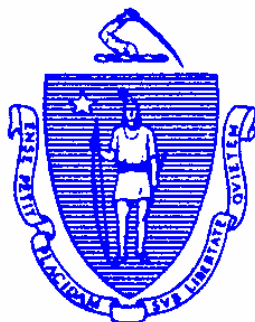
The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

NAME OF HOSPITAL

ADDRESS

TO BE POSTED BY EMPLOYER

AVISO PARA EMPLEADOS



AVISO PARA EMPLEADOS

The Commonwealth of Massachusetts DEPARTMENT OF INDUSTRIAL ACCIDENTS

LAFAYETTE CITY CENTER, 2 AVENUE DE LAFAYETTE, BOSTON, MA 02111

(617) 727-4900 - www.mass.gov/dia

De acuerdo con lo dispuesto por los artículos 21, 22 y 30 del capítulo 152 de las Leyes Generales de Massachussets, por el presente notificamos que hemos previsto el pago a nuestros empleados lesionados, conforme al capítulo antes mencionado, mediante un seguro con:

NOMBRE DE LA COMPAÑÍA DE SEGURO

_ DOMICILIO DE LA COMPAÑÍA DE SEGURO

NÚMERO DE PÓLIZA

FECHAS DE VIGENCIA

NOMBRE DEL AGENTE DE SEGUROS

DOMICILIO

TELÉFONO

EMPLEADOR

DOMICILIO

FUNCIONARIO DEL EMPLEADOR PARA ACCIDENTES DE TRABAJO (SI HUBIERA) FECHA

TRATAMIENTO MÉDICO

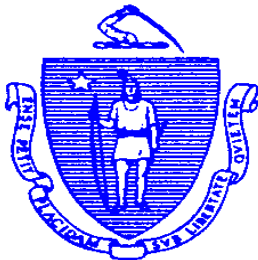
En caso de lesiones personales ocurridas a raíz del trabajo o durante el trabajo, la aseguradora cuyo nombre aparece arriba debe prestar servicios médicos y hospitalarios adecuados razonables de acuerdo con lo dispuesto por la Ley de Accidentes de Trabajo. El empleado lesionado debe recibir una copia del Primer Informe de Lesión. El empleado puede elegir su propio médico. El costo razonable de los servicios prestados por el médico que asista en el caso será abonado por la aseguradora, siempre que el tratamiento sea necesario y esté razonablemente relacionado con la lesión ocupacional. En caso de que se necesite atención hospitalaria, por la presente se notifica a los empleados que la aseguradora ha dispuesto que esa atención sea prestada en:

NOMBRE DEL HOSPITAL

DOMICILIO

ANUNCIO PUBLICADO POR EL EMPLEADOR

**AVISO AOS
EMPREGADOS**



**AVISO AOS
EMPREGADOS**

Estado de Massachusetts
Departamento de Acidentes de Trabalho
1 Congress Street, Suite 100
Boston, MA 02114-2017
617-727-4900 - <http://www.mass.gov/dia>

Nos termos da Lei Geral do Estado de Massachusetts, Capítulo 152, Parágrafos 21, 22 e 30, avisam-se os empregados que eu/nós asseguro(amos) o pagamento dos meus/nossos empregados em caso de acidente de trabalho / doença profissional, nos termos legais, através da subscrição de um seguro de acidentes de trabalho na seguinte companhia:

NOME DA COMPANHIA DE SEGUROS		
ENDEREÇO DA COMPANHIA SEGUROS		
N.º DA APÓLICE	VALIDADE DO SEGURO	
MEDIADOR	ENDEREÇO	N.º DE TELEFONE
EMPRESA (SEGURADO)	ENDEREÇO	
RESPONSÁVEL NA EMPRESA PELO SEGURO DE ACIDENTES (SE EXISTENTE))	DATA	

