Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation State Claim Kit

District of Columbia

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.

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

bhhcpolicyholder.bhhc.com/Client/External/Claims

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Workers' Compensation Posting Requirements

FORM DCWC-1 – NOTICE of Compliance Poster

- Post in one or more conspicuous places at all business locations
- Must contain the insurance carrier's name and contact information and the policy expiration date

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

- Name of your designated workers' compensation insurer
- Policy expiration date
- Your company name and federal employer identification number (FEIN)
- The name of the individual completing the form

For your convenience, our other contact information has been entered on the form DCWC-1.

(District of Columbia § 32-1536)

Department of Employment Services

LABOR STANDARDS BUREAU

DEPARTMENT OF EMPLOYMENT SERVICES

Office of Workers' Compensation

EMPLOYEE'S RIGHTS AND OBLIGATIONS

District of Columbia Workers' Compensation Law

- You are required by law to promptly report your injury by filing Form No. 7 DCWC, Employee's Notice of Accidental Injury or Occupational Disease, with your employer and the Office of Workers' Compensation within thirty (30) days of the date of injury or the date you have knowledge that the injury is related to your job.

- In order to preserve your right to workers' compensation benefits under the law, you must file a written claim on Form No. 7A DCWC, Employee's Claim Application, within one (1) year after your injury, or within one (1) year after the last payment of benefits. Benefits include indemnity payments for lost wages, medical services and treatment, and vocational rehabilitation.

- Failure to timely file the Notice of Accidental Injury or Occupational Disease, Form No. 7 DCWC, or the Employee's Claim Application, Form No. 7A DCWC, may bar your right to future compensation. Copies of these forms and other pertinent information are available on the Department of Employment Services, Office of Workers' Compensation's website. The website address is http://does.dc.gov.

- You may not sue your employer as a result of a work-related injury or disease, the Workers' Compensation Law is your exclusive remedy.

- You have the right to choose a treating physician. Once you choose a treating physician you may not change physicians unless you get approval from your employer's insurance company or the Office of Workers' Compensation. Medical treatment includes medical services, supplies, prosthetic devices, and prescriptions. Medical services include treatment by a dentist, osteopath, podiatrist, and chiropractor.

- Compensation is not paid for the first three (3) days of disability unless the disability exceeds fourteen (14) days. Compensation is paid at the rate of 66 ⅔% of your average weekly wage. Unless your employer controverts your right to compensation within fourteen (14) days after he/she has knowledge of the injury, the first installment of compensation becomes due on the 14th day and must be paid within fourteen (14) days after it is due.

- You have the right to request an informal conference or a formal hearing on disputes arising on matters regarding your claim and you have the right to be represented by an attorney or other representative if you so desire.

- You may be entitled to vocational rehabilitation services if you are unable to return to the job you had prior to the injury.

- For injuries occurring on or after 4/16/1999, disability benefits for any one (1) injury causing temporary or permanent partial disability shall be limited to 500 weeks. However, within sixty (60) days of the expiration of the 500 week duration, an employee may petition the Mayor for an extension of up to 167 weeks.

- Your employer is required to advise you of your rights and obligations under the Workers' Compensation Law and if you need further information, call the Office of Workers' Compensation at (202) 671-1000 or fax (202) 671-1929. The web address is http://does.dc.gov.

Departamento de Servicios de Empleo
OFICINA DE ESTÁNDARES LABORALES

DEPARTMENT OF EMPLOYMENT SERVICES

Oficina de Compensación de Trabajadores
DERECHOS Y OBLIGACIONES DEL EMPLEADO
Ley de Compensación de Trabajadores del Distrito de Columbia

