Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation State Claim Kit

Vermont

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.

Vermont state law requires employers to report every industrial injury or occupational disease claim to their workers compensation carrier immediately.

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

bhhcpolicyholder.bhhc.com/Client/External/Claims

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation Posting Requirements

Form 31 – Notice to Employees RE: Employer's Liability & Workers' Compensation Poster

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

To complete the form, please enter the name of your company and the name of your designated insurance carrier in the space provided.

(21 Vermont Statutes Annotated § 691)

VERMONT

DEPARTMENT OF LABOR

Employer's Liability and Workers' Compensation

NOTICE TO EMPLOYEES

This employer, _____ , has complied with the provisions of Title 21 of the Vermont Statutes, Annotated §687, by obtaining Workers' Compensation Insurance coverage through:

_____

(Insurance Carrier)

Workers' Compensation benefits for lost time, medical expenses, disability or death because of a work-related injury are available through the above named company.

- **An injured employee MUST immediately notify his/her employer of an injury.**
- **The employer MUST file an Employee Claim and Employer's First Report of Injury (Form 1) with the Vermont Department of Labor within 72 hours of the notice of an injury that requires medical attention or results in time lost from work. The employer must also provide a copy of the Form 1 to the injured worker and to the insurance carrier.**
- **If the employer fails to file a First Report, an employee may file a Notice of Injury and Claim for Compensation (Form 5) with the Vermont Department of Labor within six months of the date of injury.**
- **Information concerning injured worker rights and benefits is available on the department's Workers' Compensation website at http://www.labor.vermont.gov or by calling (802) 828-2286.**

Equal Opportunity is the Law

The State of Vermont is an Equal Opportunity/Affirmative Action Employer. Applications from women, individuals with disabilities, and people from diverse cultural backgrounds are encouraged. Auxiliary aids and services are available upon request to individuals with disabilities. 711 (TTY/Relay Service) or 802-828-4203 TDD (Vermont Department of Labor).

ESTADO DE VERMONT

Responsabilidades de la Empresa Contratante & Indemnización por Accidentes Laborales (*Workers' Compensation*)

NOTIFICACIÓN A LOS EMPLEADOS

ESTA EMPRESA CONTRATANTE, _____,
HA CUMPLIDO CON LAS DISPOSICIONES DEL TÍTULO 21 DE LOS ESTATUTOS DEL ESTADO DE VERMONT, ANOTADAS EN LA § 687, ASEGURÁNDOSE BAJO UNA PÓLIZA DE SEGURO CONTRA ACCIDENTES LABORALES EMITIDA POR:

(COMPAÑÍA DE SEGUROS)

EL EMPLEADO DE ESTA COMPAÑÍA TIENE DERECHO A SER INDEMNIZADO POR EL TIEMPO PERDIDO, GASTOS MÉDICO GENERADOS, INCAPACIDAD SUFRIDA O LA MUERTE, SI ÉSTOS FUESEN ATRIBUIBLES A UNA LESIÓN RELACIONADA CON SU TRABAJO.

- **LA LESIÓN SUFRIDA TENDRÁ QUE SER REPORTADA INMEDIATAMENTE A LA COMPAÑÍA CONTRATANTE POR EL EMPLEADO LESIONADO.**

- **LA EMPRESA CONTRATANTE TENDRÁ QUE REMITIR UNA RECLAMACIÓN A NOMBRE DEL EMPLEADO Y PRESENTAR EL PRIMER REPORTE DE UNA LESIÓN EN EL FORMULARIO CORRESPONDIENTE (FORMULARIO 1) ANTE EL MINISTERIO DE ASUNTOS LABORALES E INDUSTRIALES (*THE DEPARTMENT OF LABOR AND INDUSTRY*), POR CONCEPTO DE CUALQUIER LESIÓN QUE REQUIERA ATENCIÓN MÉDICA O QUE RESULTARA EN LA PÉRDIDA DE TIEMPO LABORAL. LA EMPRESA TENDRÁ QUE REMITIR DICHA RECLAMACIÓN Y REPORTE DENTRO DE 72 HORAS DESPUÉS DE HABER RECIBIDO NOTIFICACIÓN DE LA LESIÓN. LA EMPRESA CONTRATANTE TAMBIÉN LE TENDRÁ QUE PROPORCIONAR UNA COPIA DEL FINALIZADO FORMULARIO 1 AL EMPLEADO LESIONADO Y A LA COMPAÑÍA DE SEGUROS.**

