



Berkshire Hathaway  
HOMESTATE COMPANIES

Workers Compensation Division <sup>TM</sup>

# Workers Compensation State Claim Kit

*Minnesota*



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

## Dear Policyholder:

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

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

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

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

State law also requires that employers authorize initial medical treatment within 24 hours of knowledge that an occupational injury 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](mailto:newclaim@bhhc.com)





# Workers Compensation Posting Requirements

## Workers Compensation Poster

- Post in one or more conspicuous places at all business locations and work sites
- Must contain the name and address of the insurance carrier.

To complete the form, please enter the name of your designated insurance carrier (insurer) in the space provided. For your convenience, our other contact information has been entered on the poster.

(Minnesota Statutes § 176.139)

# Workers' compensation

## If you are injured

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not make a timely report of the injury to your employer. The time limit may be as short as 14 days.
- Provide your employer with as much information as possible about your injury.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO), you may treat with a doctor of your choice. Your employer must notify you in writing if you are covered by a CMCO.
- Cooperate with all requests for information concerning your claim.

The law allows the workers' compensation insurer to obtain medical information related to your work injury without your authorization, but they must send you written notification when they request the information.

The insurer cannot obtain other medical records unless you sign a written authorization.
- Get written confirmation from your doctor about any authorization to be off work. The note should be as specific as possible.

## Workers' compensation pays for

- Medical care for your work injury, as long as it is reasonable and necessary.
- Wage-loss benefits for part of your lost income.
- Compensation for permanent damage to or loss of function of a body part.
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer due to your work injury.
- Benefits to your spouse and/or dependents if you die as a result of a work injury.

## What the insurer must do

- The insurer must investigate your claim promptly. If you have been disabled for more than three calendar-days, the insurer must begin payment of benefits or send you a denial of liability within 14 days after your employer knew you were off work or had lost wages because of your claimed injury.
- **If the insurer accepts your claim for wage-loss benefits and you have been disabled for more than three calendar-days:** The insurer will notify you and must start paying wage-loss benefits within the 14 days noted above. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.
- **If the insurer denies your claim for wage-loss benefits and you have been disabled for more than three calendar-days:** The insurer will send notice to you within 14 days. The notice must clearly explain the facts and reasons why they believe your injury or illness did not result from your work or why the claimed wage-loss benefits are not related to your injury.

If you disagree with the denial, talk with the insurance claims adjuster who is handling your claim. If you are not satisfied and still disagree with the denial, **call the Minnesota Department of Labor and Industry's Workers' Compensation Hotline at 1-800-342-5354.**

### Fraud

Collecting workers' compensation benefits you are not entitled to is theft. Call 1-888-372-8366 to report workers' compensation fraud.

### Insurer name and contact information



(651) 284-5032 • 1-800-342-5354 • [dli.workcomp@state.mn.us](mailto:dli.workcomp@state.mn.us) • [www.dli.mn.gov](http://www.dli.mn.gov)

Posting required by law in a location where employees can easily see this notice.

August 2017

# Nyiaj raug mob ntawm hauj lwm

## Yog hais tias koj raug mob

- Qhia txog qhov kev raug mob ntawd rau tus neeg saib xyuas koj ua hauj lwm kom sai li sai tau, tsis hais seb nws me npaum li cas. Tej zaum koj yuav tsis muaj cai tau nyiaj raug mob ntawm hauj lwm yog hais tias koj tsis qhia txog qhov kev raug mob ntawd rau koj lub chaw hauj lwm kom raws sij hawm. Lub sij hawm cia koj qhia no tej zaum nws yuav luv npaum li 14 hnuv xwb.
- Muab cov ncauj lus qhia rau koj lub chaw hauj lwm kom ntau li ntau tau txog qhov koj raug mob.
- Mus muab kev pab kho mob uas tsim nyog kom sai li sai tau. Yog hais tias koj tsis muaj kev pab them nqi kho mob los ntawm ib lub koom haum tswj xyuas kev kho mob uas tau ntawv tso cai (certified managed care organization - CMCO), koj mus kho mob tau ntawm ib tug kws kho mob uas koj xaiv. Koj lub chaw hauj lwm yuav tsum tau sau ntawv qhia rau koj seb koj puas muaj kev pab them nqi kho mob los ntawm ib lub CMCO.
- Muab kev koom tes rau tag nrho cov kev thov kom xa cov ntaub ntawv mus hais txog qhov koj thov kom them nyiaj.  
Txoj cai cia cov chaw them nyiaj rau kev raug mob ntawm hauj lwm mus muab cov ntaub ntawv qhia txog kev kho mob uas muaj feem rau qhov koj raug mob ntawm hauj lwm uas tsis tas tau kev tso cai los ntawm koj, tiam sis lawv yuav tsum tau xa ib tsab ntawv tuaj qhia rau koj thaum lawv thov cov ntaub ntawv no.  
Lub chaw them nyiaj yuav muab tsis tau lwm cov ntaub ntawv kho mob tshwj tsis yog tias koj tau kos npe rau ib tsab ntawv tso cai lawm tso.
- Mus kom kws kho mob sau ib tsab ntawv tso cai rau koj los so hauj lwm. Tsab ntawv yuav tsum tau sau lub ntsiab kom meej li meej tau.

