Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

# Workers Compensation State Claim Kit

*Indiana*

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.

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

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

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

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

## BERKSHIRE HATHAWAY HOMESTATE COMPANIES

## Report a Claim

### Online

bhhcpolicyholder.bhhc.com/Client/External/Claims

### Phone

(800) 661-6029

### Fax

(800) 661-6984

### E-mail

newclaim@bhhc.com

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

# Workers Compensation Posting Requirements

## Workers' Compensation Notice Poster

- Post in one or more conspicuous places at all business locations next to any required federal postings or notices
- Must contain the insurance carrier's name, address, and phone number

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

- Your company name
- Name of your designated insurance carrier

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

(Indiana Code 22-3-2-22)

# WORKER'S COMPENSATION NOTICE

**Your employer is required to provide for payment of benefits under the Worker's Compensation Act of the State of Indiana.**

**Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.**

**The worker's compensation insurance carrier or the administrator for**

_____ **is:** Insurance Carrier -

**(name of company)** **(name of insurance carrier or administrator)**

Claims Administrator - Berkshire Hathaway Homestate Companies

**(name of carrier/administrator)**

PO Box 881716

**(mailing address)**

San Francisco, CA 94188

**(city, state, zip)**

800-661-6029

**(telephone number)**

Mr. Dustin Puntney

**(contact person)**

**For more information about rights or procedures under the Indiana Worker's Compensation system, call or write:**

**Worker's Compensation Board of Indiana**
**Ombudsman Division**
**402 W. Washington St., Rm W196**
**Indianapolis, IN 46204**
**(317) 232-3808**
**1-800-824-2667**

# NOTICIA DE COMPENSACION PARA TRABAJADORES

**A su empleador le es requerido proveer pagos de beneficios bajo el Acta de Compensación para Trabajadores del Estado de Indiana.**

**Cualquier empleado que sea lesionado mientras esté trabajando debe reportar el accidente laboral inmediatamente a su supervisor, empleador o representante designado.**

**La compaňía de seguro de compensación del trabajador o el administrador de la compaňía** _____ **es:** Insurance Carrier -

**(nombre de la compaňía)**

Claims Administrator - Berkshire Hathaway Homestate Companies

**(nombre de la compaňía de seguro/administrador)**

PO Box 881716

**(dirección)**

San Francisco, CA 94188

**(ciudad, estado, código postal)**

800-661-6029

**(número de teléfono)**

Mr. Dustin Puntney

**(persona de contacto)**

**Para más información acerca de sus derechos o los procedimientos bajo el sistema de compensación para trabajadores de Indiana, llame o escriba a:**

**Worker's Compensation Board of Indiana**
**Ombudsman Division**
**402 W. Washington St., Rm W196**
**Indianapolis, IN 46204**
**(317) 232-3808**
**1-800-824-2667**

# NOTICE FOR WORKER'S COMPENSATION AND OCCUPATIONAL DISEASES COVERAGE

State Form 36097 (R8 / 6-15)

*Mail to: Worker's Compensation Board of Indiana, 402 W. Washington St., Room W196, Indianapolis, IN 46204-2753.*

| APPLICANT INFORMATION | | |
|---|---|---|
| Name of employer | | Federal Identification number |
| Address *(number and street, city, state, and ZIP code)* | | |
| Name of insurer | Insurer policy number | Policy effective dates *(mm/dd/yy)*<br>Start: End: |
| Name of applicant | Telephone number<br>( ) | E-mail address |

**STATEMENT OF VOLUNTARY EXCLUSION (IC 22-3-6-1 (b)(1) / IC 22-3-7-9 (b)(9))**

*An officer of a corporation may not be considered to be excluded as an employee under IC 22-3-2 through IC 22-3-6 until the notice is received by the insurance carrier and the board.*

☐ I am an officer with an ownership interest in the above named corporation, and I elect not to be an employee; hereby excluding myself from workers compensation coverage.

| Signature of corporate officer | Date *(mm/dd/yyyy)* |
|---|---|
| | |

**STATEMENT OF VOLUNTARY ELECTION (IC 22-3-6-1 (b))**

☐ (2) I am the executive officer in the above named municipal corporation or other governmental subdivision or of a charitable, religious, educational or other nonprofit corporation and am electing worker's compensation coverage.

☐ (4) I am the sole proprietor in the above named entity and am electing worker's compensation coverage.

☐ (5) I am a partner in the above named entity and am electing worker's compensation coverage.

☐ (8) I am an owner-operator that provides a motor vehicle and the services of a driver under a written contract that is subject to IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 376 to a motor carrier and am electing worker's compensation coverage.