- **SI LA EMPRESA CONTRATANTE NO CUMPLIERA CON LA PRESENTACIÓN DEL PRECITADO PRIMER REPORTE, EL EMPLEADO PODRÁ LLENAR Y REMITIR EL FORMULARIO 5 TITULADO *NOTIFICACIÓN DE LESIÓN Y RECLAMACIÓN PARA INDEMNIZACIÓN* (*NOTICE OF INJURY AND CLAIM FOR COMPENSATION—FORM 5*) ANTE EL MINISTERIO DE ASUNTOS LABORALES E INDUSTRIALES DENTRO DE SEIS MESES, CONTADOS A PARTIR DE LA FECHA DE LA LESIÓN.**

- **SI DESEA INFORMACIÓN REFERENTE A LOS DERECHOS Y BENEFICIOS DEL EMPLEADO LESIONADO VISITE EL *WEB SITE* DE SEGURO CONTRA ACCIDENTES LABORALES http://www.state.vt.us/labind/wcindex.htm O SÍRVASE LLAMAR AL (802) 828-2286**

FORMULARIO 31 2/03

NOTICE

This is a translation of a document originally drawn up in English. Accordingly, it is understood that all legal rights, responsibilities and/or obligations are governed by the original English version of this document.

ADVERTENCIA

Ésta es la traducción de un documento originalmente redactado en inglés. Consiguientemente, hágase saber que todos los derechos legales, responsabilidades y/u obligaciones expresadas en el mismo se regirán por la versión original del documento redactada en inglés.

ETAT DU VERMONT

RESPONSABILITE DE L'EMPLOYEUR
ET INDEMNITES SALARIALES

AVIS AUX EMPLOYES

CET EMPLOYEUR, _____,
EST EN CONFORMITE AVEC LES TERMES DE L'ARTICLE 21 DES STATUTS DE L'ETAT DU VERMONT #687, ET A CONTRACTE UNE ASSURANCE D'INDEMNITE SALARIALE AVEC : _____

_____
_____

(NOM DE L'ASSUREUR)

CETTE COMPAGNIE OFFRE DES INDEMNITES SALARIALES DE COMPENSATION EN CAS DE PERTE DE TEMPS DE TRAVAIL, FRAIS MEDICAUX, HANDICAP OU DECES CONSECUTIFS A UN ACCIDENT DU TRAVAIL.

? ? UN EMPLOYE BLESSE DOIT AVERTIR IMMEDIATEMENT SON EMPLOYEUR DE SON ACCIDENT.

? ? L'EMPLOYEUR DOIT DECLARER LA PLAINTE DE L'EMPLOYE AINSI QUE DEPOSER « LE PREMIER RAPPORT DE L'EMPLOYEUR » CONCERNANT L'ACCIDENT (FORMULAIRE 1) AUPRES DU DEPARTEMENT DU TRAVAIL ET DE L'INDUSTRIE, POUR TOUTE BLESSURE NECESSITANT DES SOINS MEDICAUX, OU AYANT POUR CONSEQUENCE LA PERTE DE TEMPS DE TRAVAIL. CETTE DECLARATION DOIT ETRE FAITE DANS LES 72 HEURES QUI SUIVENT LA NOTIFICATION DE L'ACCIDENT OU DE LA MALADIE.

? ? SI L'EMPLOYEUR NE DEPOSE PAS UN « PREMIER RAPPORT », L' EMPLOYE A LA POSSIBILITE DE FAIRE UNE DECLARATION « NOTIFICATION DE BLESSURE ET DEMANDE D 'INDEMNITE » (FORMULAIRE #5) AUPRES DU DEPARTEMENT DU TRAVAIL ET DE L'INDUSTRIE, DANS LES SIX MOIS QUI SUIVENT LA DATE DE L'ACCIDENT.

? ? DES RENSEIGNEMENTS CONCERNANT LES DROITS D'UN EMPLOYE VICTIME D'UN ACCIDENT DU TRAVAIL PEUVENT ETRE OBTENUS AUPRES DU DEPARTEMENT DU TRAVAIL ET DE L'INDUSTRIE EN APPELANT LE NUMERO SUIVANT :
(802) 828-2286.

