Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation State Claim Kit

Nevada

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.

Nevada state law requires employers to report every industrial injury or occupational disease claim to their workers compensation carrier within six days of employer knowledge of an 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

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Workers' Compensation Posting Requirements

Form D-1 – Brief Description of Your Rights and Benefits if You are Injured on the Job or Have an Occupational Disease

- Post in one or more conspicuous places readily accessible to all employees at all business locations
- Must be printed on 11" x 17" paper
- Text for the form completion portion of the Poster must be in at least 10-point font-size

To complete the form, please enter the name, address, contact person, and phone number for MCO/health care provider, along with the name of your designated insurer. For your convenience, our other contact information has been entered on the Poster. Please note, the form fields are designated to populate at text meeting the statutory font-size requirement.

(Nevada Revised Statutes Annotated 616A.490 and Nevada Administrative Code 616A.460 and 616A.480)

Form D-2 – Brief Description of Rights and Benefits

- Post next to Form D-1 – Brief Description of Your Right sand Benefits if You are injured on the Job or Have an Occupational Disease
- Must be printed on 8.5" x 11" paper

(Nevada Administrative Code 616A.470)

Form D-22 – Notice to Employees – Tip Information

PLEASE NOTE, FORM D-22 IS ONLY UTILIZED WHEN EMPLOYEES RECEIVE TIPS!

- When applicable, post next to Form D-1 – Brief Description of Your Right sand Benefits if You are injured on the Job or Have an Occupational Disease, and Form D-2 – Brief Description of Rights and Benefits
- Must be printed on 8.5" x 11" paper

(Nevada Administrative Code 616A.470)

State of Nevada
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

A T T E N T I O N

Caution: The information below is general in nature and is not intended to be legal advice. If you have any questions regarding your status as an employer or employee or your rights and qualification for specific benefits under an industrial injury or occupational disease claim, you should consult with an attorney experienced in industrial insurance.

Brief Description of Whether the Employer is Required to Obtain Industrial Insurance and Whether a Person is a Covered Employee

Every employer … shall provide and secure compensation … for any personal injuries by accident sustained by an employee arising out of and in the course of the employment. See NRS 616B.612(1).

An **employer** is defined as, "Every person, firm, voluntary association and private corporation, including any public service corporation, which has in service any person under a contract of hire." See NRS 616A.230(2). "A person is not an employer …. if: (a)The person enters into a contract with another person or business which is an independent enterprise; and (b) The person is not in the same trade, business, profession or occupation as the independent enterprise." See NRS 616B.603(1).

An **employee** is broadly defined as, "… every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed" (See NRS 616A.105), but excludes casual employees not in the same trade, business, profession or occupation; musicians not lasting more than 2 consecutive days; household servants, farming and ranching employees; voluntary ski patrol; sports officials paid a nominal fee; clergy, rabbi or lay readers; real estate brokers or sales persons; and commissioned sales persons (See NRS 616A.110).

An **independent contractor** is a person who is hired and paid solely to produce a result. It is defined as, "… any person who renders service for a specified recompense for a specified result, under the control of the person's principal as to the result of the person's work only and not as to the means by which such result is accomplished." See NRS 616A.255.

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

Notice of Injury or Occupational Disease (Incident Report Form C-1) If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation, your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a lump-sum PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer hearing. NAIW is an independent state agency and is not affiliated with any insurer. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or
2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 3360 W. Sahara Ave., Suite 250, Las Vegas, NV 89102, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the State of Nevada Office for Consumer Health Assistance, 3320 West Sahara Avenue, Suite 100, Las Vegas, Nevada 89102, Toll Free 1- 888-333-1597, Web site: http://dhhs.nv.gov/Programs/CHA, E-mail cha@govcha.nv.gov

The information in this publication is derived from Chapters 616A through 616D, inclusive, and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administrator:_____ Contact Person: _____

Address:_____ Telephone Number: _____
City State Zip

MCO/Health Care Provider:_____ Contact Person: _____

Address:_____ Telephone Number: _____
City State Zip

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

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NOTICE TO EMPLOYEES

Pursuant to: **NRS 616B.227 Election by employee to report his tips; effect; regulation.**

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:
   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;
   (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and
   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

Where can I obtain additional information on workers' compensation?

