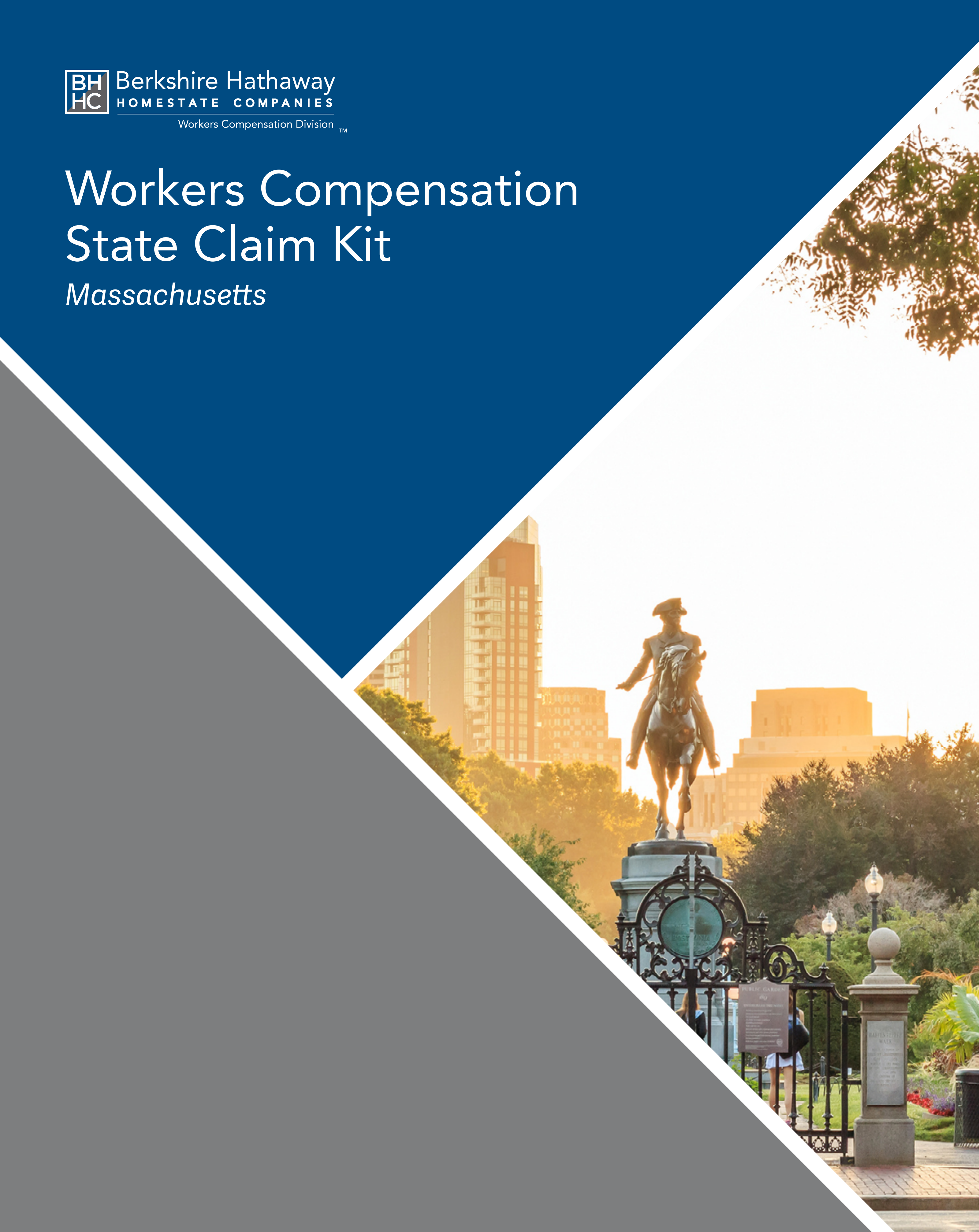


# Workers Compensation State Claim Kit

*Massachusetts*

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P.O. Box 881236 San Francisco, CA 94188
(888) 495-8949
bhhc.com