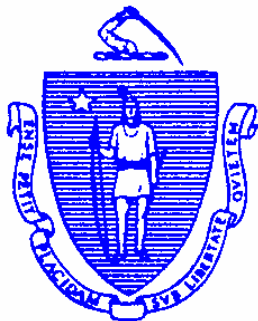
ASSISTÊNCIA MÉDICA EM CASO DE ACIDENTE

A seguradora acima referida deverá, nos casos de lesões corporais decorrentes ou no curso da actividade do segurado, proporcionar assistência médica ou hospitalar adequada e razoável, nos termos da Lei sobre Seguros de Acidentes de Trabalho. Uma cópia do Relatório Inicial de Acidente de Trabalho deverá ser entregue ao trabalhador acidentado. O trabalhador tem direito a seleccionar o seu médico assistente. A seguradora pagará os custos razoáveis dos serviços prestados pelo médico assistente, no caso de o tratamento ser necessário, desde que razoavelmente relacionados com a lesão profissional sofrida pelo trabalhador. Nos casos em que seja necessária assistência hospitalar, avisam-se os empregados de que a seguradora assegura a prestação dos serviços necessários no

NOME DO HOSPITAL	ENDEREÇO
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A AFIXAR PELA ENTIDADE EMPREGADORA

員工告示



員工告示

麻薩諸塞州 工傷部

Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
(617) 727-4900 - <http://www.mass.gov/dia>

謹此依麻薩諸塞州普通法 152 章第 21、22 和 30 各節規定向您告知，我（我們）業已根據上述法令規定向下列公司投保，藉以為受傷員工付款：

保險公司名稱

保險公司地址

保單號碼

生效日期

保險經紀姓名

地址

電話號碼

僱主

地址

僱主的工傷賠償主管 (若有)

日期

醫治

發生因工與工作期間內受傷時，上述保險人必需根據工傷賠償法規定，提供適當與合理的醫院以及醫療服務。受傷員工必須接獲第一份受傷報告。員工可以自行選擇他/她的醫生。如果所獲治療確屬必要且與其工傷有合理關聯，治療醫師所提供服務的合理費用將由保險人支付。若必需到醫院就醫，我們謹此告示員工，保險人已與下列單位做好就醫安排

醫院名稱

地址

由僱主張貼

إخطار إلى أصحاب العمل



كومونولث ولاية ماساتشوستس إدارة الحوادث الصناعية

LAFAYETTE CITY CENTER, 2 AVENUE DE LAFAYETTE, BOSTON, MA 02111

<http://www.mass.gov/dia> - (617) 727-4900

بموجب القانون العام لولاية ماساتشوستس، القانون 152، المواد 21 و 22 و 30، سوف يعطيك هذا إخطارًا بأن أنا (نحن) قد قمنا بالسداد لموظفينا المصابين بموجب القانون المذكور أعلاه من خلال توفير الغطاء التأميني بواسطة:

اسم شركة التأمين

عنوان شركة التأمين

رقم البوليصه

تواريخ السريان

اسم وكيل التأمين

العنوان

رقم الهاتف

صاحب العمل

العمل

تاريخ مسؤول تعويض موظفي صاحب العمل (إن وجد)

العلاج الطبي

مطلوب من شركة التأمين المذكور اسمها أعلاه في حالات الإصابات الشخصية الناتجة عن التوظيف وأثناء فترة التوظيف أن توفر مستشفى وخدمات طبية معقولة طبقًا لمواد قانون تعويض العمال. ويجب إعطاء نسخة من أول تقرير إصابة إلى الموظف المصاب. ويمكن للموظف اختيار الطبيب الخاص به أو الطبيبة الخاصة بها. وسيتم سداد التكلفة المعقولة لهذه الخدمات التي قدمها الطبيب المعالج بواسطة شركة التأمين إذا كان العلاج مرتبط بالضرورة وبشكل معقول بإصابة خاصة بالعمل. في الحالات التي تستدعي رعاية بالمستشفى، فإن الموظفين بموجب هذه الوثيقة قد تم إبلاغهم بأن شركة التأمين قد قامت بالترتيب لهذه الرعاية في

