



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Division TM

Workers Compensation State Claim Kit

Connecticut



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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.

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

[bhhcpolicyholder.bhhc.com/
Client/External/Claims](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 readily accessible to all employees at all business locations
- Text must be bolded and in at least 10-point font-size

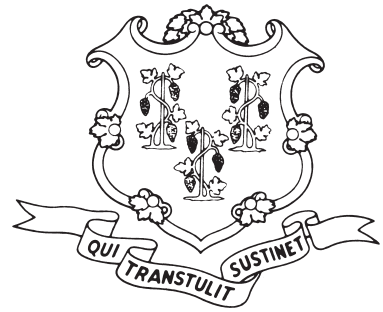
To complete the form, please enter the following information in the spaces provided:

- Your company name
- Your designated insurance company/carrier name
- The address and phone number for the Connecticut Workers' Compensation District Office that is assigned to your area
- Date posted

For your convenience, our other contact information has been entered on the poster and we have attached a copy of a listing of the Commission's District Offices. Please note, the form fields are designed to populate text meeting the statutory font-size requirement.

(Connecticut General Statutes § 31-279(a), § 32-281(f) and Regulations of Connecticut State Agencies § 31-279(B))

NOTICE TO EMPLOYEES



State of Connecticut Workers' Compensation Commission

Revised 10-01-2021

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,

_____ to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the administrative law judge may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name _____

Address _____ Telephone _____

City/Town _____ State _____ Zip Code _____

Approved Medical Care Plan Yes No

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address _____ Telephone _____

City/Town _____ State _____ Zip Code _____

Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.

If your employer has listed a location below, you **MUST** file your compensation claim there.

When filing your claim, you are also required – by law – to send it by certified mail.

If blank below, ask your employer where to file your claim.

Employer Name _____

Address _____ Telephone _____

City/Town _____ State _____ Zip Code _____

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMPLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted: _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).

Connecticut Towns and their Workers' Compensation Districts

Rev. 12-20-2021

Workers' Compensation Commission District Offices and the cities, towns and subdivisions they serve.

First District — Administrative Law Judge, 999 Asylum Avenue, Hartford, CT 06105; (860) 566-4154

The Hartford District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Bloomfield	East Windsor Hill	Poquonock	Somersville	Warehouse Point
Blue Hills	Ellington	Rainbow	South Windsor	West Suffield
Broad Brook	Enfield	Rockville	Suffield	Wilson
Crystal Lake	Hartford	Sadds Mill	Talcotville	Windsor
Dobsonville	Hazardville	Scantic	Thompsonville	Windsor Locks
East Granby	Melrose	Scitico	Tolland	Windsorville
East Hartford	North Somers	Silver Lane	Vernon	
East Windsor	North Thompsonville	Somers	Vernon Center	

Second District — Administrative Law Judge, 55 Main Street, Norwich, CT 06360; (860) 823-3900

The Norwich District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Abington	East Thompson	Killingly Center	Oakdale	Stafford
Almyville	East Willington	Laurel Glen	Occum	Stafford Springs
Amston	East Woodstock	Lebanon	Ocean Beach	Staffordville
Andover	Ekonk	Ledyard	Old Mystic	Sterling
Ashford	Elmville	Ledyard Center	Oneco	Sterling Hill
Attawaugan	Exeter	Liberty Hill	Orcuttville	Stonington
Atwoodville	Fabyan	Lisbon	Pachaug	Storrs
Ballouville	Fitchville	Long Society	Packerville	Taftville
Baltic	Franklin	Lords Point	Pawcatuck	Thompson
Bolton	Gales Ferry	Mansfield	Phoenixville	Uncasville
Bolton Notch	Gilead	Mansfield Center	Plainfield	Union
Bozrah	Gilman	Mansfield Depot	Pleasure Beach	Versailles
Bozrah Street	Glasgo	Mansfield Hollow	Pomfret	Village Hill
Brooklyn	Goshen Hill	Mashantucket	Pomfret Center	(Lebanon)
Burnetts Corner	Graniteville	Mashapaug	Pomfret Landing	Voluntown
Canterbury	Greenville	Mechanicsville	Poquetanuck	Warrenville
Center Groton	Griswold	(Thompson)	Poquonock Bridge	Waterford
Central Village	Grosvenordale	Marrow	Preston	Wauregan
Chaplin	Groton	Mohegan	Putnam	Wequetequock
Chesterfield	Groton Heights	Montville	Putnam Heights	Westford
Chestnut Hill	Groton Long Point	Moosup	Quaddick	Westminster
(Lebanon)	Gurleyville	Morningside Park	Quaker Hill	West Mystic
Clark Falls	Hallville	Mystic	Quinebaug	West Stafford
Clarks Corner	Hampton	Newent	Rogers	West Thompson
Columbia	Hanover	New London	Scotland	West Willington
Coventry	Harrisville	Noank	Sodom	West Woodstock
Danielson	Hebron	North Ashford	South Chaplin	Willimantic
Dayville	Hopeville	North Franklin	South Killingly	Willington
Doaneville	Hop River	North Grosvenordale	South Willington	Wilsonville
Eagleville	Hydeville	North Stonington	South Windham	Windham
East Brooklyn	Jewett City	North Windham	South Woodstock	Woodstock
Eastford	Jordan Village	North Woodstock	Sprague	Woodstock Valley
East Killingly	Kenyonville	Norwich	Spring Hill	Yantic
East Putnam	Killingly	Norwichtown	(Mansfield)	