## Dear Policyholder,

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

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

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

Massachusetts 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

### Phone

(800) 661-6029

### Fax

(800) 661-6984

### E-mail

newclaim@bhhc.com

# Workers Compensation Posting Requirements

## Notice to Employees Poster

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

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

- Name of your designated insurance company
- Policy number and effective dates (start and end)
- Name, address, and phone number of your insurance agent
- Your company name and address
- Name of your company workers' compensation officer (if any)
- Date
- Name and address of a local hospital to provide emergency medical treatment

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

(Annotated Laws of Massachusetts 152 § 21 and § 22)

# NOTICE TO EMPLOYEES

**THE COMMONWEALTH OF MASSACHUSETTS**
**DEPARTMENT OF INDUSTRIAL ACCIDENTS**

## IF YOU ARE INJURED ON THE JOB:

- **Immediately notify your employer that you have been injured.**

Employer HR/Workers' Compensation Contact | Phone Number

- **Tell the medical provider that you have been injured at work and give the information below:**

Insurance Carrier | Address | Phone Number

Employer | Address

- **If the employer fails to report the injury to the insurer, the employee may file an Employee's Claim (Form 110).**
- **Additional information regarding your rights and eligibility for benefits pursuant the Workers' Compensation law may be obtained by contacting the Department of Industrial Accidents at 617.727.4900 or visiting www.mass.gov/dia.**

## IF MEDICAL TREATMENT IS NEEDED:

**Injured workers may select their own medical provider. Medical treatment costs that are reasonable, necessary, and related to the work injury will be paid by the above-named insurer.**

**If medical facility information is provided below, the above-named insurer has a preferred provider arrangement and the insurer has arranged for your initial treatment at:**

Medical Facility: | Address:

Phone Number:

EMPLOYER: THIS NOTICE MUST BE FILLED OUT AND POSTED WHERE EMPLOYEES CAN READ IT PURSUANT M.G.L. C. 152, SECTIONS 21, 22, 30, AND 75B (2). EMPLOYERS MAY NOT RETALIATE, DISCRIMINATE (IN ACCORDANCE WITH ANY APPLICABLE STATE OR FEDERAL LAWS WHICH INCLUDES IMMIGRATION STATUS), OR PROVIDE FALSE INFORMATION ABOUT THE WORKERS' COMPENSATION PROCESS TO THEIR EMPLOYEES. THIS NOTICE MUST BE UPDATED, POSTED AND REDISTRIBUTED WHEN THERE ARE CHANGES TO THE INFORMATION.

REVISED JUNE 2024

# AVISO PARA EMPLEADOS

## COMMONWEALTH DE MASSACHUSETTS
## DEPARTAMENTO DE ACCIDENTES INDUSTRIALES

## SI USTED TIENE UN ACCIDENTE EN EL TRABAJO:

- **Avise inmediatamente a su empleador que tuvo un accidente.**

Contacto de RH del Empleador/Indemnización por Accidente Laboral ____________________ Número de Teléfono ____________________

- **Avise al proveedor médico que usted tuvo un accidente en el trabajo y proporcione la siguiente información:**

Compañía de Seguros ____________________ Dirección ____________________ Número de Teléfono ____________________

Empleador ____________________ Dirección ____________________

- **Si el empleador no informa el accidente a la compañía de seguros, el trabajador puede presentar un Reclamo del Empleado (Form. 110).**
- **Puede contactar al Departamento de Accidentes Industriales a través del 617.727.4900 o www.mass.gov/dia para obtener información adicional sobre sus derechos y elegibilidad para los beneficios según la ley de Indemnización por Accidentes de Trabajo.**

## SI SE REQUIERE TRATAMIENTO MÉDICO:

**Los trabajadores que resulten lesionados pueden elegir sus propios proveedores médicos. Los costos por tratamientos médicos que sean razonables, necesarios y relativos al accidente laboral serán pagados por la compañía aseguradora que se menciona anteriormente.**

**Si se incluye información de una institución médica a continuación, significa que la compañía aseguradora mencionada tiene un acuerdo con un proveedor de preferencia para que su tratamiento inicial se realice en:**