اسم المستشفى

العنوان

يتم نشرها بواسطة صاحب العمل

**AVIZU
PA
ENPREGADUS**



**AVIZU
PA
ENPREGADUS**

**The Commonwealth of Massachusetts
DEPARTMENTU DI ASIDENTI INDUSTRIAL**

Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750

(617) 727-4900 - <http://www.mass.gov/dia>

Konformi rikizitu di Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, kel li e pa notifikabu ki mi (nos) ta fazi pagamentu pa nos enpregadus asidentadu pa kapitulo mensionadu di riba pa seguru ku:

NOMI DI KONPANHIA DI SEGURU

ENDERESU DI KONPANHIA DI SEGURU

_ NUMBRU DI APOLISE

DATAS EM

EFEITU

NOMI DI AGENTI DI SEGURU

ENDERESU

TELEF #

PATRON

ENDERESU

REPREZENTANTI (SI TEN) DI PATRON PA KONPENSASON DI TRABADJADOR DATA

TRATAMENTU MEDIKU

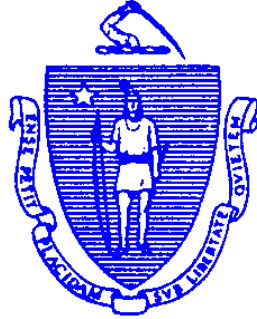
Konpanhia di seguru nomiadu di riba ten obrigason di na kazu di danu pesual ki kontisi na, o pur kauza di trabadju, di da serbisus mediku y di hospital adekuadu y razuavel di akordu ku stipuladu pa Lei di Kompensason di Trabadjador (*Workers' Compensation Act*). Enpregadu asidentadu debi resebi un kopia di Prumeru Relatorio di Pankada. Enpregadu podi skodji se propi doktor. Seguru ta paga kustu di sirbisus di tratamentu pa doktor, si tratamentu for nesesario y razuavelmenti ligadu ku pankada na trabadju. Na kazu ki mesti tratamentu di hospital, enpregadus ta fika asin notifikadu ki konpanhia di seguru dja ranja hospital pa tal tratamentu na

NOMI DI HOSPITAL

ENDERESU

PA SER PUBLIKADU PA PATRON

**AVI
POU
ANPLWAYE**



**AVI
POU
ANPLWAYE**

**Commonwealth of Massachusetts
DEPATMAN AKSIDAN ENDISTRIYÈL**

Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
(617) 727-4900 - <http://www.mass.gov/dia>

Daprè lalwa jeneral leta Massachusetts, chapit 152, seksyon 21, 22 & 30, dokiman sa a ap mete w okouran ke mwen (nou) ap peye pou anplwaye blese ou a daprè chapit ki make anlè a e ki gen asirans ak :

NON KONPAYI ASIRANS LAN

ADRÈS KONPAYI ASIRANS LAN

NIMEWO KONTRA A

DAT KONTRA A

NON AJAN KONPAYI ASIRANS LAN
KONPAYI TRAVAY

ADRÈS

ADRÈS

TELEFÒN

REPREZANTAN ASIRANS POU AKSIDAN NAN TRAVAY (SI GENYEN) DAT

SWEN MEDIKAL

Konpayi asirans ki make anlè a oblije, si gen aksidan pèsònèl nan travay, ofri sèvis medikal ak sèvis lopital rezonab daprè paragraf nan lwa pou aksidan nan travay la. Li enpòtan pou remèt anplwaye blese a yon fotokopi dokiman premye rapò sou aksidan li a. Anplwaye a ka chwazi nenpòt doktè li vle. Se konpayi asirans lan ki va peye pou frè sèvis rezonab doktè a ofri, si tretman an nesèsè epi rezonab pou aksidan nan travay la. Si anplwaye a gen pou li entène, anplwaye a gen pou l di konpayi asirans lan ap peye pou sa nan