DRZAVA VERMONT

Odgovornost i kompenzacija radnika

OBAVIJEST ZAPOSLENIM

POSLODAVAC, _____JE POSTUPIO U SKLADU SA ODREDBOM BROJ 21, VERMONTSKOG STATUTA, § 687, TAKO STO JE UVEO OSIGURANJE ZA KOMPENZACIJU RADNIKA, PREKO:

_____

NOSILAC OSIGURANJA

KOMPENZACIJA RADNIKA ZA IZGUBLJENO VRIJEME, TROSKOVE LIJECENJA, INVALIDNOST I SMRT, KOJI SU REZULTAT POVREDA NA RADU STOJI NA RASPOLAGANJU PUTEM OVE KOMPANIJE.

POVRIJEDJENI RADNIK MORA ODMAH DA OBAVIJESTI SVOGA POSLODAVCA O POVREDI.

POSLODAVAC MORA ZA SVAKU POVREDU KOJA ZAHTIJEVA ZDRAVSTVENU INTERVENCIJU ILI IMA ZA POSLJEDICU GUBITAK VREMENA NA RADNOM MJESTU, U ROKU OD 72 SATA OD PRIMANJA OBAVIJESTI O NESRECI ILI BOLESI, ISPUNITI ZAHTJEV I PRVI IZVJESTAJ ZAPOSLENOG – FORMULAR 1 (FIRST REPORT), ZAJEDNO SA ZAVODOM ZA RAD I INDUSTRIJU (DEPARTMENT OF LABOR AND INDUSTRY).

AKO POSLODAVAC NE ISPUNI PRVI IZVJESTAJ, ZAPOSLENI MOZE ISPUNITI OBAVIJEST O POVREDI I ZAHTJEV ZA KOMPENZACIJU (FORMULAR 5), ZAJEDNO SA UREDOM ZA RAD I INDUSTRIJU (DEPARTMENT OF LABOR AND INDUSTRY), U ROKU OD SEST MJESECI OD DATUMA POVREDE.

INFORMACIJE O PRAVIMA POVRIJEDJENIH RADNIKA SE MOGU DOBITI OD ZAVODA ZA RAD I INDUSTRIJU (DEPARTMENT OF LABOR AND INDUSTRY), NA TELEFON:
(802) 828 – 2286 ili TDD 800-650-4152.

FORM 31 6/2017

STATE OF VERMONT
TI"U BANG VERMONT

Trách NhiŒm Pháp Lš Cûa Chû Hãng và S¿ BÒi ThÜ©ng Cho Công Nhân

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THÔNG BÁO CHO TƒT C• CÔNG NHÂN

CHÑ H,NG N? Y,
_____, ñ, TUÂN THEO ñI"U L S – CHÑ ñ" 21 CÑA ñO LUT VERMONT, 687, B? NG CÁCH MUA B• O HI"M CHO VIC B —I THÐ? NG CHO CÔNG NHÂN QUA:

_____
_____

(TÊN H,NG B• O HI"M)

NHNG QUY"N L÷I CHO VIC B —I THÐ? NG CHO CÔNG NHÂN DO Vµ MƒT GI? L? M, TR• TI"N BNH VIN, TT N GUY"N HOC CH • T BŸI DO TAI NN LIÊN QUAN ñ• N VIC L? M ñ, SðN S? NG QUA CÔNG TY N? Y.

?? M¶t Công Nhân BÎ ThÜÖng Phäi LÆp TÙc Báo Cáo ThÜÖng Tích Cho Hãng Cûa Anh Ta/Cô Ta Ngay LÆp TÙc.

?? Hãng Làm Phäi Làm HÒ SÖ Cho Công Nhân và Bän Báo Cáo ThÜÖng Tích ñÀu Tiên Cûa Hãng (Form 1) V§i Væn Phòng Lao ñ¶ng Cho BÃt CÙ Tai Nån Nào CÀn ñi BŒnh ViŒn Ho¥c Phäi NghÌ Làm Trong Vòng 72 Gi© Sau Khi NhÆn ñÜ®c Báo Cáo Cûa Tai Nån Ho¥c BŒnh. Hãng Làm CÛng Phäi Cung CÃp M¶t Bän Sao cûa Form 1 Cho NgÜ©i Công Nhân BÎ ThÜÖng Và M¶t Cho Hãng Bäo Hi‹m.

?? N‰u Hãng Không Làm HÒ SÖ Báo Cáo ñÀu Tiên, Công Nhân Có Th‹ Làm ñÖn Thông Báo Tai Nån Và Xin ñÜ®c Bòi ThÜ©ng (Form 5) V§i Væn Phòng Lao ñ¶ng Trong Vòng Sáu Tháng K‹ TØ Ngày BÎ ThÜÖng.