Third District — Administrative Law Judge, 700 State Street, New Haven, CT 06511; (203) 789-7512

The New Haven District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Allingtown	East River	Montowese	Orange	Short Beach
Augerville	Fair Haven	Morningside	Pine Orchard	Spring Glen
Bethany	Foxon	Mount Carmel	(Branford)	Stony Creek
Branford	Guilford	New Haven	Pond Meadow	West Haven
Burr Hill	Hamden	North Branford	(Killingworth)	Westville
Clinton	Indian Neck	Northford	Quinnipiac	Whitneyville
Clintonville	Killingworth	North Guilford	Rivercliff	Woodbridge
Durham	Madison	North Haven	Rockland	
East Haven	Momauguin	North Madison	Sachem Head	

Fourth District — Administrative Law Judge, 350 Fairfield Avenue, Bridgeport, CT 06604; (203) 382-5600

The Bridgeport District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Ansonia	Easton	Huntington	Nichols	Stepney
Berkshire	East Village	Huntingtontown	Riverside	Stevenson
Botsford	Fairfield	Long Hill District	(Newtown)	Stratford
Bridgeport	Greenfield Hill	Lordship	Sandy Hook	Trumbull
Derby	Greens Farms	Milford	Saugatuck	Upper Stepney
Devon	Hattertown	Monroe	Shelton	Westport
Dodgingtown	Hawleyville	Newtown	Southport	Woodmont

Fifth District — Administrative Law Judge, 55 West Main Street, Waterbury, CT 06702; (203) 596-4207

The Waterbury District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Amesville	East Morris	Lower City	Oxford	Terryville
Bantam	East Plymouth	Macedonia	Pequabuck	Thomaston
Beacon Falls	Ellsworth	Middlebury	Plymouth	Torrington
Bethlehem	Falls Village	Millville	Pomperaug	Torrington
Burrville	Flanders	Milton	Prospect	Twin Lakes
Campville	Goshen	Minortown	Quaker Farms	Union City
(Litchfield)	Greystone	Morris	Salisbury	Warren
Canaan	Harwinton	Naugatuck	Seymour	Waterbury
Canaan Valley	Hotchkissville	Newfield	Sharon	Watertown
Cornwall	Huntsville	(Torrington)	South Britain	West Cornwall
Cornwall Bridge	Kent	Norfolk	Southbury	West Goshen
Cornwall Center	Kent Furnace	North Canaan	South Canaan	West Torrington
Cornwall Hollow	Lakeside	Northfield	Southford	White Oak
Drakeville	Lakeville	North Kent	South Kent	Woodbury
East Canaan	Lime Rock	North Woodbury	Straitsville	Wrightville
East Litchfield	Litchfield	Oakville	Taconic	

Sixth District — Administrative Law Judge, 24 Washington Street, New Britain, CT 06051; (860) 827-7180