- La ley le exige informar rápidamente de su lesión a su empleador y a la Oficina de Compensación de Trabajadores en el término de treinta (30) días de la fecha de la lesión o de la fecha en que tuvo conocimiento de que la lesión estaba relacionada con su trabajo, completando el Formulario N°. 7 DCWC, Notificación del empleado sobre lesión accidental o enfermedad laboral.
- Con el fin de preservar su derecho a los beneficios de la compensación de trabajadores en el marco de la ley, usted debe completar una reclamación por escrito en el Formulario N°. 7A DCWC, Solicitud de reclamación del empleado, en el término de un (1) año después de su lesión, o en el término de un (1) año después del último pago de beneficios. Los beneficios incluyen pagos de indemnización por salarios perdidos, servicios y tratamiento médico, y rehabilitación vocacional.
- Si no presenta la Notificación de lesión accidental o enfermedad laboral, Formulario N°. 7 DCWC, o la Solicitud de reclamación del empleado, Formulario N°. 7A DCWC, podría bloquear su derecho a una futura compensación. Copias de estos formularios y demás información pertinente están disponibles en el sitio web del Departamento de Servicios de Empleo, Oficina de Compensación de Trabajadores. La dirección del sitio web es http://does.dc.gov.
- Usted no debe demandar a su empleador como resultado de una lesión o enfermedad relacionada con el trabajo, la Ley de Compensación de Trabajadores es su único recurso.
- Usted tiene derecho a elegir el médico tratante. Una vez que elija al médico tratante no podrá cambiar de médico a menos que obtenga la aprobación de la compañía de seguros de su empleador o de la Oficina de Compensación de Trabajadores. El tratamiento médico incluye servicios médicos, suministros, dispositivos protésicos y prescripciones. Los servicios médicos incluyen el tratamiento del dentista, osteópata, podíatra y quiropráctico.
- No se paga compensación por los primeros tres (3) días de discapacidad a menos que la discapacidad exceda los catorce (14) días. La compensación se paga a razón del 66 ⅔% de su salario semanal promedio. A menos que su empleador controvierta su derecho a compensación en el plazo de catorce (14) días después de tener conocimiento de la lesión, el primer pago de compensación vence el día 14 y debe ser pagado a los catorce (14) días después del vencimiento.
- Usted tiene derecho a solicitar una conferencia informal o una audiencia formal sobre disputas que surjan en cuanto a cuestiones referidas a su reclamación y tiene derecho a ser representado por un abogado u otro representante si así lo desea.
- Usted podrá tener derecho a servicios de rehabilitación vocacional si no puede regresar al trabajo que tenía antes de la lesión.
- En el caso de lesiones ocurridas el o después del 4/16/1999, los beneficios de discapacidad por cada una (1) de las lesiones que provoquen una discapacidad parcial temporaria o permanente se limitarán a 500 semanas. No obstante, a sesenta (60) días de expirar la duración de 500 semanas, un empleado podrá solicitar al alcalde una extensión de hasta 167 semanas.
- Su empleador deberá informarle sus derechos y obligaciones en el marco de la Ley de Compensación de Trabajadores y si necesita más información, llame a la Oficina de Compensación de Trabajadores al (202) 671-1000 o envíe un fax al (202) 671-1929. La dirección web es http://does.dc.gov.

District of Columbia Government
Office of Workers' Compensation
4058 Minnesota Avenue, N.E.
Washington, DC 20019
(202) 671-1000

Warning: *It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.*

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

IMPORTANT: Every employer shall file this report as soon as possible after knowledge of an occupational injury or disease to one of its employees, but no later than ten (10) days thereafter. Failure to file this form shall be subject to civil penalty not to exceed $1,000.

Date and time of Injury: _____am/pm? Day of the week?_____
Normal starting time: _____am/pm? If employee back to work, give date and time: _____am/pm?
At what wage? _____ If fatal, give date of death _____(file supplement report)
Date/time disability began? _____ am/pm? Was the injured paid in full for this day? _____
Was the injured given Form No. 7 DCWC? ☐ Yes ☐ No Foreman/Supervisor_____
When did you or the foreman first learn of the injury? _____
☐ Male ☐ Female DOB: _____ Employee's Telephone No.: _____
Occupation when injured? _____ Was this his/her regular occupation?_____
(Department or branch regularly employed): _____
Was the injured hired in DC? _____ How long employed by you? _____
Piece or time worker? _____ Hourly wage? _____ Hours worked/day? _____
Daily wages: _____ Days worked per week: _____ Average weekly earnings:_____
If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week, or month:_____
Employer's principal business function in DC:_____
Employer's Telephone No.: _____ Insurance Policy No.:_____
Location of plant or place where accident occurred: _____
On employer's premises? _____
Describe fully the events which resulted in injury or disease, what the employee was doing when injured and type of injury including parts of the body affected: _____
_____
Name of Witnesses: _____
Nature and location of injury (Describe fully): _____
_____
Attending Physician and Address (If Hospital Involved – Indicate):_____
_____