☐ (9) I am a member or manager in the above named limited liability company and am electing worker's compensation coverage.

**STATEMENT OF VOLUNTARY ELECTION (IC 22-3-2-9)**

*The notice of acceptance referred to in subsection 22-3-2-9(b) shall be given thirty (30) days prior to any accident resulting in injury or death, provided that if any such injury occurred less than thirty (30) days after the date of employment, notice of acceptance given at the time of employment shall be sufficient notice thereof. A copy of the notice in prescribed form shall also be filed with the Worker's Compensation Board, within five (5) days after its service in such manner upon the employee or employer.*

☐ (1) I am the employer of casual laborers and hereby elect to provide worker's compensation coverage.

☐ (2) I am the employer of farm or agricultural employees and hereby elect to provide worker's compensation coverage.

☐ (3) I am the employer of household employees and hereby elect to provide worker's compensation coverage.

☐ (4) I am the employer of part-time volunteer coaches for a nonprofit corporation and hereby elect to provide worker's compensation coverage.

**STATEMENT OF VOLUNTARY ELECTION (IC 22-3-2-5)**

☐ I am the owner or representative of a state, county, township, city, town, school city, school town, school township, other municipal corporation, state institution, state board, state commission, bank, trust company or building and loan association and am electing worker's compensation coverage.

**STATEMENT OF VOLUNTARY ELECTION (IC 22-3-2-2)**

☐ I am the employer of members of a fire department or police department of a municipal corporation, who are also members of a firefighters' pension fund or a police officers' pension fund; and hereby elect to purchase and procure worker's compensation insurance to insure said employees with respect to medical benefits.

☐ I am the employer of "rostered volunteers"; and hereby elect to cover said volunteers under the medical treatment provisions of the worker's compensation act.

| Signature of employer or authorized agent | Date *(mm/dd/yyyy)* |
|---|---|
| | |

# INSTRUCTIONS

## General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.

2. Enter all dates in MM/DD/YY format.

3. Please return completed form electronically by an approved EDI process.

4. For answers to questions, please call (317) 232-3808.

## Definitions:

**AGENT NAME AND CODE NUMBER:** Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

**ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED:** List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (*e.g. Acetylene cutting torch, metal plate, etc.*).

**AVG WG/WK:** Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

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

**CONTACT NAME / TELEPHONE NUMBER:** Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc.*)

**DATE DISABILITY BEGAN:** The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised deigned by statute.

**DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED:** If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc.*).

**EMPLOYEE STATUS:** Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: (*FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK*).

**HOW INJURY / ILLNESS OCCURRED:** Describe the sequence of events leading to the injury or exposure (*e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall*).

**NCCI CLASS CODE:** A four-digit code classifying the occupation of the claimant.

**OCCUPATION / JOB TITLE:** Enter the primary occupation of the claimant at the time of the accident or exposure.

**PART OF BODY AFFECTED:** Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc.*)

**REPORT PURPOSE CODE:** 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

**RTW DATE (***Return to Work Date)***:** Enter the date following the most recent disability period on which the employee returned to work.

**SIC CODE:** This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

**SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE:** Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

**TYPE OF INJURY / ILLNESS:** Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc.*)

**WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE:** Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).

Reset Form

# INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

| FOR WORKER'S COMPENSATION BOARD USE ONLY | | |
|---|---|---|
| Jurisdiction | Jurisdiction claim number | Process date |
| | | |

Please return completed form electronically by an approved EDI process.

**PLEASE TYPE or PRINT IN INK**

*NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.*

## EMPLOYEE INFORMATION

| Social Security number | Date of birth | Sex ☐ Male ☐ Female ☐ Unknown | Occupation / Job title | NCCI class code |
|---|---|---|---|---|
| Name (*last, first, middle*) | | Marital status ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown | Date hired / State of hire | Employee status |
| Address (*number and street, city, state, ZIP code)* | | | Hrs / Day / Days / Wk / Avg Wg / Wk | ☐ Paid Day of Injury ☐ Salary Continued |
| Telephone number (include area | | Number of dependents | Wage $ Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other | |

## EMPLOYER INFORMATION

| Name of employer | Employer ID# | SIC code | Insured report number |
|---|---|---|---|
| Address of employer (*number and street, city, state, ZIP code*) | Location number / Telephone number | Employer's location address (*if different)* | |
| | Carrier / Administrator claim number | OSHA log number | Report purpose code |
| Actual location of accident / exposure (*if not on employer's premises*) | | | |

## CARRIER / CLAIMS ADMINISTRATOR INFORMATION

| Name of claims administrator | Carrier federal ID number | Check if appropriate ☐ Self Insurance |
|---|---|---|
| Address of claims administrator (*number and street, city, state, ZIP code*) | ☐ Insurance Carrier ☐ Third Party Admin. | Policy / Self-insured number |
| Telephone number | | Policy period From To |
| Name of agent | Code number | |