Institución Médica: ____________________ Dirección: ____________________

Número de Teléfono: ____________________

EMPLEADOR: ESTE AVISO DEBE COMPLETARSE Y PUBLICARSE EN UN LUGAR EN EL QUE LOS EMPLEADOS PUEDAN LEERLO, TAL COMO SE ESTABLECE EN M.G.L. C. 152, SECCIONES 21, 22, 30 Y 75B (2). LOS EMPLEADORES NO PODRÁN TOMAR REPRESALIAS, DISCRIMINAR (SEGÚN LO ESTABLECIDO PARA CUALQUIERA DE LAS LEYES ESTATALES O FEDERALES APLICABLES, INCLUYENDO LA CONDICIÓN MIGRATORIA), NI BRINDAR INFORMACIÓN FALSA SOBRE EL PROCESO DE INDEMNIZACION POR ACCIDENTE LABORAL A SUS EMPLEADOS. ESTE AVISO DEBE ACTUALIZARSE, PUBLICARSE Y DISTRIBUIRSE CADA VEZ QUE SE PRODUZCAN CAMBIOS EN LA INFORMACIÓN.

REVISADO EN JUNIO DE 2024

# NOTIFICAÇÃO AOS EMPREGADOS

**Estado de Massachusetts**

**Departamento de Acidentes Industriais**

## SE VOCÊ SE FERIR NO TRABALHO:

- **Notifique imediatamente seu empregador de que se feriu.**

Contato do Departamento de RH/Indenização Trabalhista do Empregador ______ Telefone ______

- **Diga ao seu provedor de serviços médicos que se feriu no trabalho e dê a ele as seguintes informações:**

Seguradora ______ Endereço ______ Telefone ______

Endereço do empregador ______

- **Se o empregador não informar o ferimento à seguradora, o empregado pode fazer um Requerimento do Empregado (Formulário 110).**
- **Para obter mais informações a respeito de seus direitos e sua elegibilidade de acordo com a Lei de Indenização Trabalhista (Workers' Compensation Law), contate o Departamento de Acidentes Industriais pelo telefone 617.727.4900 ou acesse www.mass.gov/dia.**

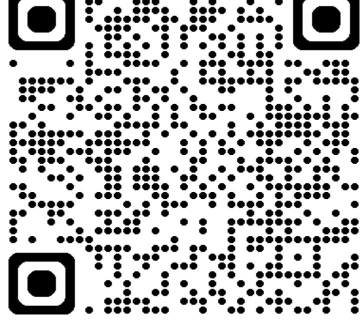
## SE FOR NECESSÁRIO TRATAMENTO MÉDICO:

**Os empregados feridos podem selecionar seus próprios provedores de serviços médicos. Custos razoáveis e necessários do tratamento médico, e que estejam relacionados à lesão serão pagos pela seguradora indicada acima.**

**Se informações sobre a instalação médica estão fornecidas abaixo, a seguradora indicada acima tem um acordo de provedores preferenciais e a seguradora tem um acordo para seu tratamento inicial em:**

Instalação médica: ______ Endereço: ______

Telefone: ______



EMPREGADOR: ESTA NOTIFICAÇÃO DEVE SER PREENCHIDA E AFIXADA EM UM LOCAL ONDE OS EMPREGADOS POSSAM LÊ-LA, DE ACORDO COM AS M.G.L. (LEIS GERAIS DE MASSACHUSSETS) C. 152, SEÇÕES 21, 22, 30 E 75B (2). OS EMPREGADORES NÃO PODEM RETALIAR, DISCRIMINAR (DE ACORDO COM AS LEIS ESTADUAIS OU FEDERAIS APLICÁVEIS, INCLUINDO A SITUAÇÃO IMIGRATÓRIA), OU FORNECER INFORMAÇÕES FALSAS SOBRE O PROCESSO DE INDENIZAÇÃO TRABALHISTA A SEUS EMPREGADOS. ESTA NOTIFICAÇÃO DEVE SER ATUALIZADA, AFIXADA E REDISTRIBUÍDA QUANDO HOUVER MUDANÇAS NAS INFORMAÇÕES.