## Nyiaj raug mob ntawm hauj lwm yuav them rau dab tsi

- Nqi kho mob rau qhov koj raug mob ntawm hauj lwm, tsuav yog tias tsim nyog.
- Nyiaj pab rau ib feem ntawm koj qhov nyiaj ua hauj lwm uas koj tsis tau.
- Them rau cov kev puas tsuaj los yog kev siv tsis tau ib qho ntawm lub cev mus li lawm.
- Cov kev pab kom lub cev rov zoo yog hais tias koj rov tsis tau mus ua koj txoj hauj lwm qub los sis lub chaw hauj lwm qub thaum koj tsis tau raug mob ntawd lawm vim qhov koj raug mob ntawm hauj lwm.
- Nyiaj pab rau koj tus txij nkawm thiab/los sis cov me nyuam yog hais tias koj tuag vim ua hauj lwm es raug.

## Lub chaw them nyiaj yuav tsum tau ua dab tsi

- Lub chaw them nyiaj yuav tsum tau tshawb fawb txog qhov koj thov kom them nyiaj kom sai. Yog hais tias koj muaj kev tsis taus mus ntev tshaj peb hnuv, lub chaw them nyiaj yuav tsum tau pib them nyiaj rau koj los sis xa ib tsab ntawv tsis kam them nyiaj ntawd tuaj rau koj ua ntej 14 hnuv tom qab koj lub chaw hauj lwm paub tias koj tsis mus ua hauj lwm los sis tsis tau nyiaj ua hauj lwm vim tias koj raug mob.
- **Yog hais tias lub chaw them nyiaj lees them rau qhov koj thov kom them nyiaj pab rau ib feem ntawm koj qhov nyiaj ua hauj lwm uas koj tsis tau thiab koj muaj kev tsis taus mus ntev tshaj peb hnuv:** Lub chaw them nyiaj yuav qhia rau koj thiab yuav tsum tau pib them nyiaj pab rau ib feem ntawm koj qhov nyiaj ua hauj lwm uas koj tsis tau ua ntej 14 hnuv li tau hais los saud. Lub chaw them nyiaj yuav tsum tau them nyiaj kom ncav sij hawm. Cov nyiaj them rau qhov uas tsis tau nyiaj ua hauj lwm lawm yuav them tib lub sij hawm li lub chaw ua hauj lwm them nyiaj rau koj.
- **Yog hais tias lub chaw them nyiaj tsis kam them nyiaj pab rau ib feem ntawm koj qhov nyiaj ua hauj lwm uas koj tsis tau thiab koj tau muaj kev tsis taus mus ntev tshaj peb hnuv:** Lub chaw them nyiaj yuav xa ib tsab ntawv tuaj qhia rau koj ua ntej 14 hnuv. Tsab ntawv yuav tsum tau tshab txhais meej meej txog cov lus qhia tseeb thiab yog vim li cas lawv ntseeg tias qhov koj raug mob los sis tus mob ntawd nws tsis yog los ntawm qhov koj ua hauj lwm los sis yog vim li cas qhov kev thov kom them nyiaj pab rau ib feem ntawm koj qhov nyiaj ua hauj lwm uas koj tsis tau ntawd tsis muaj feem rau qhov koj raug mob.  
Yog hais tias koj tsis pom zoo txog qhov uas tsis kam them nyiaj ntawd, nrog lub chaw tuav pov hwm tus neeg tuav koj cov ntaub ntawv thov kom them nyiaj tham tau. Yog hais tias koj tsis txaus siab thiab tseem tsis pom zoo txog qhov uas tsis kam them nyiaj ntawd, **hu rau Minnesota Tuam Tsev Xyuas Txog Kev Ua Hauj Lwm (Department of Labor) thiab Tus Xov Tooj Pab Txog Chaw Hauj Lwm Kev Them Nyiaj Raug Mob Ntawm Hauj Lwm (Industry's Workers' Compensation Hotline) ntawm 1-800-342-5354.**