_____
Name (Please Print or Type)

_____
Name of Person Completing Form

_____
Signature

_____
Official Position

Form No. 8 DCWC 9-2491

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKERS' COMPENSATION
4058 MINNESOTA AVENUE, N.E.
WASHINGTON, D.C. 20019

(202) 671-1000

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_____
Date of This Report

_____
Employee Social Security No.

_____
Employer Identification No.

_____
Insurer No.

EMPLOYEE'S
NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

NOTICE TO EMPLOYEE

YOU MUST FILE THIS REPORT WITHIN 30 DAYS AFTER YOU BECOME AWARE OF AN ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE AND ITS RELATIONSHIP TO YOUR JOB. PART 1 SHOULD BE MAILED TO THE D.C. GOVERNMENT, OFFICE OF WORKERS' COMPENSATION AT THE ABOVE ADDRESS. PART 2 SHOULD BE MAILED OR DELIVERED TO YOUR EMPLOYER, AND PART 3 RETAINED FOR YOUR RECORDS. IN ORDER TO PRESERVE YOUR RIGHTS UNDER THE LAW, YOU MUST FILE A CLAIM FORM NO. 7a DCWC, A COPY OF WHICH CAN BE OBTAINED FROM YOUR EMPLOYER OR THE OFFICE OF WORKERS' COMPENSATION.

Date and Time of Injury: _____ am/pm?

Place where injury occurred: _____

Description of Injury: _____

_____

THIS IS TO NOTIFY YOU _____
(Employer)

THAT I _____ while in your employ, sustained an injury ☐ or contracted an occupational disease ☐ as described above, caused by:

_____

Treating Physician's Name and Address: _____

_____

_____
(Employee's Signature)

Employee's Rights and Obligations

District of Columbia Workers Compensation Law

- You are required by law to promptly report your injury by filing DCWC Form 7, employee's Notice of Accidental Injury or Occupational Disease, with your employer and the Office of Workers' Compensation within 30 days of the date of injury or the date you have knowledge that the injury is related to your job.

- In order to preserve your right to workers' compensation benefits under the law, you must file a written claim on DCWC Form 7a, Employee's Claim Application, within 1 year after your injury, or within 1 year after the last payment of benefits. Benefits include indemnity payments for lost wages, medical services and treatment, and vocational rehabilitation.

- Failure to properly file the Notice of Accidental Injury or Occupational Disease, DCWC Form 7 or the Employee's Claim Application DCWC, Form 7a, may bar your right to future compensation. Copies of these forms and other pertinent information are available on the Department of Employment Services, Office of Workers' Compensation's web site. The web site address is listed below.

- You may not sue your employer as a result of a work-related injury or disease, the Workers' Compensation law is your exclusive remedy.

- You have the right to choose a treating physician. Once you choose a treating physician you may not change physicians unless you get approval from your employer's insurance company or the Office of Worker's Compensation. The medical treatment includes medical services, supplies, prosthetic devices, and prescriptions. The medical services include treatment by a dentist, osteopath, podiatrist and chiropractor.

- Compensation is not paid for the first 3 days of disability unless the disability exceeds 14 days. Compensation is paid at the rate of $66^{2/3}$% of your average weekly wage. Unless your employer controverts your right to compensation within 14 days after he has knowledge of the injury, the 1st installment of compensation becomes due on the 14^{th} day and must be paid within 14 days after it is due.

- You have the right to request an informal conference or a formal hearing on disputes arising on matters regarding your claim and you have the right to be represented by an attorney or other representative if you so desire.

- You may be entitled to vocational rehabilitation services if you are unable to return to the job you had prior to the injury.

- For injuries occurring on or after 4/16/99, temporary partial or permanent partial or permanent partial disability benefits will be limited to 500 weeks. Within 60 days of the expiration date, the claimant may petition for an extension of benefits up to 167 weeks beyond the 500-week cap.

- Your employer is required to advise you of your rights and obligations under the Workers' Compensation law and if you need further information, you may call the Office of Workers' Compensation on (202) 671-1000 or fax (202) 671-1929. The web address is http//does.dc.gov

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

District of Columbia Government
Office of Workers' Compensation
4058 Minnesota Avenue, N.E.
Washington, DC 20019
(202) 671-1000

Warning: *It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.*

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

Wage Schedule

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

Employer must forward to insurer copies of this schedule no later than employee's tenth (10th) day of loss of wages.