NON LOPITAL LA

ADRÈS

POU KONPAYI TRAVAY LA AFICHE

សេចក្តីជូនដំណឹង
ជូន
និយោជិត

សេចក្តីជូនដំណឹង
ជូន
និយោជិត

The Commonwealth of Massachusetts
(ឧបទ្វីបម៉ាសាឈូសេត)
DEPARTMENT OF INDUSTRIAL ACCIDENTS
(ក្រសួងគ្រប់គ្រងគ្រោះថ្នាក់ឧស្សាហកម្ម)

Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
(617) 727-4900 - <http://www.mass.gov/dia>

ប្រព័ន្ធបញ្ជាចាត់វាយបញ្ជប់ទៅលើម៉ាសាឈូសេត (Massachusetts General Law) ជំពូក 152 លេខ 21, 22 និង 30 តាមរយៈនេះជូនដំណឹងដល់អ្នកថា ខ្ញុំ (យើងខ្ញុំ) បានផ្តល់នូវការបំពេញតួនាទីនិយោជិតដល់បុរស/ស្រី/កុមារ ដោយស្មើគ្នា ក្រោមចិត្តផ្តល់ បានប្រៀបបង្គាប់ដល់ តាមរយៈការចាត់វាយបញ្ជប់ដូចខាងក្រោម :

ឈ្មោះក្រុមហ៊ុនចាត់វាយបញ្ជប់		
អាសយដ្ឋានក្រុមហ៊ុនចាត់វាយបញ្ជប់		
លេខប័ណ្ណកម្មវិធី	អាសយដ្ឋាន	កាលបរិច្ឆេទមានប្រសិទ្ធភាព
ឈ្មោះភ្នាក់ងារចាត់វាយបញ្ជប់	អាសយដ្ឋាន	លេខទូរស័ព្ទ
និយោជក	អាសយដ្ឋាន	
មន្ត្រីទទួលបន្ទុកសំណុំរឿងនិយោជិតសហនិយោជក (ប្រសិនបើមាន)		កាលបរិច្ឆេទ

ការព្យាបាលវេជ្ជសាស្ត្រ

ក្រុមហ៊ុនចាត់វាយបញ្ជប់ដែលមានឈ្មោះខាងលើ ត្រូវបានឱ្យមាននៅក្នុងការបំពេញនីតិវិធីបុរស/ស្រី/កុមារ ដែលកើតឈាមកពី និងដោយសារការងារ ដើម្បីផ្តល់ឱ្យនូវសេវានៅមន្ទីរពេទ្យ និងវេជ្ជសាស្ត្របានគ្រប់គ្រាន់ និងសមរម្យ ដោយសេរីដោយបញ្ជាក់នូវការងារច្បាប់សំណុំរឿងនិយោជិត (Workers' Compensation Act)។ សេចក្តីចម្លងនៃរបាយការណ៍របស់បុរស/ស្រី/កុមារ (First Report of Injury) ត្រូវបានផ្តល់ជូននិយោជិតដល់បុរស/ស្រី/កុមារ និងនិយោជិតអាចប្រើសិទ្ធិត្រូវបានផ្តល់ឱ្យបាន។ ចំណាយសេវាកម្មសមរម្យដែលបានផ្តល់ជូនដោយក្រុមហ៊ុនចាត់វាយបញ្ជប់ និងត្រូវបំពេញដោយក្រុមហ៊ុនចាត់វាយបញ្ជប់ ប្រសិនបើការព្យាបាលចាំបាច់ និងពាក់ព័ន្ធសមរម្យទៅនឹងការងារបុរស/ស្រី/កុមារ។ នៅក្នុងករណីក្តីការការពារចិត្តក្នុងកំរិតមន្ទីរពេទ្យ តាមរយៈនេះនិយោជិតត្រូវបានជូនដំណឹងថា ក្រុមហ៊ុនចាត់វាយបញ្ជប់បានប្រៀបបង្គាប់ការយកចិត្តទុកដាក់នេះទៅ។