### Kev Dag

Kev tau nyiaj raug mob ntawm hauj lwm uas koj tsis tsim nyog tau mas suav tau tias yog nyiaj. Hu 1-888-372-8366 mus ceeb toom txog kev dag txog kev raug mob tom hauj lwm.

**Tus neeg muaj ntawv tiv thaiv lub npe thiab kuv cuag tau nws**

**mn** DEPARTMENT OF  
LABOR AND INDUSTRY

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Tiv ntawv ceeb toom kom raws li txoj cai mas yuav tsum tiv rau qhov chaw kom txhua tus neeg ua hauj lwm pom yooj yim.

Lub 8 hlis xyoo 2017

# Magadhowga Shaqaalaha

## Haddii aad dhaawacanto

- U soo sheeg horjoogahaada dhaawac kasta sida ugu dhaqsiyaha badan, iyadoo aan loo eegin sida uu u yaryahay. Waxaa laga yaabaa in aad lumiso waxtarrada ah xaqa magdhowga shaqaalaha haddii aanad waqtiga habboon dhaawaca u soo sheegin loo shaqeeyahaaga. Xadka waqtiga wuxuu noqon karaa ugu yaraan 14 cisho.
- Loo shaqeeyahaaga u sheeg macluumaad badan ee ku saabsan dhaawacagaada hadba sida suurtagalka ah.
- Qaado daawo kasta oo lagama maarmaana sida ugu dhaqsiyaha badan. Haddii caafimaadkaadku aanu daboolayn urur maamul daryeel oo shati haysta (CMCO), waxa aad iska daawayn kartaa hadba dhaqtarka aad doorato. Loo shaqeeyahaagu waa inuu qoraal kugu soo wargaliyaa haddii CMCO uu kaa daboolayo.
- Gacan ku sii codsiyada idil ee ku saabsan macluumaadka quseeya dalabyadaada.
- Sharciyu waxa uu u fasaxayaa caymiyaha maqdhowga shaqaalaha in ay helaan macluumaadka caafimaadka oo la xariira dhaawaca shaqadaada adiga oo aan u fasaxin, laakiin waa in ay qoraal kugu soo wargaliyaan marka ay codsanayaan macluumaadka.
- Caymiyuhu ma heli karo xog kale ee caafimaad haddii aadan saxiixin oggolaasho qoran.
- Ka qaado dhaqtarkaada hubaal-celin qoraala wixii ku saabsan fasax kasta ee shaqada looga tagayo. Ogaysiisku waa inuu qeexnaadaa hadba sida suurtagalka ah.

## Shaqaalaha magdhowgiisa wuxuu bixinayaa

- Daryeelka caafimaadka ee dhaawaca shaqada, kolba muddada dheer ee macquulka iyo lagama maarmaanka ah.
- Waxtarrada mushaarka aan la qaadan oo ka mida qaybta daqliga aan la qaadan.
- Magdhowga waxyeellada joogtada ah ama aad weydo xubin jirkaada ka mida ama.
- Adeegyada xirfadaha shaqada ayaa lagu siinaya haddii aanad ku soo noqon karin shaqadaadi ee dhaawac ka hor ama loo shaqeeyahaaga dhaawac ka hor sababo la xariira shaqada aad ku dhaawacantay.
- Waxtarrada xaaskaada iyo/ama dadka kaa tirsan la siiyo haddii aad dhaawaca shaqada u geeriyooto.