?? Tin TÙc VŠ QuyŠn L®i Cûa M¶t NgÜ©i BÎ ThÜÖng Có Th‹ LÃy Tải Væn Phòng Lao ñ¶ng B¢ng Cách G†i SÓ (802) 828-2286.

VERMONT

DEPARTMENT OF LABOR – ATTN: WORKERS' COMPENSATION
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

Form 1 (Rev. 9/11)
(Approved for use as OSHA 101 and 301)

State File No. _____

EMPLOYER FIRST REPORT OF INJURY

Answer every question fully and report promptly to avoid a penalty. Employer's Federal ID Number and Employee Social Security Number MUST be provided.

EMPLOYER

1. Legal Name:
2. Business Name:
3. Mail Address: No. and Street | City | State | Zip
4. Location (if different from Mail Address):
5. Telephone Number, Extension and Contact Person.:
6. Nature of Business (list principal products or service of concern):
7. Do you regularly employ 10 or more employees? ☐ Yes ☐ No
8. Federal ID No.:

EMPLOYEE

9. Name: First Name | Middle Initial | Last Name
10. Social Security No.:
11. Date of Birth:
12. Home Address: No. and Street
13. Home Phone No.:
14. Work Phone No:
15. Age:
City | State | Zip
16. Job Title:
17. Sex: ☐ M ☐ F
18. Wages $ Per
Hours Per Day Days Per Week
19. If board, lodging, etc. were furnished in addition to wages, state estimated value: $
20. Was employee hired in VT? ☐ Yes ☐ No
21. Date of Hire

ACCIDENT

22. Date of Accident:
Accident Time: AM PM
Began Shift: AM PM
23. Location of Accident: Town or City | State
24. Machine, tool, object, motor vehicle or substance directly causing injury:
25. On employer's premises? ☐ Yes ☐ No If yes, name of department:
26. Describe what employee was doing:
Was this the employee's regular occupation? ☐ Yes ☐ No
27. How did accident occur? Describe events leading up to the accident:

INJURY

28. Describe the injury and the part of the body injured.
29. Was this a first-aid only injury: ☐ Yes ☐ No
30. Any Lost Time? ☐ Yes ☐ No
If yes, date disability began
Last date paid in full:
31. Employee returned to work? ☐ Yes ☐ No
If yes, date
Medical Only Incident: Yes ☐ No ☐
32. Did injury result in death? ☐ Yes ☐ No
If yes, date of death.
33. Name and address of Physician:
34. Name and address of Hospital:
Remained Overnight ☐ Yes ☐ No

INS

35. Insurance Company Named on Workers' Compensation Policy
Name in full: _____
Policy No.
35A. Claim Administrator
Company Name _____
Phone Number

Signed by: _____
Employer or Representative | Title | Date

Equal Opportunity is the Law

Employee's Claim and Employer First Report of Injury
First-Aid Only Injuries and Deductible Policies

21 V.S.A. Title 21, Chapter 9, §640(e) was changed by S.345 in the 2007-08 Legislative Session. The new language is below.

(e) In the case of a work-related, first-aid-only injury, the employer shall file the first report of injury with the department of labor. The employer shall file the first report of injury with the workers' compensation insurance carrier or pay the medical bill within 30 days. If the employer contests a claim, a first report of injury shall be forwarded to the department of labor and the insurer within five days of notice. If additional treatment or medical visits are required or if the employee loses more than one day of work, the claim shall be promptly reported to the workers' compensation insurer, which shall adjust the claim. "Work-related, first-aid-only-treatment" means any one-time treatment that generates a bill for less than $750.00 and for which the employee loses no time from work except for the time for medical treatment and recovery not to exceed one day of absence from work.

Please ensure that you have completed box 35 on all Employee's Claim and Employer First Report of Injury.

DOL Form 4 Rev 9/11

Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

State File No. _____
Ins. Co. File No. _____
Date of Injury _____
Soc. Sec. No. _____

REPORT OF FATAL ACCIDENT

IMPORTANT: This report is to be used only when a work related injury results in a fatality. In all such cases, the Employer's First Report of Injury (Form 1) also must be filed.