ឈ្មោះមន្ទីរពេទ្យ អាសយដ្ឋាន

ប្រាំបានបិទជញ្ជោលដោយនិយោជិត

**THÔNG BÁO
CHO NHÂN
VIÊN**



**THÔNG BÁO
CHO NHÂN
VIÊN**

Khôi Cộg Đöng Massachusetts

BAN TAI NẠN KỸ NGHỆ

Lafayette City Center, 2 Avenue de Lafayette, Boston, MA

02111-1750

(617) 727-4900 - <http://www.mass.gov/dia>

Theo ðòi hỏi từ M.G.L. (Luật Lệ Chung của Massachusetts), Chương 152, Đoạn 21, 22 & 30, nơi ðây thông báo cho quý vị biết rằng tôi (chúng tôi) ðã lo liệu vấn ðề chi trả cho nhân viên bị thương tật theo chương nhắc ðến bên trên bằng cách mua bảo hiểm tại:

TÊN HÃNG BẢO HIỂM

ĐỊA CHỈ HÃNG BẢO HIỂM

SỐ HỢP ĐỒNG

NGÀY CÓ HIỆU LỰC

TÊN ĐẠI LÝ BẢO HIỂM

ĐỊA CHỈ

SỐ ĐIỆN THOẠI

HÃNG SỞ

ĐỊA CHỈ

VIÊN CHỨC BỒI THƯỜNG TAI NẠN LAO ĐỘNG CỦA HÃNG SỞ (NẾU CÓ) NGÀY

ĐIỀU TRỊ Y TẾ

Nếu xảy ra thương tật cá nhân - xuất phát từ việc làm và trong quá trình làm việc - thì nơi bảo hiểm nhắc ðến bên trên phải lo liệu dịch vụ y tế và dịch vụ bệnh viện thích ðáng và hợp lý ðúng theo các ðiều khoản của Đạo Luật Bồi Thường Tai Nạn Lao Động. Phải giao bản sao Khai Báo Đầu Tiên về Thương Tật cho nhân viên bị thương tật. Nhân viên có thể chọn bác sĩ riêng của mình. Chi phí dịch vụ hợp lý do bác sĩ ðiều trị thực hiện sẽ do nơi bảo hiểm chi trả, nếu chữa trị ðó là cần thiết, hợp lý, và can hệ với thương tật liên quan ðến công việc. Nếu cần phải săn sóc tại bệnh viện, thì nhân viên cũng ðược thông báo rằng nơi bảo hiểm ðã lo liệu công việc chăm sóc ðó tại

TÊN BỆNH VIỆN

ĐỊA CHỈ

HÃNG SỞ PHẢI NIÊM YẾT THÔNG BÁO NÀY

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		OSHA LOG NUMBER		REPORT PURPOSE CODE			
		JURISDICTION		JURISDICTION CLAIM NUMBER					
		INSURED REPORT NUMBER							
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #			
INDUSTRY CODE		EMPLOYER FEIN						PHONE #	
CARRIER/CLAIMS ADMINISTRATOR									
CARRIER (NAME, ADDRESS, & PHONE #)			POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)				
			TO						
			CHECK IF APPROPRIATE						
			<input type="checkbox"/> SELF INSURANCE						
CARRIER FEIN		POLICY/SELF-INSURED NUMBER			ADMINISTRATOR FEIN				
AGENT NAME & CODE NUMBER									
EMPLOYEE/WAGE									
NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED	STATE OF HIRE	
ADDRESS (INCL ZIP)			SEX		MARITAL STATUS		OCCUPATION/JOB TITLE		
			<input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN		<input type="checkbox"/> U UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN		EMPLOYMENT STATUS		
PHONE			# OF DEPENDENTS				NCCI CLASS CODE		
RATE PER:		<input type="checkbox"/> DAY WEEK	<input type="checkbox"/> MONTH OTHER:	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
		<input type="checkbox"/> YES	<input type="checkbox"/> NO					<input type="checkbox"/> YES	<input type="checkbox"/> NO
OCCURRENCE/TREATMENT									
TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE () CANNOT BE DETERMINED		<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE		DATE EMPLOYER NOTIFIED
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED			
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE			
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL								CAUSE OF INJURY CODE	
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
				WERE THEY USED?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)			INITIAL TREATMENT			
						0 NO MEDICAL TREATMENT			
						1 MINOR: BY EMPLOYER			
						2 MINOR CLINIC/HOSP			
						3 EMERGENCY CARE			
						4 HOSPITALIZED > 24 HOURS			
				5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED					
OTHER									
WITNESSES (NAME & PHONE #)									
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE			PHONE NUMBER		