Website: http://dir.nv.gov/WCS/Home/

Email: WCSHelp@dir.nv.gov

For information concerning claims administration or failure to obtain or maintain workers' compensation insurance:

Department of Business and Industry
Division of Industrial Relations Workers' Compensation Section

400 West King Street, Suite 400
Carson City, Nevada 89703
(775) 684-7270

3360 W. Sahara Ave., Suite 250
Las Vegas, Nevada 89102
(702) 486-9080

For information regarding occupational safety and health program development and implementation:

SAFETY CONSULTATION & TRAINING SECTION

Website: www.4safenv.state.nv.us
Toll Free: 877-4SAFENV
OSHA 10 & 30 Hr Construction Class must register on-line.

The material contained in this publication is derived from chapters 616A to 617, inclusive, of the Nevada Revised Statutes (NRS) & Nevada Administrative Code (NAC), and is provided for informational purposes only. For more detailed information, please refer to the specific statute or code. The NRS and NAC relating to Workers' Compensation can be accessed via the Internet at:
http://dir.nv.gov/WCS/Nevada_Law/

What will happen to an employer who fails to obtain or maintain workers' compensation insurance?

The Division of Industrial Relations, Workers' Compensation Section (WCS) is responsible for ensuring all employers are in compliance with the law. Employers who do not provide workers' compensation will be charged with an administrative fine up to $15,000; appropriate premium penalties; may be ordered to close business until insurance has been obtained; and will be held financially responsible for all costs arising from a work-related injury. In addition, the uninsured employer may be subject to a criminal penalty for claims resulting in substantial bodily harm or death. (NRS 616D.200 & NAC 616D.345)

Who can provide workers' compensation coverage in Nevada?

Employers may purchase insurance from a private carrier licensed in Nevada or be certified by the Division of Insurance (DOI) as a self-insured employer or a member of an association of self-insured public or private employers.

Private carriers currently utilize competitive premium rates which allows them to deviate on the expense portion of the premiums. This rate must be filed with the DOI 15 days before if is effective and can be disapproved. Contact DOI for further information at the following:

Carson City (775) 687-7000
Las Vegas (702) 486-4009
http://doi.nv.gov/

EMPLOYER GUIDE

WORKERS' COMPENSATION

Email Notification
Stay connected to what's new in Nevada's workers' compensation by registering to receive email notifications.
http://dir.nv.gov/wcs/home/

PUBLISHED BY:
STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
WORKERS' COMPENSATION SECTION

This pamphlet is provided to inform stakeholders of some significant points concerning workers' compensation insurance in Nevada.

06/20

What is workers' compensation?

Workers' compensation is a no-fault insurance program in the State of Nevada, which provides benefits to employees who are injured on the job and protection to employers who have provided coverage at the time of injury.

What protection is provided for the employer?

Because Nevada has "exclusive remedy," the injured workers' benefits are set forth in the statutes. Employers who provide coverage for their employees at the time of injury are protected from any additional damages claimed by their employees as a result of an injury on the job. This protection is established when the injured employee opts to receive workers' compensation benefits.

What type of benefits are employees entitled to?

Nevada's Workers' Compensation Program provides a variety of benefits which are designed to assist the injured employee. These benefits may include (among others):

- Medical treatment;
- Lost time compensation (TTD/TPD);
- Permanent Partial Disability (PPD);
- Permanent Total Disability (PTD);
- Vocational Rehabilitation;
- Dependent's benefits in the event of death; and
- Other claims-related benefits or expenses (i.e., mileage)

How do the Subsequent Injury Accounts benefit employers?

The Subsequent Injury Accounts encourage employers to hire workers with a permanent physical impairment. The costs of any qualified subsequent injury are paid from the appropriate subsequent injury account. (NRS 616B.557 – 590) Contact Jacque Everhart at (702) 486-9098 or VSkrinjaric@dir.nv.gov for more information.

Which employers are required to provide workers' compensation insurance?

Unless excluded by statute, it is mandatory for an employer who has one or more employees to provide workers' compensation insurance coverage. Some employees are excluded by NRS 616A.110 due to unique criteria.