## Maxaa caymiyaha laga doonayaa in uu sameeyo

- Caymiyuhu waa inuu baaraa waxa aad sheeganayaso sida ugu dhaqsiyaha badan. Haddii aad naafowdo wax ka badan saddex jadwal maalmaha la shaqeeyo, caymiyuhu waa inuu bilaabaa waxtarrada lacag-bixinta ama kuu soo diraa sababaha masuuliyadda diidmada muddo 14 cisho ku siman ka dib marka loo shaqeeyahaagu ogaaday in aad shaqada bannaanka ka joogtay ama aad mushaar weyday sababa ah dhaawaca aad ku soo dacwootay.
- **Haddii caymiyuhu uu oggolaaday sheegashadaada waxtarrada mushaarka aan la qaadan iyo aad naafo ahayd muddo ka badan saddex cisho la shaqeeyo:** Caymisku waxa uu ku soo ogaysiinayaa isagoo laga doonayo in uu kuu bilaabo bixinta waxtarrada mushaarkii kaa baaqday 14 cisho gudahood sida kor lagu soo xusay. Caymisku waa inuu waxtarrada ku bixiyo isla watiga. Waxtarrada mushaarka-baaqday waxaa la bixinayaa isla xilliyadii u dhexeeya mushaar bixintaada shaqada.
- **Haddii uu caymisku diido dalabkaada ah waxtarrada mushaarkaan qaadan isla markaana aad saddex cisho la shaqeeyo ka badan aad naafo ahayd:** Caymisku wuxuu kuu soo diri doona ogaysiis 14 cisho gudahood. Ogaysiisku waa inuu si cad u fasiraa falalka iyo sababaha ay ku rumaysteen in dhaawacaaga ama jirradaada aanay ka imaan sababo shaqadaada la xariira ama sababta sheegashada mushaarku kaa baaqday aanay dhawacaaga ku taxaluqin.

Haddii aadan ku waafaqsanayn diidmada, la hadal hagaajiyaha dacwadaha caymiska ee kiiskaada gacanta ku haya. Haddii aadan ku qancin oo weli aadan waafaqsanayn diidmada, **wac Waaxda Shaqaalaha Minnesota iyo laanta Magdhowga Shaqaalaha (Minnesota Department of Labor and Industry's Workers' Compensation) Telefoonka degdegga 1-800-342-5354.**

### Magaca Caymiyaha Khiyaamada

Qaadashada waxtarrada magdhowga shaqaalaha oo aadan xaq u yeelan waa mid tuugo ah. Wac 1-888-372-8366 si aad u sheegto khiyaano lagu sameynayo magdhawga shaqaalaha.

### Magaca shirkadda caymiska iyo macluumaadka xiriirka

 **DEPARTMENT OF  
LABOR AND INDUSTRY**

(651) 284-5032 • 1-800-342-5354 • [dli.workcomp@state.mn.us](mailto:dli.workcomp@state.mn.us) • [www.dli.mn.gov](http://www.dli.mn.gov)

Sharciga ayaa qaba in lagu dhajiyo meel shaqaalaha si fudud u arki karan.

Agoosto 2017

# Compensación laboral

## Si usted se lesiona

- Informe cualquier lesión a su supervisor tan pronto le sea posible; no importa qué tan leve le pueda parecer. Usted podría perder el derecho a los beneficios de compensación laboral si no presenta a tiempo un informe de la lesión a su empleador. El tiempo límite puede ser tan corto como 14 días.
- Provea a su empleador la mayor cantidad de información posible sobre su lesión.
- Obtenga el tratamiento médico que necesite lo más pronto posible. Si no está cubierto por una organización de atención médica certificada, (CMCO), usted puede recibir tratamiento con el doctor que usted elija. Su empleador debe notificarle por escrito si tiene cobertura con un CMCO.
- Colabore con todas las solicitudes de información relacionadas con su reclamo.
- La ley permite que la aseguradora de compensación laboral obtenga la información médica relacionada con su lesión sin su autorización, pero le debe enviar una notificación por escrito cuando solicite la información.
- La compañía aseguradora no puede obtener otros expedientes médicos a menos que usted firme una autorización por escrito.
- Obtenga una confirmación por escrito de su médico sobre cualquier autorización para ausentarse del trabajo. La nota debe ser lo más específica posible.