This wage schedule is for 26 weeks prior to date of injury, for wages fixed by week, month, or year, and must be filed with Office of Workers' Compensation by insurer, together with Form No. 9 DCWC, except when maximum compensation is paid. ***(Wages: In addition to money payments, wages mean reasonable value of board, rent, and housing that were received from employer as well as gratuities declared for tax purposes.)***

Date of Hire: _____ Date of Injury: _____

Hourly Wages: _____ Average Weekly Earnings: _____

	1	2		3	4
Week Ending	**Gross Earnings**	**Other Advantages** (see wages definition above)	**Week Ending**	**Gross Earnings**	**Other Advantages** (see wages definition above)
1			**14**		
2			**15**		
3			**16**		
4			**17**		
5			**18**		
6			**19**		
7			**20**		
8			**21**		
9			**22**		
10			**23**		
11			**24**		
12			**25**		
13			**26**		

Total of columns 1,2,3 and 4 _____

If wages fixed by week, month, or year, state amount _____ per _____

_____ Representatives Name

_____ Signature

THE GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION
4058 Minnesota, Avenue, N.E.
WASHINGTON, DC 20019
(202) 671-1000

Date of This Report: _____

Employee Social Security No. _____

Employer Identification No. _____

Insurer No. _____

MEDICAL REPORT

IMPORTANT – THIS REPORT SHALL BE FILED IMMEDIATELY. FAILURE TO COMPLY WITHIN TWENTY (20) DAYS CAN RESULT IN UNNECESSARY DELAY IN PAYMENT OF BENEFITS TO THE INJURED WORKER AND PAYMENT FOR SERVICES RENDERED. (sec. 8, d)

EMPLOYEE _____
(Name) (Age) (Sex) (Soc. Sec. No.)

EMPLOYER _____
(Name) (Address) (Identification No.)

CARRIER _____
(Name) (Address) (Policy No.)

PHYSICIAN _____
(Name) (Address) (Specialty) (Tel. No.)

FOR USE OF PHYSICIAN

Accident	1. Date of accident: _____ 2. Time :_____AM/PM 3. Date disability began: _____ 4. State where and how the accident occurred as described by patient: _____
Injury	5. Give diagnosis of injury or disease: _____ 6. Will the injury result in a permanent defect? _____7. If so, what? _____ 8. Has the patient any physical impairment due to previous injury or disease? _____ If so, what? _____ 9. State physical limitations, if any: _____ 10. In your opinion is the injury and disability as a result of the accident described in (4) above? ☐ Yes ☐ No
Treatment	11. Date of your first treatment: _____ 12. Describe: _____ 13. Who engaged your services? _____ 14. Were X-Rays taken? ☐ Yes ☐ No 15. When? _____ 16. Where? _____ 17. X-Ray diagnosis: _____ 18. Did anyone else treat the patient? ☐ Yes ☐ No 19. If so, who? _____ 20. When? _____ 21. Hospital, if any? _____ 22. Admission Date: _____ 23. Discharge Date:_____ 24. If further treatment needed? ☐ Yes ☐ No 25. How long? _____
Disability	26. Will the patient ever be able to resume their regular occupation? ☐ Yes ☐ No 27. Expected length of disability? ☐ 2 weeks ☐ 1 month ☐ 3 months ☐ 6 months or longer ☐ Unknown 28. Patient was or will be able to resume regular work on: _____ 30. Date of death, if any? _____

_____
Physician's IRS Number

_____
Physician's Signature

_____
Date

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Medical History Request

Employee Name

Date of Injury

Employer Name

Completion Date

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

Thank you for your cooperation.