Employment exempt from workers' compensation insurance coverage requirements includes:

- Employment related to those interstate commerce entities that are not subject to the legislative power of the state of Nevada.
- Employment covered by private disability and death benefit plans which comprehend compensation payments of equal or greater amounts than those provided in NRS 616 and which have been in effect for one year prior to July 1, 1947;
- Employees who are brought into Nevada on a temporary basis and who are insured in another state if extraterritorial coverage provisions are in effect with the other state.

Exception: the construction trades.

- Casual employment (employment lasting not more than 20 days and having a total labor cost of less than $500) is exempt **if employment is not in the course of trade, business, profession or occupation of the employer.**

CONSTRUCTION TRADES ARE REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE.

Workers' Compensation Employer Compliance Checklist

☑Provide requisite workers' compensation insurance coverage and furnish a place of employment free from recognized hazards that may cause death or serious physical harm to employees.

☑Prominently display in your place of business the required workers' compensation information:

(1) *Informational poster to be displayed by employers.* **(**NAC 616A.460, Form D-1)

(2) *Poster to be displayed by employers with employees who receive tips.* **(**NAC 616A.470, Form D-22)

☑Have available at all times and at all locations for inspection by agent of the Division of Industrial Relations or Attorney General:

- The policy including the declaration page issued by private carrier; or
- Certificate issued by the Commissioner if self-insured; or,
- Certificate issued by the Commissioner and a certificate or letter issued by an association of self-insured public or private employers if a member of an association.

Note: Temporary worksites (less than 1 year) must produce the above information within 24 hours. (NRS 616A.495)

☑Provide forms for employee use and complete injury or occupational disease reporting requirements and forward the required documents in the allowable timeframe: *(1) C-1, Notice of Injury or Occupational Disease (Incident Report) and (2) C-3, Employers' Report of Industrial Injury or Occupational Disease* (NRS 616C.015 & 616C.045)

☑Provide immediate first aid to an injured employee (NRS 616C.085)

☑Complete the Employer's Report of Industrial Injury or Occupational Disease Form (Form C-3) within 6 working days of receipt of the Form C-4 from the medical provider and file it with insurer. (NRS 616C.045)

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Nevada Department of Industrial Relations (DIR)

Employer Forms

Form Name	Statutes	Information on Requirements	Maximum Fine
C-1 Form	NRS 616C.015	Please note this is an Employee form but the Employer's requirement are underlined. Employee should complete within seven days after the accident; must be maintained by employer for three years; employer required to keep adequate supply of blank forms for employee use. Insurer/TPA should supply forms to employer.	N/A
C-3 Form	NRS 616C.045	Employer must complete and file with the insurer within six working days after receiving a copy of the C-4 Form. Insurer/TPA should supply forms to employer.	$1,000 per occurrence
D-8 Form	NRS 616C.045 NRS 616A.480	Employer must complete and file with the insurer within six working days of receipt of the C-4 (if the C- 4 indicates the injured employee will be off work for 5 consecutive days or more or five days in a 20 day period) or when requested by the insurer. Insurer/TPA should supply forms.	$1,000 per occurrence
Blank Forms	NRS 616A.480	Employer must fully complete any blank form received by the insurer or the administrator and return to appropriate party within six working days.	$1,000 per occurrence

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

NV Statute NRS 616C.045 and NRS 616A.480 - 11/2020

NRS 616C.045

Report of industrial injury or occupational disease: Duty of employer to file; electronic filing; form and contents; penalty.

1. Except as otherwise provided in NRS 616B.727, within 6 working days after the receipt of a claim for compensation from a physician or chiropractor, or a medical facility if the duty to file the claim for compensation has been delegated to the medical facility pursuant to NRS 616C.040, an employer shall complete and file with his or her insurer or third-party administrator an employer's report of industrial injury or occupational disease.
2. The report must:
   - **a** Be filed on a form prescribed by the Administrator
   - **b** Be signed by the employer or the employer's designee;
   - **c** Contain specific answers to all questions required by the regulations of the Administrator; and
   - **d** Be accompanied by a statement of the wages of the employee if the claim for compensation received from the treating physician or chiropractor, or a medical facility if the duty to file the claim for compensation has been delegated to the medical facility pursuant to NRS 616C.040, indicates that the injured employee is expected to be off work for 5 days or more.
3. An employer who files the report required by subsection 1 by electronic transmission shall, upon request, mail to the insurer or third-party administrator the form that contains the original signature of the employer or the employer's designee. The form must be mailed within 7 days after receiving such a request.
4. The Administrator shall impose an administrative fine of not more than $1,000 on an employer for each violation of this section.