## Compensación laboral paga por lo siguiente

- Atención médica para su lesión ocurrida en el trabajo, siempre que sea razonable y necesaria.
- Beneficios por salario perdido para cubrir parte de los ingresos no recibidos.
- Compensación por daños permanentes o por pérdida de la función de una parte del cuerpo.
- Servicios de rehabilitación vocacional si usted no puede regresar al trabajo o a su empleador previo al accidente debido a su lesión en el trabajo.
- Beneficios para su cónyuge o dependientes si usted fallece como consecuencia de una lesión laboral

## Lo que la aseguradora debe hacer

- La compañía aseguradora deberá investigar su reclamo con prontitud. Si usted ha estado incapacitado por más de tres días calendario, la aseguradora debe iniciar el pago de beneficios o enviarle un aviso de negación de responsabilidades dentro de los 14 días después que su empleador se enteró de su ausencia laboral o había perdido parte de su salario debido a su reclamo por lesión.
  - **Si la compañía aseguradora acepta su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días calendario:** La aseguradora le notificará y deberá iniciar el pago de los beneficios por pérdida de salario dentro de los 14 días mencionados anteriormente. La aseguradora deberá pagar los beneficios puntualmente. Los beneficios por pérdida de salario se pagan en los mismos intervalos que sus cheques de nómina.
  - **Si la compañía aseguradora deniega su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días calendario:** La aseguradora le enviará una notificación dentro de los 14 días. La notificación debe explicar claramente los hechos y motivos por los cuales ellos consideran que su lesión o enfermedad no fue resultado de su trabajo o por qué los beneficios por pérdida de salarios que reclama no están relacionados con su lesión.
- Si usted no está de acuerdo con la denegación, hable con el ajustador de reclamos de la aseguradora a cargo de su reclamo. Si usted no está satisfecho y aún está en desacuerdo con la denegación, **comuníquese con el teléfono gratuito para Compensación para Trabajadores del Departamento de Trabajo e Industria de Minnesota (Minnesota Department of Labor and Industry) al 1-800-342-5354.**

### Fraude

Cobrar beneficios de compensación laboral a los cuales no tiene derecho, se considera robo. Llame al 1-888-FRAUD MN (1-888-372-8366) para reportar fraude de compensación laboral.

### Nombre e información de contacto de la compañía aseguradora



DEPARTAMENTO DE  
TRABAJO E INDUSTRIA

(651) 284-5032 • 1-800-342-5354 • [dli.workcomp@state.mn.us](mailto:dli.workcomp@state.mn.us) • [www.dli.mn.gov](http://www.dli.mn.gov)

Se requiere la publicación de este aviso por ley en un lugar donde los empleados puedan verlo fácilmente.

Agosto de 2017



# First Report of Injury

See Instructions on Reverse Side



FRO 1

Print in ink or type  
 Enter dates in MM/DD/YYYY format

DO NOT USE THIS SPACE

1. <b>EMPLOYEE SOCIAL SECURITY #</b>		2. OSHA case #		3. Time employee began work on date of injury <input type="checkbox"/> am <input type="checkbox"/> pm	
4. <b>DATE OF CLAIMED INJURY</b>		5. Time of injury <input type="checkbox"/> am <input type="checkbox"/> pm		6. Date of death # of dependents (if death is related to injury)	
7. <b>EMPLOYEE</b> Name (last, suffix, first, middle)				8. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
				9. Marital status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried	
10. Home address			11. Home phone #		12. Date of birth
City		State	Zip Code		13. Date hired
			14. Occupation		15. Regular department
					16. Apprentice <input type="checkbox"/> Yes <input type="checkbox"/> No
17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week		21. Employment status (check all that apply)
			Normal work schedule Sun - Sat <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S		<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer
22. <b>Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.</b> Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."					
23. <b>What was the injury or illness (include the part(s) of body)?</b> Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.			24. <b>What tools, equipment, machines, objects, or substances were involved?</b> Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.		
25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. Date of first day of any lost time		27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI	
Name and address of the place of the occurrence		28. Date employer notified of injury		29. Date employer notified of lost time	
		30. Return to work date		31. RTW same employer <input type="checkbox"/> Yes <input type="checkbox"/> No	32. RTW with restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No
33. Treating physician (name)		34. Extent of medical treatment (check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Minor on-site by employer's medical staff <input type="checkbox"/> Minor clinic/hospital			
35. Certified Managed Care Organization (if any)		<input type="checkbox"/> Emergency room <input type="checkbox"/> Hospitalization more than 24 hours <input type="checkbox"/> Future major medical anticipated			
36. <b>EMPLOYER</b> Legal name			37. <b>EMPLOYER</b> DBA name (if different)		
38. <b>Mailing</b> address			39. Employer FEIN		40. Unemployment ID #
City		State	Zip Code		41. Employer's contact name and phone #
42. <b>Physical</b> address (if different)			43. Witness (name and phone) - if more than 1 attach a separate sheet		
City		State	Zip Code		44. NAICS code
					45. Date form completed
46. <b>INSURER</b> name			51. <b>CLAIMS ADMIN COMPANY (CA)</b> name (check one) <input type="checkbox"/> Insurer <input type="checkbox"/> TPA		
47. Insured legal name and FEIN			52. CA address		
48. Policy # (including effective dates) or self-insured certificate #			City		State Zip Code
49. Insurer FEIN		50. Date insurer received notice		53. CA FEIN	54. CA claim #
55. To be completed by the CA:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