The New Britain District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Avon	East Hartland	Milldale	Pleasant Valley	West Hartland
Bakersville	Edgewood	Nepaug	Riverton	West Simsbury
Barkhamsted	Elmwood	New Britain	Robertsville	Wethersfield
Berlin	Farmington	New Hartford	Simsbury	Whigville
Bristol	Forestville	Newington	Southington	Winchester
Burlington	Granby	North Canton	Tariffville	Winchester Center
Canton	Hartland	North Colebrook	Unionville	Winsted
Canton Center	Kensington	North Granby	Weatogue	Wolcott
Colebrook	Marion	Pine Meadow	West Avon	
Collinsville	Mechanicsville	Plainville	West Granby	
East Berlin	(Granby)	Plantsville	West Hartford	

Seventh District — Administrative Law Judge, 111 High Ridge Road, Stamford, CT 06905; (203) 325-3881

The Stamford District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Banksville	Gaylordsville	New Fairfield	Riverside	Titicus
Belltown	Georgetown	New Milford	(Greenwich)	Topstone
Bethel	Germantown	New Preston	Romford	Turn Of River
Boardmans Bridge	Glenbrook	Noroton	Round Hill	Upper Merryall
Branchville	Glenville	Noroton Heights	(Greenwich)	Washington
Bridgewater	Greenwich	North Stamford	Rowayton	Washington Depot
Brookfield	High Ridge	Northville	Roxbury	West Norwalk
Brookfield Center	Long Ridge	North Wilton	Roxbury Falls	Weston
Byram	(Stamford)	Norwalk	Roxbury Station	West Redding
Cannondale	Lower Merryall	Old Greenwich	Sherman	Wilton
Church Hill	Lyons Plains	Park Lane	Silvermine	Winnipauk
Cos Cob	Marble Dale	Redding	(Norwalk)	Woodville
Cranbury	Merryall	Redding Ridge	South Norwalk	
Danbury	Mianus	Ridgebury	South Wilton	
Darien	Mill Plain	(Ridgefield)	Springdale	
East Norwalk	New Canaan	Ridgefield	Stamford	

Eighth District — Administrative Law Judge, 649 South Main Street, Middletown, CT 06457; (860) 344-7453

The Middletown District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Addison	East Glastonbury	Highland	Middletown	Salem
Baileyville	East Haddam	Highland Park	Millington	Salem Four Corners
Bashan	East Hampton	Hopewell	Mixville	Saybrook Manor
Black Hall	East Lyme	Ivoryton	Moodus	Saybrook Point
Black Point	Essex	Knollwood Beach	Niantic	Shailerville
Buckingham	Fenwick	Laysville	North Lyme	Sound View
Buckland	Flanders Village	Leesville	North Plains	South Glastonbury
Centerbrook	Gildersleeve	Little Haddam	North Westchester	South Lyme
Cheshire	Glastonbury	Lyme	Old Lyme	South Meriden
Chester	Grove Beach	Manchester	Old Saybrook	Tylerville
Cobalt	(Westbrook)	Manchester Green	Pond Meadow	Wallingford
Colchester	Haddam	Marlborough	(Westbrook)	Westbrook
Cornfield Point	Haddam Neck	Meriden	Ponset	Westfield
Crescent Beach	Hadlyme	Middlefield	Portland	Winthrop
Cromwell	Hamburg	Middlefield Center	Rockfall	Yalesville
Deep River	Higganum	Middle Haddam	Rocky Hill	



**State of Connecticut
Workers' Compensation Commission**

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Date filed in Chairman's Office

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

(for WCC use only)