1. Name of Employer: _____
2. Address of Employer: _____
3. Nature of Business: _____
4. Name of Injured Person: _____
5. Residence of Injured Person at Time of Death: _____
6. Date of Accident: _____
7. Date of Death: _____
8. Place where Injured Person Died: _____
9. ☐ Single ☐ Married ☐ Civil Union ☐ Widower ☐ Widow ☐ Divorced
10. Number of Children under Eighteen years of age: _____
11. If no Spouse or Reciprocal Beneficiary or Children Survive, State Other Relatives Dependent Upon Deceased: _____
12. Relationship of Dependents: _____

Dated this _____ day of _____ 20 _____ (year)

_____
Employer

By _____
Official Position

VERMONT

State File No.: _____

Ins. Co. File No.: _____

VERMONT WORKERS' COMPENSATION MEDICAL AUTHORIZATION

NOTE: Title 21 VSA §655a requires all providers to utilize and comply with this medical release authorization form when seeking or providing medical information relative to a workers' compensation claim. Workers' Compensation claims are expressly exempted from the terms and provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), *45 CFR 164.512(1).*

A copy of 21 VSA §655a is included with this form (see Page 2 of 2).

TO: _____
(Physician, Hospital or other medical practitioner)

This, or a photocopy, will authorize you to release to _____
(Insurance Carrier, Employer and/or its counsel of record, Vocational Rehabilitation Counselor)

at the following address: _____

All relevant medical information you may have relating to the treatment or diagnosis of my work related injury claim that involves injury to my:

_____
(enter body part(s) or health condition)

that occurred on or about _____ , 20 _____

RELEVANT MEDICAL INFORMATION INCLUDES records relating to a past history of complaints or treatment of a condition similar to that presented in the work injury claim or other conditions related to the same body part and may include:

(1) Minimum data to justify services and payment, including that on the standard paper 1500 form or electronic 837 form.

(2) Office visit notes, diagnostic reports, medical evaluations relating to the injury diagnosis or treatment.

(3) Any other relevant provider records contained in the file.

Name: _____
(Print Claimant/Patient Name)

Date of Birth: _____

_____ _____
Signature Date

Title 21: Labor

Chapter 9: EMPLOYER'S LIABILITY AND WORKERS' COMPENSATION

21 V.S.A. § 655a. Release of relevant medical records by health care providers; department to oversee release and use of relevant medical information

§ 655a. Release of relevant medical records by health care providers; department to oversee release and use of relevant medical information

(a) Health care providers examining or attending the examination of an injured worker pursuant to this chapter shall provide relevant medical records and reports as requested by the injured worker, the employer, or the department regarding the diagnosis, condition, or treatment of the worker, permanent impairment, or any restrictions or limitations on the worker's ability to work upon receiving a written medical release authorization from the injured worker. The authorization shall be on a form approved by the department. If the relevance of any medical information is disputed, the department shall determine whether the requested medical information is relevant.

(b) Medical information relevant to the specific claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. Information that may be requested includes:

(1) Minimum data to justify services and payment, including that on the standard paper 1500 form or electronic 837 form.

(2) Office notes of the examination relating to the injury diagnosis or treatment.

(3) Any other relevant provider records contained in the file.

(c) An injured worker shall only be obligated to sign a medical record release authorization approved by the department.

(d) Any medical information received by the employer or the insurance carrier that is found not to be relevant to the claim may not be used to deny or limit a claim. The commissioner may order that specific disclosure requests be denied or rescinded and may make such other interim orders as are appropriate.

(e) Any medical information received in conjunction with a claim shall be used only for the purpose of advancing or defending a claim relating to the injury or of investigating a claim of false representation or of ensuring compliance with the workers' compensation statutes and rules. (Added 2011, No. 50, § 4.)

VERMONT

Department of Labor, Workers' Workers' Compensation
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286; TDD 800-650-4152
www.labor.vermont.gov

DOL FORM 25 (Rev. 1/2018)

State File No. _____
Ins. Co. File No. _____
Date of Injury _____
Fed. ID No. _____

WAGE STATEMENT – For injuries occurring on or after July 1, 2008

Employee: _____

Employer: _____

Wage Rate: $ _____ per _____ Number of Days Hired to Work: _____ Number of Hours Hired to Work: _____

	Week Ending			Number of Hours or Days Worked	Gross Wages	Extras (as in 6 or 7) Please indicate what the extra is, for example, $1000.00 bonus
	Month	Day	Year			
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						