(Added to NRS by 1993, 661; A 1995, 649; 1997, 1435; 1999, 3146; 2003, 2305)

NRS 616A.480

Required execution of blank forms by employer; penalty for noncompliance.

1. Every employer receiving from the insurer or Administrator any blank form with directions to fill it out shall:
   - **a** Cause it to be filled out properly.
   - **b** Answer fully and correctly all questions therein propounded, and if unable to do so, shall give sufficient reasons for his or her failure. Answers to questions must be verified and returned to the insurer or Administrator, as appropriate, within six working days.
2. If an employer fails to comply with the provisions of subsection 1, the Administrator shall impose a fine of not more than $1,000 for each failure to comply.

[46:168:1947; 1943 NCL § 2680.46] — (NRS A 1981, 1469; 1991, 2404; 1993, 712; 1995, 2022) — (Substituted in revision for NRS 616.330)

Reset Form

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"
(Incident Report)
Pursuant to NRS 616C.015

Name of Employer _____

Name of Employee	Social Security Number	Telephone Number

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)

What is the nature of the injury or occupational disease?	List any body parts involved:

Briefly describe accident or circumstances of occupational disease:
(Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)

Names of witnesses:

Did the employee leave work because of the injury or occupational disease? ____ YES ____ NO	If yes, when (date and time)?	Has the employee returned to work? ____ YES ____ NO	If yes, when (date and time)?
Was first aid provided? ____ YES ____ NO	If yes, by whom?	Name and address of treating physician, if applicable or known	
Did the accident happen in the normal course of work? (if applicable) ____ YES ____ NO			
Was anyone else involved? ____ YES ____ NO	Names of others involved		

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature Date

Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov

Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee

C-1 (Rev. 01/20)

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Office Mail Address	Location . . . If different from mailing address		Telephone
City State Zip	**INSURER**		**THIRD-PARTY ADMINISTRATOR**

EMPLOYEE

First Name M.I. Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Home Address (Number and Street)	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
City State Zip	Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No		How long has this person been employed by you in Nevada?	
In which state was employee hired?	Employee's occupation (job title) when hired or disabled		Department in which regularly employed:	
Telephone	Is the injured employee a corporate officer? . . . sole proprietor? . . . partner? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No		Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No	

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
Address or location of accident (Also provide city, county, state) (if applicable)			Accident on employer's premises? (if applicable) ☐ Yes ☐ No
What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)			
How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.			

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)		Witness	Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No
Part of body injured or affected	If fatal, give date of death	Witness	
Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)		Witness	
		Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No	Will you have light duty work available if necessary? ☐ Yes ☐ No
If validity of claim is doubted, state reason		Location of Initial Treatment	
Treating physician/chiropractor name		Emergency Room ☐ Yes ☐ No	Hospitalized ☐ Yes ☐ No

IMPORTANT	How many days per week does employee work?	From ☐ am ☐ pm To ☐ am ☐ pm	Last day wages were earned
Scheduled days off	S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐	Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No	

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
Was the employee hired to work 40 hours per week? ☐ Yes ☐ No	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know	

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	Emloyee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY	On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov

I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.	Employer's Signature and Title	Date

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

EMPLOYER'S WAGE VERIFICATION FORM
(Pursuant to NRS 616C.045(2)(d))

Please provide the following information for the employee named below by completing this form. The information is needed so that the amount of disability compensation to which your employee is entitled may be calculated. Prompt completion and return of this form will ensure the timely payment of any compensation due this injured worker. Please answer all questions and sign the form where indicated.