Employer (Name, Address & Zip)		Phone #	Carrier / Administrator Claim #		OSHA Log Case #	Report Purpose Code
SIC Code		FEIN	Jurisdiction	Jurisdiction Claim #		
Carrier (Name, Address & Zip)		Phone #	Claims Administrator (Name, Address & Zip)		Phone #	
Policy / Self-Insured #		<input type="checkbox"/> Check, if Self-Insured	Policy Period (MM/DD/YY)		FROM: TO:	
Employee: Last Name		First Name	Middle Name	Gender	Date Hired (MM/DD/YY)	State of Hire
D.O.B. (required)		Phone #		<input type="checkbox"/> Male	Occupation / Job Title	
Address (incl. Zip)				<input type="checkbox"/> Female	Rate of Pay \$ _____ per	NCCI Class Code
				<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other		
Date of Injury / Illness (MM/DD/YY)		Town of Injury / Illness		Physician / Health Care Provider (Name, Address & Zip)		
Time Employee Began Work		<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Did Injury / Illness occur on Employer's Premises?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Time of Occurrence		<input type="checkbox"/> cannot be determined <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Type of Injury / Illness		Hospital (Name, Address & Zip)	
Date Employer Notified (MM/DD/YY)		Part of Body Affected				
Date Disability Began (MM/DD/YY)		Type of Injury / Illness Code				
Date Last Worked (MM/DD/YY)		Part of Body Affected Code				
Date Return(ed) to Work (MM/DD/YY)		Were Safeguards or Safety Equipment provided?		Initial Treatment		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Care		
		If provided, were they used?		<input type="checkbox"/> Minor — by Employer <input type="checkbox"/> Hospitalized More Than 24 Hours		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Minor — by Clinic / Hospital <input type="checkbox"/> Future Major Medical — Lost Time Anticipated		
If Fatal, Date of Death (MM/DD/YY)		How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:		Date Administrator Notified (MM/DD/YY)		
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:				Date Prepared (MM/DD/YY)		
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:				Preparer's Name & Title		
Contact Name				Phone #		
Phone #		Cause of Injury Code				



Employee Incident Report

This form should be filled out by the injured employee.

Name

Employer Name

Date of Incident

Time of incident

Time you began work on day of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)

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

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

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

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

What witnesses were present when the incident occurred? Please provide names if applicable.

Who did you report the injury to? When was the injury reported? Please provide name(s) and job title(s).

What did you do after the incident occurred?

The above form is true and correct.

Signature

Date Completed

Informe de Incidente del Empleado

A ser completado por el trabajador lesionado.



Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Hora en que usted empezó a trabajar el día del incidente

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

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

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

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

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

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

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

¿Qué hizo después de ocurrido el incidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario

Supervisor's Report of Employment Incident



Employee Name

Employer Name

Date of Incident

Time of incident

Time the employee began work on day of incident

Did the employee report the incident immediately?

Address of Incident

City, State

Zip

Offsite? (Y/N)

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

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

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

What witnesses were present when the incident occurred (including self)?

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



Supervisor's Report of Employment Incident

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

Unused/unavailable lifting equipment

Obstructed view

Interaction with patient or resident

Unused/unavailable PPE (gloves, hardhat, goggles, etc.)

Lack of training

Interaction with customer

Unused/unavailable sharps container

Wet/slippery floor

Chemical exposure

Unguarded or improperly guarded equipment

Poor housekeeping

Motor vehicle incident

Electrical exposure

Interaction with co-worker

Other:

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

The above form is true and correct.

Prepared by

Signature

Date Completed

Informe de Incidente del Supervisor



Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente?

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

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

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

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

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

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



Informe de Incidente del Supervisor

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

Equipo para levantar no usado/no disponible

Vista obstruida

Interacción con paciente o residente

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

Falta de capacitación

Interacción con cliente

Contenedor de objetos punzantes no usado/no disponible

Herramientas o equipo defectuosos

Exposición a producto químico

Equipo no resguardado o incorrectamente resguardado

Piso mojado/resbaloso

Incidente de vehículo motorizado

Exposición eléctrica

Mala limpieza

Other:

Interacción con compañero de trabajo

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

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración:



Witness' Report/Statement of Employee Incident

Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)

Date of Incident

Time of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)

Did you witness the above-reported incident? If so, how did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were injured? Describe the type of injury (strain, bruise, etc.)

What did the injured employee say at the time of injury? Did the injured employee complain of pain at the time of injury? If they complained of pain, please specify the body part(s).

What did the employee do after the incident occurred?

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

The above form is true and correct.

Witness' Signature

Date Completed

Informe de Incidente del Testigo



Nombre del Empleado

Nombre del Testigo

Teléfono del Testigo

Dirección del Testigo

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/No)

Fecha Del Incidente

Hora del incidente

Dirección del incidente

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/ No)

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

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

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

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

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

La forma anterior es verdadera y correcta.