## GENERAL INSTRUCTIONS TO THE EMPLOYER

**Employers, not employees,** are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at [www.dli.mn.gov](http://www.dli.mn.gov).

**Filing this form is not an admission of liability.** You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

**If the claim involves death or serious injury (including injuries that later result in death),** you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence, at P.O. Box 64221, St. Paul, MN 55164-0221.

### SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

#### SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see <https://www.irs.gov/Businesses/Small-Businesses-&Self-Employed/Lost-or-Misplaced-Your-EIN>.
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

#### INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR (For first reports of injury filed on or after Jan. 1, 2014)

Pursuant to Minnesota Statutes, section 176.231, and Minnesota Rules, part 5220.2530, insurers and self-insured employers must file with the Department's Workers' Compensation Division an electronic first report of injury, according to the requirements set out in sections 2 to 4 of the Minnesota implementation guide, in all cases where a first report of injury is required to be filed under Minnesota Statutes, chapter 176. The Minnesota implementation guide can be found on the Department's website at [www.dli.mn.gov/WC/Edi.asp](http://www.dli.mn.gov/WC/Edi.asp).

A first report of injury submitted by the insurer or self-insured employer in any other manner or format is not considered filed with the division, except for a written first report of injury on a paper form filed by a self-insured employer within seven days of death or serious injury.

If the claim does not involve lost time beyond the waiting period or potential permanent partial disability (PPD), or has not been requested to be filed by the Department, a first report of injury does **not** need to be filed.

***This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198***

**ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.**

# Minnesota workers' compensation system employee information sheet

## What does workers' compensation pay for?

- Medical care for the work injury, as long as it is reasonable and necessary.
- Wage-loss benefits for part of your lost income (there is a three-calendar-day waiting period before these benefits start).
- Benefits for permanent damage or loss of function of a body part.
- Benefits to your spouse and/or dependents if you die of a work injury.
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer.

## How are workers' compensation benefits paid?

Your workers' compensation benefits are paid by an insurance company or your employer, if your employer is self-insured. State law sets the benefit levels. Note: Pursuant to statute, the insurer can obtain medical information specific to your work injury without your authorization.

### If the insurer *accepts* your claim for wage-loss benefits and you have been disabled for more than three calendar days:

- The insurer will send you a copy of the Notice of Insurer's Primary Liability Determination form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

### If the insurer *denies* your claim for wage-loss benefits:

- The insurer will send you a copy of the Notice of Insurer's Primary Liability Determination form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.

Insurer name:

Phone:

- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below.

If you have other questions or need more help, call the Minnesota Department of Labor and Industry's Workers' Compensation Hotline. Your call will be answered by experienced workers' compensation specialists, who will provide instant, accurate information and assistance.

Twin Cities and southern Minnesota: 651-284-5005 or 800-342-5354  
Duluth and northern Minnesota: 218-733-7810 or 800-342-5354

Additional information is available at [www.dli.mn.gov/workers/workers-compensation-workers](http://www.dli.mn.gov/workers/workers-compensation-workers).