Past Injuries, Disabilities, or Other Medical Conditions

Hospitalizations

Hospital Name & Address	Phone	Date(s) Adimitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

RESET FORM

PRINT THIS FORM

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKERS' COMPENSATION
4058 MINNESOTA AVENUE, N.E.
WASHINGTON, D.C. 20019

(202) 671-1000

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_____
Date of This Report

_____
Employee Social Security No.

_____
Employer Identification No.

_____
Insurer No.

EMPLOYEE'S CLAIM APPLICATION

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

NOTICE TO EMPLOYEE

A CLAIM FOR WORKERS' COMPENSATION BENEFITS HAS BEEN FILED WITH THIS OFFICE. YOU HAVE 14 DAYS FROM THE RECEIPT OF THIS NOTICE IF YOU HAVE NO PREVIOUS KNOWLEDGE OF INJURY OR ITS RELATIONSHIP TO EMPLOYMENT, TO BEGIN VOLUNTARY PAYMENTS OF WORKERS' COMPENSATION BENEFITS TO THE ABOVE NAMED EMPLOYEE, OR YOU MUST FILE A NOTICE OF CONTROVERSION, MEMO OF DENIAL OF BENEFITS, FORM NO. 11 DCWC WITH THIS OFFICE. FAILURE TO PAY BENEFITS, UNLESS YOU CONTROVERT THE EMPLOYEE'S RIGHT TO BENEFITS, WILL SUBJECT YOU TO PENALTIES UNDER THE ACT. YOU SHOULD CONTACT YOU INSURER IMMEDIATELY.

Date and Time of Injury: _____ am/pm? Office Representative _____

Place where injury occurred: _____

Description of Injury: _____

_____

THIS IS TO NOTIFY YOU _____

That while in the employ of the above named employer I sustained a disabling injury ☐ or contracted an occupational disease ☐ as described above. The disability was caused by: _____

Treating Physician's Name and Address: _____

_____

YOU SHOULD HAVE ALREADY FILED OR SHOULD FILE EMPLOYEE'S NOTICE OF ACCIDENTIAL INJURY OR OCCUPATIONAL DISEASE, FORM NO. 7 DCWC.

I HAVE FILED THE CLAIM WITH THE OFFICE OF WORKERS' COMPENSATION.

FORM NO. 7A DCWC

_____
(Employee's Signature)

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

RESET FORM

PRINT THIS FORM

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Informe de Incidente del Empleado

A ser completado por el trabajador lesionado.

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Hora en que usted empezó a trabajar el día del incidente

Dirección del Incidente

Ciudad, Estado

Código Postal

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

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

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

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

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

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

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

¿Qué hizo después de ocurrido el incidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario

RESTABLECER FORMULARIO

IMPRIMIR FORMULARIO

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Supervisor's Report of Employment Incident

Employee Name

Employer Name

Date of Incident

Time of incident

Time the employee began work on day of incident

Did the employee report the incident immediately? Yes or No

Address of Incident

City, State

Zip

Offsite? (Y/N) No

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

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

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

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

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

Supervisor's Report of Employment Incident

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

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

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

The above form is true and correct.

Prepared by

Signature

Date Completed

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Workers Compensation Division ™

Informe de Incidente del Supevisor

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente? Si/No

Dirección del Incidente

Ciudad, Estado

Código Postal

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

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

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

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

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

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

Informe de Incidente del Supevisor

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

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

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

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración:

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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
By EVERNORTH

Temporary Prescription Card

To the Injured Worker:

On your first visit, please give this form to any pharmacy listed on the back side to speed processing of your approved work-related injury prescriptions (based on the guidelines established by your employer).

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

Atencion Trabajador Lesionado:

En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador).

¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

ID#: _____
Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: G3YA

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

Employee Information

_____
Full Name

_____
Street Address or PO Box

_____
City State ZIP

_____
Date of Birth

_____
Employer Name

To the Pharmacist:

MyMatrixx 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, please call MyMatrixx at 888.786.9640.

Processing Steps:

1. Enter RxBin 003858
2. Enter PCN WC
3. Enter Rx Group Number G3YA
4. Enter 9-digit member ID (Patient SSN)
5. Enter Date of Injury