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

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

CARRIER:

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

CLAIMS ADMINISTRATOR:

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

AGENT NAME & CODE NUMBER:

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

OCCUPATION/JOB TITLE:

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

EMPLOYMENT STATUS:

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

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

DATE DISABILITY BEGAN:

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

CONTACT NAME/PHONE NUMBER:

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

TYPE OF INJURY/ILLNESS:

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

PART OF BODY AFFECTED:

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

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

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

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

EMPLOYER'S INSTRUCTIONS – cont'd

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

(eg. Acetylene cutting torch, metal plate)

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

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

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

(eg. Cutting metal plate for flooring)

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

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

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

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

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

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

DATE RETURN(ED) TO WORK:

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

The Commonwealth of Massachusetts
Department of Industrial Accidents

Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line (800) 323-3249 Inside Mass. / (857) 321-7470 Outside Mass.
www.mass.gov/dia

DIA USE ONLY



AVERAGE WEEKLY WAGE COMPUTATION SCHEDULE

Print or Type

1. Employer's Name and Address:		2. Insurer's Case File #:	
4. Employee's Name and Address:		3. DIA Board # (if known):	
		5. # of dependent children:	
7. Date of Injury (mm/dd/yyyy):		6. # of other dependents:	
		9. Date of Employment (mm/dd/yyyy):	
8. Date of Disability (mm/dd/yyyy):		10. Has employee been certified by U.S. Veterans Administration for any type of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Date of Employment (mm/dd/yyyy):			

Indicate only those wages earned by the injured worker during the 52 week period immediately preceding the accident. If the injured employee has worked for less than 52 weeks, report wages from the time worked and, for the remaining weeks on this schedule, substitute wages of a fellow employee in the same class of employment who has worked for one year or more.

11. Week No.	Year:		Gross Amount Before Taxes	Week No.	Year:		Gross Amount Before Taxes	Week No.	Year:		Gross Amount Before Taxes
	Week Ending				Week Ending				Week Ending		
	Month	Day			Month	Day			Month	Day	
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				Total:			
18				36							

12. Was room furnished to the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. If tips or other benefits were earned, describe and state value per week:
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THIS IS A TRUE COPY OF THE PAYROLL RECORD OF THE ABOVE NAMED EMPLOYEE OR FELLOW EMPLOYEE IN THE SAME CLASS OF EMPLOYEMENT

14. Name of Fellow Employee (if applicable):	15. Employer/Preparer Signature:	16. Date Signed (mm/dd/yyyy):
--	----------------------------------	-------------------------------



Claim Number/Número de Reclamo

Date of Injury / Fecha de la Lesión

Employee/Empleado

Date of Birth / Fecha de Nacimiento

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

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

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

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

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

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

The released information is required for the following reasons:

La información liberada es requerida por las siguientes razones:

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

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

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

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



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

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

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

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

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

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

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

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

A copy or fax is as valid as the original.

Una copia o fax es tan válida como el original.

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

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

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

Signature/Firma

Date/Fecha





Medical History Request

Employee Name

Date of Injury

Employer Name

Completion Date

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

Thank you for your cooperation.

Past Injuries, Disabilities, or Other Medical Conditions

Hospitalizations

Hospital Name & Address	Phone	Date(s) Admitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

Employee 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



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.