# Información sobre el Sistema de Compensación a trabajadores por accidentes en Minnesota

## ¿Por cuales cosas paga el seguro de compensación a trabajadores?

- Atención medica por su accidente/lesión de trabajo, siempre y cuando sea razonable y necesaria.
- Beneficios parciales por pérdida de ingresos. (Hay un período de espera de tres días civiles antes de que comiencen estos beneficios.)
- Compensación por daños permanentes o por la pérdida del funcionamiento de una parte del cuerpo.
- Beneficios a su cónyuge y/o sus dependientes si usted fallece como resultado de una lesión en el trabajo.
- Servicios de rehabilitación vocacional si, a causa de una lesión en el trabajo, usted no puede regresar al trabajo que tenía o a la empresa para la que trabajaba antes de sufrir dicha lesión.

## ¿Como se pagan los beneficios de compensación a trabajadores accidentados?

Sus beneficios de compensación a trabajadores son pagados por un asegurador o por su empleador si el está asegurado si- mismo. La ley estatal de Minnesota define los niveles de pago de beneficios. Tome nota: de acuerdo a estatutos, el asegurador de compensación podrá obtener información médica relacionada específicamente con su lesión de trabajo sin su autorización, siempre y cuando le envíe un aviso por escrito de dicha solicitud al momento de hacerla.

### **Si la aseguranza acepta su reclamación de beneficios por pérdida de ingresos y usted ha estado incapacitado por más de tres días civiles:**

- El asegurador le enviará una copia del formulario de Aviso de Determinación de Responsabilidad Principal del Asegurador (Notice of Insurer's Primary Liability Determination) indicando que aceptó su reclamación.
- El asegurador deberá comenzar a pagarle los beneficios por pérdida de ingresos. El asegurador deberá pagar los beneficios de manera puntual. Los beneficios por pérdida de ingresos se pagan a los mismos intervalos de tiempo que sus cheques de nómina.

### **Si el asegurador rechaza su reclamación de beneficios por pérdida de ingresos:**

- El asegurador le enviará una copia del formulario de Aviso de Determinación de Responsabilidad Principal del Asegurador (Notice of Insurer's Primary Liability Determination) indicando que está rechazando la reponsabilidad principal por su reclamación. El formulario debe explicar claramente los hechos y los motivos por los cuales el asegurador cree que su lesión o enfermedad no es resultado de su trabajo.
- Si usted no está de acuerdo con el rechazo, debe hablar con el tasador de reclamaciones de seguro que esté encargado de su reclamación. La compañía de seguros de su empleador podrá responder a la mayoría de sus preguntas acerca de su reclamación.

Nombre de Aseguranza:

Número de teléfono:

- Si no está satisfecho con la respuesta que reciba del empleador y aún no está de acuerdo con el rechazo, debe comunicarse con el Departamento del Trabajo y la Industria llamando a uno de los números que se indican a continuación para hablar acerca de sus opciones.

Si tiene preguntas o necesita más ayuda, llame al Departamento del Trabajo y la Industrial de Minnesota:

Ciudades gemelas el area Sur de Minnesota: 651-284-5005 or 800-342-5354

Duluth y el area norte de Minnesota: 218-733-7810 or 800-342-5354

Especialistas en compensación a trabajadores con experiencia responderán a su reclamación y le proveerán información y asistencia instantáneas y precisas.

Hay información adicional acerca de la compensación a trabajadores por accidentes en el trabajo disponible en el sitio de Internet del Departamento en [www.dli.mn.gov/workers/workers-compensation-workers](http://www.dli.mn.gov/workers/workers-compensation-workers).

Su empleador está requerido por ley a proveerle esta información. Este formulario puede ser copiado o reproducido electrónicamente. Este documento puede ser provisto en audio, Braille o letra grande por el Departamento de Trabajo e Industria. (Updated August 2018, formatting and website address only.