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

MyMatrixx
By EVERNORTH

Participating Pharmacy List

AHF PHARMACY
AHOLD CORPORATION
ALBERTSONS
ALIGNRX LLC
AMERITA INC
AURORA PHARMACY INC
BIG Y FOODS INC
BI-LO HOLDINGS LLC
BROOKS/MAXI DRUG
BROOKSHIRE BROTHERS LTD
BROOKSHIRE GROCERY CO
CARDINAL HEALTH
CHEN NEIGHBORHOOD MEDICAL CENT
COBORN'S INC.
COSTCO WHOLESALE, INC
CVS CORP
DEDICATED US HOLDINGS LLC
DISCOUNT DRUG MART
ECKERD
EPIC PHARMACY NETWORK
ESSENTIA HEALTH
EXPRESS RX
FAIRVIEW PHARMACY SVCS
FAMILY FARE, LLC
FOOD LION PHARMACY
FRUTH PHARMACY
GENOA HEALTHCARE LLC
GIANT EAGLE PHARMACY
GUARDIAN PHARMACY LLC
HAC INC
HANNAFORD BROS. CO.
HARPS FOOD STORES INC
HARTIG DRUG
HEALTH MART ATLAS LLC
H-E-B LP
HENRY FORD HEALTH SYSTEM
HOMETOWN PHARMCY INC
HY-VEE FOOD STORES INC
INGLES MARKETS
INSTYMEDS CORP
KPH HEALTHCARE SERVICES
KS PHARM LLC
K-VA-T FOOD STORES INC
LEWIS DRUGS INC
LONGS DRUG STORE
MARC GLASSMAN INC
MEDICAP PHARMACY, INC.
MEDICINE SHOPPE
MEIJER PHARMACY
MERCY PHARMACY SERVICES
NCS HEALTHCARE
NEIGHBORCARE PHARMACY
OSBORN DRUGS INC
PATIENT FIRST
PHARMEDQUEST PHARMACY
PHARMERICA, INC
PMR US HOLDINGS
PRESBYTERIAN MEDICAL
PRESCRIBEIT RX
PRICE CHOPPER PHARMACY
PUBLIX SUPER MARKETS, INC
RALEY'S
RECEPT PHARMACY LP
RITE AID CORPORATION
SAFEWAY, INC.
SAM'S CLUB
SUPERVALU PHARMACIES, INC.
TARGET
THRIFTY WHITE STORES
TOPS MARKETS LLC
UNITED SUPERMARKETS INC
WALGREENS
WAL-MART
WEGMANS FOOD MARKETS,
WEIS MARKETS INC

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

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.

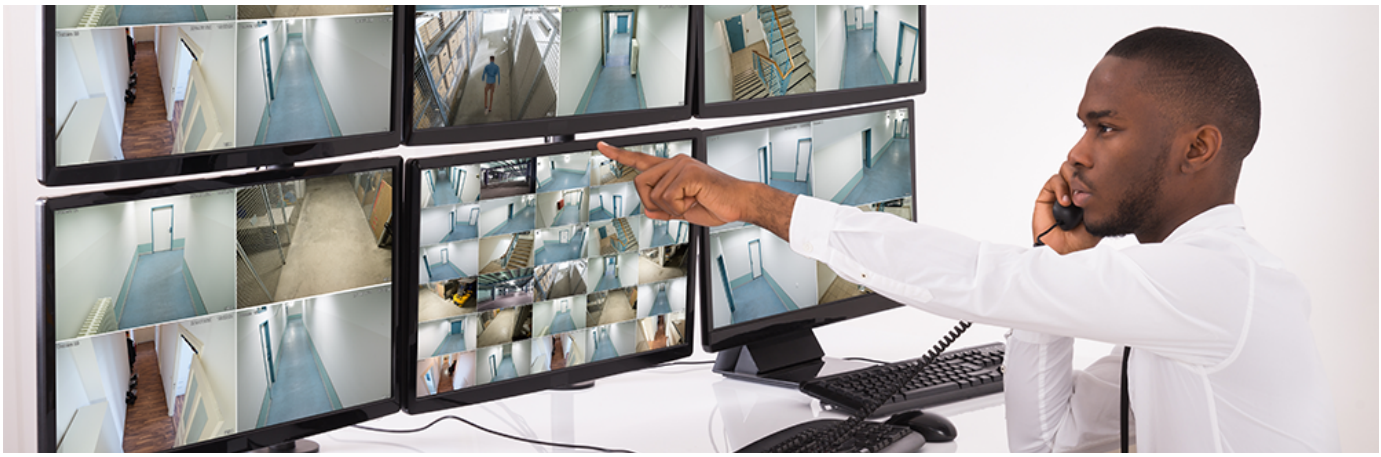
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

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.