INSTRUCTIONS:
Read Carefully

1. Enter **GROSS** wages of employee for 26 weeks before date of accident (**NOT take-home pay**).
2. Do not include the week of the accident.
3. Leave blank those weeks in which the employee had excused absences for which he/she was paid for less than ½ of a work week.
4. Leave blank those weeks in which you had reduced operations or a plant shutdown and for which the employee was paid for less than ½ of a work week.
5. Do not enter those weeks in which an employee was on vacation for more than ½ of a work week.
6. If room, board, lodging or other "extras" (electricity, fuel, etc.) are provided in addition to monetary wages, break these down into a weekly value, and include and describe the income in the column marked "EXTRAS." This includes tips if not included in gross wages.
7. Include any bonuses and commissions paid to the employee in addition to wages in the column marked "EXTRAS."
8. Enter the dates when your normal work week ends (not the date a check is issued to the employee) and the number of hours or days worked.

When did the employee begin losing time? _____ Was the employee paid in full for the day of the accident? _____

Are employee's wages subject to any child support withholding order? ☐Yes ☐No
If yes, in what amount? $ _____ per _____

Day of the week the check will be mailed to the claimant or deposited in the claimant's account _____

This is a correct statement of the employee's earnings as taken from the employer's payroll records.

By: _____ Position Title: _____
Signature of Preparer

Print Name: _____ Date: _____

Vermont Department of Labor
Workers' Compensation
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

Form 10 (rev 9/11)

State File # _____
Ins. Co. File # _____
Date of Injury _____

www.labor.vermont.gov

Certificate of Dependency and Concurrent Employment

Employee: _____

Employer: _____

TO THE EMPLOYEE: This form MUST be completed in every workers' compensation case in which an injured worker has lost time from work as the result of a work-related injury. The form must be completed even when the injured worker has no dependents. The information must be supplied and the form signed by the injured worker. This information is required to determine the employee's right to additional weekly compensation of $10.00 for each dependent child under the age of twenty-one (21) years.

List below your dependent child(ren) up to 21 years old that have not already been declared by your spouse on his/her current workers' compensation claim.**

Name of Dependent	Date of Birth	Relationship

Concurrent employment: If you were working for more than one employer on the date of injury indicated above please provide the following information.**

Name of Employer	Employer's Address	Employer's Phone Number	Date of Hire

I hereby certify that the above is a true, complete and accurate statement of my dependents and concurrent employment.

Employee Signature _____ Date Signed _____ Address _____

Telephone Number _____ City/State/Zip _____

**Attach additional sheets if necessary and return this to the insurance carrier

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Direct Deposit for Workers Compensation Benefit Checks

Per 21 V.S.A. § 650(f), beginning January 1, 2021, recovering workers have the right to have workers' compensation benefit checks directly deposited into a bank account of their choosing.

Included is a direct deposit form for the claimant to complete and return to the insurance carrier.

Upon notice of a work related injury, please provide the form to the recovering worker for his/her consideration.

If you or the recovering worker have questions, please contact our Customer Care Center at 888-495-8949.

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

VT Direct Deposit Authorization Form

Depositor/Claimant's Name

Claim Number

Phone Number

Email Address

Address

City, State

Zip

DEPOSITOR/CLAIMANT/JOINT ACCOUNT HOLDER CERTIFICATION I certify that I am entitled to receive the underlying compensation payments or death benefits and circumstances entitling me to benefits or death benefits have not changed.

Depositor/Claimant Certification Signature

Date

Joint Account Holder Certification Signature

Date

DEPOSITOR/CLAIMANT/JOINT ACCOUNT HOLDER CERTIFICATION I certify that I am entitled to receive the underlying compensation payments or death benefits and circumstances entitling me to benefits or death benefits have not changed.

Name of Financial Institution

Account Type

Checking

Savings

Depositor's Account Number

Routing Number

RESET FORM

PRINT THIS FORM

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

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

Claim Number/Número de Reclamo

Date of Injury / Fecha de la Lesión

Employee/Empleado

Date of Birth / Fecha de Nacimiento

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

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

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

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

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

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

The released information is required for the following reasons:

La información liberada es requerida por las siguientes razones:

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

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

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

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

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

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

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

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

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

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

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

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

A copy or fax is as valid as the original.

Una copia o fax es tan válida como el original.