Firma del Testigo

Fecha

STATE OF CONNECTICUT
WORKERS' COMPENSATION COMMISSION

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
BY A HOSPITAL/PROVIDER
FOR THE PURPOSE OF ADMINISTERING A
CONNECTICUT WORKERS' COMPENSATION CLAIM FOR BENEFITS**

PATIENT NAME: _____ DATE OF BIRTH: _____
(PLEASE PRINT NAME) (REQUIRED)

BODY PART(S): _____

I, the undersigned, authorize: _____
(HOSPITAL/PROVIDER)

to disclose, in writing, protected health information [PHI] to:

(PERSON OR ENTITY TO WHOM INFORMATION IS TO BE DISCLOSED)

and its attorneys and/or representatives. The PHI to be disclosed is relevant medical records and reports relating to my medical treatment/consultation/examination and/or diagnostic procedures performed at the above-named medical facility and which pertain to an injury/occupational disease for which I am claiming benefits under the Connecticut Workers' Compensation Act. I understand the information disclosed based on this authorization may include mental health treatment records and information regarding HIV/AIDS status, treatment or testing. **INFORMATION RELATING TO TREATMENT FOR ALCOHOL AND DRUG ABUSE WILL NOT BE RELEASED WITHOUT MY SPECIFIC CONSENT in accordance with state and federal law.**¹ I understand I have the right to inspect or copy the PHI to be disclosed as permitted under federal HIPAA law and state law.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION. In order to revoke this authorization I may, at any time, send written notification to the above-named HOSPITAL/PROVIDER. I understand that my revocation of this authorization is ineffective to the extent that the above-named HOSPITAL/PROVIDER has relied on this authorization to disclose PHI relating to me.

I UNDERSTAND THAT PHI DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE PERSON OR ENTITY I HAVE IDENTIFIED ABOVE AND MAY NO LONGER BE PROTECTED FROM DISCLOSURE TO OTHERS BY FEDERAL OR STATE LAW. I understand that the above-named HOSPITAL/PROVIDER may not condition my treatment on whether I provide authorization for the requested use or disclosure.

I UNDERSTAND THAT I HAVE THE RIGHT TO DETERMINE A DATE OR EVENT AT WHICH TIME THIS AUTHORIZATION EXPIRES. I am identifying the expiration date of this authorization to be COMPLETION OF WORKERS' COMPENSATION LITIGATION AS EVIDENCED BY A STIPULATION OR FINDING AND AWARD/DISMISSAL, OR IN THE EVENT OF APPELLATE REVIEW, A FINAL DETERMINATION BY THE HIGHEST APPELLATE AUTHORITY TO WHOM AN APPEAL IS MADE.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this authorization relates to a Workers' Compensation matter. However, I understand that as a practical matter, my authorization in this form may facilitate the processing and administration of my claim for Workers' Compensation benefits.

My signature below indicates that I have read and understand this Authorization and its terms.

Signature of Patient

Date

¹ Any consent to release information pertaining to treatment for drug and alcohol abuse must conform to the requirements of state law and the federal regulations, e.g., Part 2 of Title 42 of the Code of Federal Regulations.



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



State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 7-13-2009

1A

Filing Status and Exemption

This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER October 1, 1991, and must be completed in its entirety.

WCC File #

Date filed in District

(for WCC use only)

DATE OF INJURY:

EMPLOYEE

Name Date of Birth (required)

Address

City/Town State Zip Code

FILING STATUS AND EXEMPTIONS — In order to determine your weekly benefit rate, as per Sec. 31-310 C.G.S., we need the following information:

1. Select your Federal tax filing status based upon your ACTUAL filing status as of the date of injury, listed at right: (Must match your tax return, as if you were filing with the IRS on the date of your injury.)

- Single Head of Household Married filing jointly Married filing separately

2. Number of exemptions (including yourself) as of the date of injury listed at right =

3. FICA withheld for the above-named employee? YES NO — If NO, insurer must manually calculate weekly benefit rate.

4. Check all appropriate boxes:

- Employee 65 years of age or older Employee legally blind Spouse 65 years of age or older Spouse legally blind

5. List name (yourself first), date of birth, and relationship to you for all exemptions included in question #2, above:

Table with 3 columns: Name, Date of Birth, Relationship. Row 1: SELF

CONCURRENT EMPLOYMENT — To be certain you receive all the benefits to which you are entitled, provide the following information if you were working for more than one employer on the date of injury indicated above:

Table with 3 columns: Name of Employer, Address, Date of Hire

NOTE: Wage information for each concurrent employer must be supplied by the claimant.

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

I hereby attest that the above information is correct to the best of my knowledge.

Employee's Signature Date

»» 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.