EMPLOYER: PLEASE PROVIDE THE FOLLOWING INFORMATION ANSWERING ALL QUESTIONS

Date: _____ Injured Employee's Name (Last/First/M.I.): _____ Social Security # _____

Claim No.: _____ Date of Injury: _____ Date of Hire: _____

Was employee hired to work 40 hours per week: [ ] Yes [ ] No If no, # of hours per week: _____ # of days per week: _____

On the date of injury, the employee's wage was: $ _____ per [ ] Hour [ ] Day [ ] Week [ ] Month Date the wage became effective: _____

Was vacation paid during the applicable twelve week period?_____ If so, during what pay period? _____

Was sick leave paid during the applicable twelve week period? _____ Was the injured employee paid for any holidays during the applicable twelve week period? _____ Did employee receive payment for overtime during the applicable twelve week period? _____ Did employee receive termination pay during the applicable twelve week period? _____

Provide prior wage if current wage was in effect less than 12 weeks prior to date of injury: $ _____ per [ ] Hour [ ] Day [ ] Week [ ] Month

During this 12-week period did employee change to a job with different (1) duties, (2) hours of employment, (3) rate of pay? [ ] Yes [ ] No

If so, date: _____ Explain: _____

Does the employee receive commissions? [ ] Yes [ ] No Period of commission earned _____ to _____.

Indicate the amount of commission received over the last 6 months, or since date of hire: $ _____

Does the employee receive bonuses/incentive pay? [ ] Yes [ ] No Period of bonuses/incentive pay earned _____ to _____.

Indicate the amount of bonuses received over last 12 months, or since date of hire: $ _____

Are the commission and bonus amounts included in GROSS EARNINGS below? [ ] Yes [ ] No

Does the employee declare tips for the purpose of worker's compensation? [ ] Yes [ ] No **See payroll declaration below. Attach declaration forms.**

Does the employee receive meals or lodging (excluding reimbursement for travel per diem)? [ ] Yes [ ] No **(Do not include in gross earnings)**

How many meals per day?_____ Monetary value of meals $_____per [ ] Day [ ] Week [ ] Month

Lodging $_____per [ ] Day [ ] Week [ ] Month

TWELVE WEEK VERIFICATION FROM PAYROLL RECORDS. Report GROSS EARNINGS, include overtime payment and any other remuneration (except reimbursement for expenses). (See NAC 616C.423)

Give payroll information from _____ through _____. If employed less than twelve weeks, give gross earnings from date of hire to date of injury.

If absent from work for the following reasons, please specify the date(s) absent and the number code for the reason of absence.

1. Certified illness or disability; 2. Institutionalized in a hospital, or other institution; 3. Enrolled as full-time student, not employed on days of attendance; 4. In military service other than training duty conducted on weekends; 5. Absent because of officially sanctioned strike; 6. Absence because of leave approved pursuant to Family and Medical Leave Act.

Payroll Period Beginning	Payroll Period Ending	Gross Salary (Excluding Tips)	Declared Tips	Payroll Period Beginning	Payroll Period Ending	Gross Salary (Excluding Tips)	Declared Tips

Dates of Absence Begin	Dates of Absence End	Reason	Dates of Absence Begin	Dates of Absence End	Reason	Dates of Absence Begin	Dates of Absence End	Reason

Pay period ends on (check one) [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday

Employee is paid: [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [ ] Other

Employee scheduled day(s) off: [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Other

Explain "other":

Date the employee last worked AFTER injury occurred: _____ Date returned to work: _____

This information is true and correct as taken from the employee's payroll records.

Print Name: _____ Signature: _____

Date: _____ Employer: _____

Insurer: _____ Third-Party Administrator: _____

EMPLOYEE'S DECLARATION OF ELECTION TO REPORT TIPS

For the Purpose of Workers' Compensation

Pursuant to NRS 616B.227

EMPLOYER: _____

EMPLOYEE: _____

EMPLOYEE IDENTIFICATION NUMBER: _____

DEPARTMENT: _____

SOCIAL SECURITY NUMBER: _____

PAY PERIOD: _____ TO _____

AMOUNT OF TIPS RECEIVED DURING PERIOD: $_____

I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties. I declare under penalty of perjury that the information provided concerning the amount of tips which I have received is true and correct to the best of my knowledge. Those tips are declared as wages for the calculation of workers' compensation.

_____ _____

Employee Signature Date

THIS FORM MUST BE SUBMITTED TO YOUR EMPLOYER BEFORE THE END OF THE PAY PERIOD THAT FOLLOWS THE PAY PERIOD INDICATED ABOVE.