## OCCURRENCE / TREATMENT INFORMATION

| Date of Inj./ Exp. | Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined | Date employer notified | Type of injury / exposure | Type code |
|---|---|---|---|---|
| Last work date | Time workday began | Date disability began | Part of body | Part code |
| RTW date | Date of death | Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No | Name of contact | Telephone number |
| Department or location where accident / exposure occurred | | | All equipment, materials, or chemicals involved in accident | |
| Specific activity engaged in during accident / exposure | | | Work process employee engaged in during accident / exposure | |
| How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances. | | | | Cause of injury code |
| Name of physician / health care provider | | | | |
| Hospital or offsite treatment (*name and address*) | | | | INITIAL TREATMENT ☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor: Clinic / Hospital ☐ Emergency Care ☐ Hospitalized > 24 Hours ☐ Future Major Medical / Lost Time Anticipated |
| Name of witness | Telephone number | Date administrator notified | | |
| Date prepared | Name of preparer | Title | Telephone number | |

*An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).*

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

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

Claim Number/Número de Reclamo

Date of Injury / Fecha de la Lesión

Employee/Empleado

Date of Birth / Fecha de Nacimiento

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

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

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

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

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

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

The released information is required for the following reasons:

La información liberada es requerida por las siguientes razones:

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

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

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

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

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

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

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

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

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

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

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

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

A copy or fax is as valid as the original.

Una copia o fax es tan válida como el original.

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

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

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

Signature/Firma

Date/Fecha

PRINT THIS FORM/ IMPRIMIR FORMULARIO

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

# Medical History Request

Employee Name

Date of Injury

Employer Name

Completion Date

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

Thank you for your cooperation.

## Past Injuries, Disabilities, or Other Medical Conditions

## Hospitalizations

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

## Treating Physicians or Groups

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

RESET FORM

PRINT THIS FORM

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 Incident

Employee Name

Employer Name

Date of Incident

Time of incident

Time the employee began work on day of incident

Did the employee report the incident immediately? Yes or No

Address of Incident

City, State

Zip

Offsite? (Y/N) Yes or No

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

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

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

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

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

# Supervisor's Report of Employment Incident

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

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

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

The above form is true and correct.

Prepared by

Signature

Date Completed

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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

RESET FORM

PRINT THIS FORM

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.

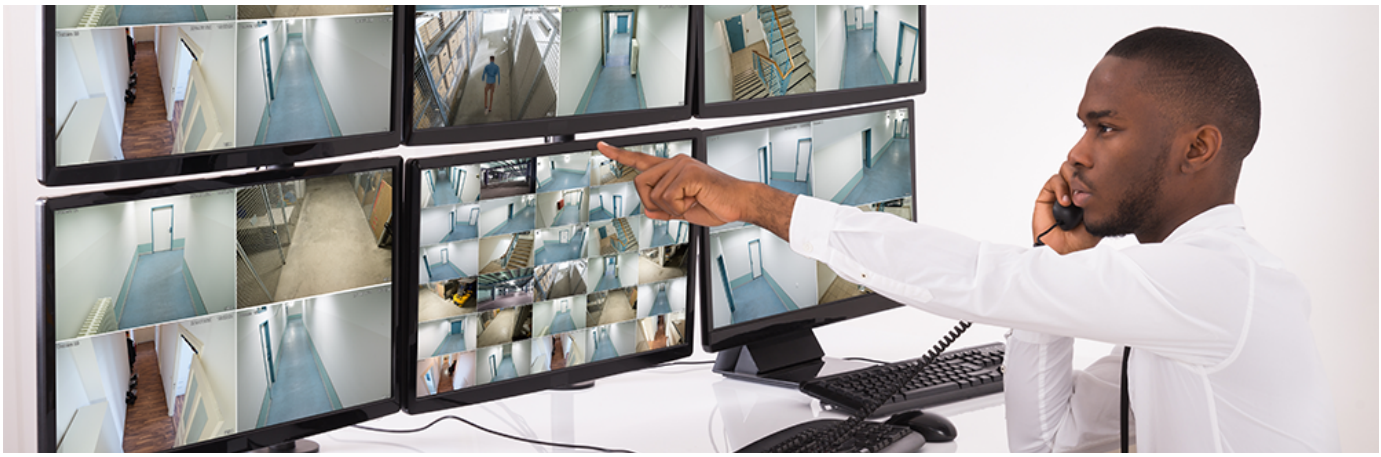
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

## 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.