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

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

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

Signature/Firma

Date/Fecha

PRINT THIS FORM/ IMPRIMIR FORMULARIO

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Medical History Request

Employee Name

Date of Injury

Employer Name

Completion Date

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

Thank you for your cooperation.

Past Injuries, Disabilities, or Other Medical Conditions

Hospitalizations

Hospital Name & Address	Phone	Date(s) Adimitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

RESET FORM

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Employee Incident Report

This form should be filled out by the injured employee.

Name

Employer Name

Date of Incident

Time of incident

Time you began work on day of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)
Yes or No

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

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

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

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

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

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

What did you do after the incident occurred?

The above form is true and correct.

Signature

Date Completed

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Informe de Incidente del Empleado

A ser completado por el trabajador lesionado.

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Hora en que usted empezó a trabajar el día del incidente

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)
Si/No

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

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

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

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

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

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

¿Qué hizo después de ocurrido el incidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario

RESTABLECER FORMULARIO

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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) 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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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Informe de Incidente del Supevisor

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente? Si/No

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)
Si/No

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

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

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

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

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

Informe de Incidente del Supevisor

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

- ☐ Equipo para levantar no usado/no disponible
- ☐ PPE (guantes, casco, gafas, etc.) no usado/no disponible
- ☐ Contenedor de objetos punzantes no usado/no disponible
- ☐ Equipo no resguardado o incorrectamente resguardado
- ☐ Exposición eléctrica
- ☐ Vista obstruida
- ☐ Falta de capacitación
- ☐ Herramientas o equipo defectuosos
- ☐ Piso mojado/resbaloso
- ☐ Mala limpieza
- ☐ Interacción con compañero de trabajo
- ☐ Interacción con paciente o residente
- ☐ Interacción con cliente
- ☐ Exposición a producto químico
- ☐ Incidente de vehículo motorizado
- ☐ Other:

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

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración:

RESTABLECER FORMULARIO

IMPRIMIR FORMULARIO

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Witness' Report/Statement of Employee Incident

Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)
Yes or No

Date of Incident

Time of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)
Yes or No

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

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

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

What did the employee do after the incident occurred?

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

The above form is true and correct.

Witness' Signature

Date Completed

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Informe de Incidente del Testigo

Nombre del Empleado

Nombre del Testigo

Teléfono del Testigo

Dirección del Testigo

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/No)
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.

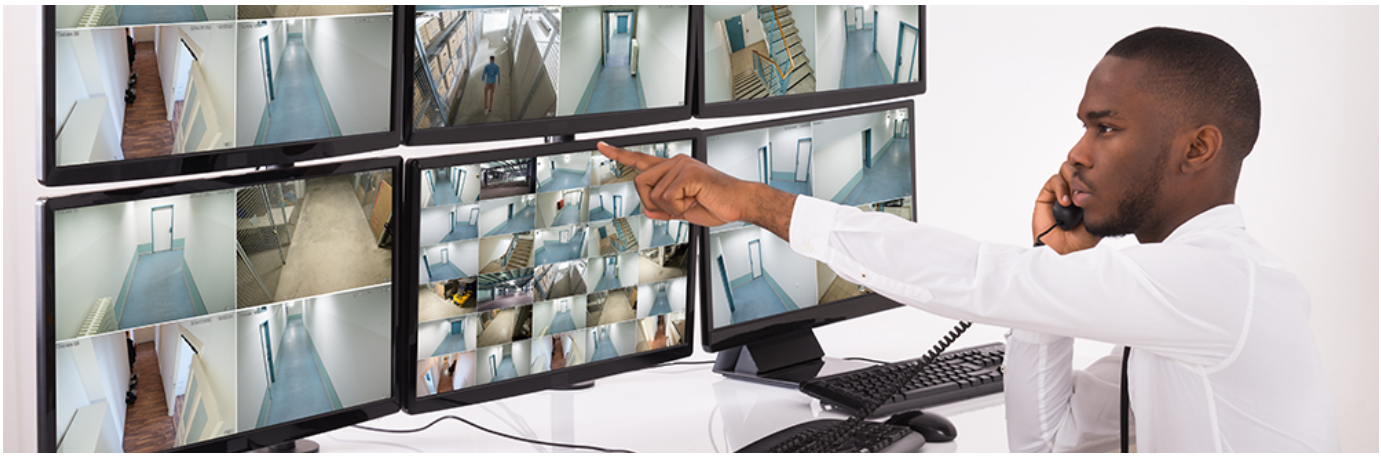
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

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.