Claim Number/Número de Reclamo

Date of Injury / Fecha de la Lesión

Employee/Empleado

Date of Birth / Fecha de Nacimiento

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

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

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

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

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

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

The released information is required for the following reasons:

La información liberada es requerida por las siguientes razones:

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

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

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

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



- 3 To facilitate recovery of all benefits paid toward your workers' compensation claim from any third party responsible for this injury.  
Para facilitar la recuperación de todos los beneficios pagados por su reclamo de compensación de trabajadores de cualquier tercer parte responsable de esta lesión.
- 4 To ensure that you are accurately compensated for any amount of lost wages, time or resources while undergoing evaluation, treatment and recovery for this injury.  
Para asegurar que usted se encuentra compensado correctamente por cualquier cantidad de salarios, tiempo, o recursos perdidos mientras se somete a la evaluación, tratamiento, y recuperación de esta lesión.
- 5 To obtain any information necessary to appropriately determine further actions as a result of the injury or condition and to prevent further issues for you and other employees.  
Para obtener cualquier información necesaria para determinar apropiadamente acciones adicionales como resultado de la lesión o condición, y para prevenir problemas adicionales para usted y otros empleados.
- 6 This consent and authorization is effective immediately, and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate on conclusion of the claim without express revocation.  
Este consentimiento y autorización es efectivo inmediatamente, y está sujeto a la revocación del abajo firmante en cualquier momento excepto a la extensión en que se hayan tomado acciones en dependencia con esto de aquí en adelante, y si no es revocado anteriormente, terminará con la conclusión del reclamo si no se presenta una revocación expresa.  
A copy or fax is as valid as the original.  
Una copia o fax es tan válida como el original.

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

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

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

Signature/Firma

Date/Fecha





# Medical History Request

Employee Name

Date of Injury

Employer Name

Completion Date

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

Thank you for your cooperation.

## Past Injuries, Disabilities, or Other Medical Conditions

### Hospitalizations

Hospital Name & Address	Phone	Date(s) Admitted

### Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment



# Employee Incident Report

This form should be filled out by the injured employee.

Name

Employer Name

Date of Incident

Time of incident

Time you began work on day of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)

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

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

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

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

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

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

What did you do after the incident occurred?

The above form is true and correct.

Signature

Date Completed



# Informe de Incidente del Empleado

A ser completado por el trabajador lesionado.



Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Hora en que usted empezó a trabajar el día del incidente

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

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

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

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

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

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

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

¿Qué hizo después de ocurrido el incidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario

# Supervisor's Report of Employment 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)

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

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 accident

Electrical exposure

Interaction with co-worker

Other:

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

The above form is true and correct.

Prepared by

Signature

Date Completed



# Informe de Incidente del Supervisor



Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente?

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

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

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

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

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

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



## Informe de Incidente del Supervisor

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

Equipo para levantar no usado/no disponible

Vista obstruida

Interacción con paciente o residente

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

Falta de capacitación

Interacción con cliente

Contenedor de objetos punzantes no usado/no disponible

Herramientas o equipo defectuosos

Exposición a producto químico

Equipo no resguardado o incorrectamente resguardado

Piso mojado/resbaloso

Incidente de vehículo motorizado

Exposición eléctrica

Mala limpieza

Other:

Interacción con compañero de trabajo

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

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración:

# Witness' Report/Statement of Employee Incident



Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)

Date of Incident

Time of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)

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

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

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

What did the employee do after the incident occurred?

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

The above form is true and correct.

Witness' Signature

Date Completed

# Informe de Incidente del Testigo



Nombre del Empleado

Nombre del Testigo

Teléfono del Testigo

Dirección del Testigo

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/No)

Fecha Del Incidente

Hora del incidente

Dirección del incidente

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/ No)

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

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

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

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

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

La forma anterior es verdadera y correcta.

Firma del Testigo

Fecha

## »» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

### Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.

## »» To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of \$150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

### Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

### Express Scripts

ID#: \_\_\_\_\_

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM/DD/YYYY

**G3YA**

Group #: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Thank you** for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

*Please see other side for a list of participating retail network pharmacies.*

»» **To the Supervisor:** Please fill in the information requested for the injured worker.

### Employee Information

\_\_\_\_\_  
First M Last

\_\_\_\_\_  
Street Address or PO Box

\_\_\_\_\_  
City State ZIP

### Employer Name

\_\_\_\_\_



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



# \$1000 REWARD

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

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

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

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

# 1 (800) 300-JAIL

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



# \$1000 RECOMPENSA

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

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

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

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

# 1 (800) 300-JAIL

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