Request for Additional Medical Information And Medical Release

(Pursuant to NRS 616C.177 & 616C.490(4))

Injured Employee's Name: _____

Claim Number: _____ Social Security Number: _____

Injured Employee's Address: _____

Injury/Occupational Disease Date: _____ Date this Notice Printed: _____

Insurer's Name: _____ Employer: _____

Insurer's Address: _____ Employer's Address: _____

_____ _____

Please provide the information requested below, sign and date the form, and return it to your insurer. Your signature on this form also acts as a release to acquire information affecting your claim from other entities. This renews the release you signed on your C-4 form at the time your claim was submitted to your insurer. Failure to fully complete and return this form to your claims agent in a timely manner could affect your benefits or delay the resolution of your claim.

Prior History Information

Please check the appropriate box below and provide the information requested.

☐ **I have no prior conditions, injuries or disabilities of which I am aware, that might affect the disposition of the claim referenced above. (If you checked this box, no further information is needed at this point)**

☐ **I have a prior condition, injury or disability that could affect the disposition of the claim referenced above. This can include birth defects, prior surgeries, injuries, etc., whether work related or not. (If you checked this box, indicating a pre-existing condition, please explain in detail in the space below. Please attach additional sheets of paper to this form if necessary to fully explain the condition)**

_____

_____

_____

I certify that the above is true and correct to the best of my knowledge and that I have provided this information in order to obtain the benefits of Nevada's industrial insurance and occupational diseases acts (NRS 616A to 616D, inclusive or chapter 617 of NRS). I hereby authorize any physician, chiropractor, surgeon, practitioner, or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any insurance company, or other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to diagnosis, treatment and/or counseling for aids, psychological conditions, alcohol or controlled substances, for which I must give specific authorization. A photostat of this authorization shall be as valid as the original.

_____ _____

Signature Date

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

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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

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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 Accident

Employee Name

Employer Name

Date of Accident

Time of accident

Time you began work on day of accident

Did the employee report the accident immediately?

Address of Accident

City, State

Zip

Offsite? (Y/N)
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 accident occurred (including self)?

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

Supervisor's Report of Employment Accident

Indicate working conditions present that led to accident (please check all that apply)

- ☐ Unused/unavailable lifting equipment
- ☐ 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 accident
- ☐ 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

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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)
Yes or No

Date of Incident

Time of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)
Yes or No

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

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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

_____

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

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.

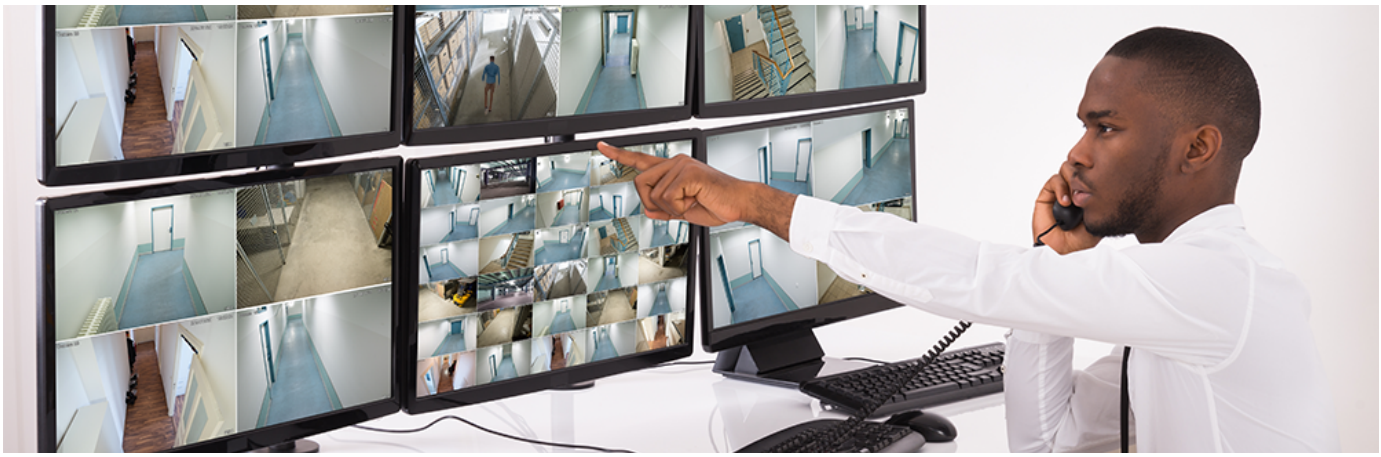
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

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.