REVISADA EM JUNHO DE 2024

# 员工的通知

## 马萨诸塞州工业事故部门

## 如果你在工作中受伤:

- **立即通知您的雇主您受伤了.**

雇主人力资源部/工伤赔偿联系 ______________________ 电话 ______________________

- **告诉医务人员您在工作中受伤,并提供以下信息:**

保险公司 ______________ 地址 ______________ 电话 ______________

雇主 ______________ 地址 ______________

- **如果雇主未能向保险公司报告受伤情况,员工可以提交员工索赔（表格 110）.**
- **附加信息关于您的权利和享受福利的资格根据工人赔偿法, 您可以致电 617.727.4900 联系工业事故部或游览 www.mass.gov/dia.**

## 如果需要治疗:

**受伤的工人可自行选择医疗机构. 合理的费用, 必要的治疗, 和上述的保险公司将支付与工伤相关的医疗费用.**

**如果下面提供了医疗机构信息, 上述保险公司有优先医疗权安排治疗 服务,并且保险公司已安排您在:**

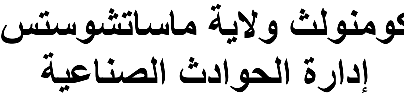
医疗机构: ______________ 地址: ______________

电话: ______________

**雇主：根据 M.G.L. C. 152 第 21、22、30 和 75B (2) 条，必须填写本通知并将其张贴在员工可以阅读的地方。雇主不得报复、歧视（根据任何适用的州或联邦法律，包括移民身份）或向其员工提供有关工人赔偿流程的虚假信息。当信息发生变化时，必须更新、张贴和重新分发本通知.**

REVISED JUNE 2024

# إشعار إلى الموظفين



## إذا تعرضت للإصابة في العمل:

- **أخبر جهة العمل على الفور أنك قد أُصِبت.**

طرف الاتصال بإدارة الموارد البشرية/ إدارة شؤون تعويضات العمال التابعة لجهة العمل     رقم الهاتف

- **أخبر مقدم الخدمة الطبية أنك قد أُصِبت في العمل وقدم المعلومات أدناه:**

اسم شركة التأمين     العنوان     رقم الهاتف

---

جهة العمل     العنوان

---

- **إذا فشلت جهة العمل في الإبلاغ عن الإصابة إلى شركة التأمين، يمكن للموظف تقديم مطالبة الموظف (النموذج 110).**
- **يمكن الحصول على معلومات إضافية حول حقوقك وأهليتك للحصول على الإعانات وفقاً لقانون تعويض العمال عن طريق الاتصال بإدارة الحوادث الصناعية على رقم الهاتف 617.727.4900 أو زيارة الرابط www.mass.gov/dia.**

## إذا كانت هناك حاجة إلى العلاج الطبي:

**يمكن للعمال المصابين اختيار مقدم الرعاية الطبية الخاص بهم. سيتم دفع تكاليف العلاج الطبي المعقولة والضرورية والمتعلقة بإصابة العمل من قبل شركة التأمين المذكورة أعلاه.**

**إذا تم تقديم معلومات المنشأة الطبية أدناه، فإن شركة التأمين المذكورة أعلاه لديها ترتيب مقدم خدمة مفضّل وقد قامت شركة التأمين بترتيب علاجك الأولي في:**

المنشأة الطبية:     العنوان:

______________________

رقم الهاتف:

______________________

**جهة العمل: يجب ملء هذا الإشعار ونشره حيث يمكن للموظفين قراءته وفقاً للقانون العام لولاية ماساتشوستس (M.G.L.C. 152، الأقسام 21، و22، و30، و(2) 75B). لا يجوز لجهات العمل الانتقام أو التمييز (وفقاً لأي قوانين تابعة للولاية أو قوانين اتحادية معمول بها بما في ذلك وضع الهجرة) أو تقديم معلومات خاطئة عن عملية تعويض العمال لموظفيهم. يجب تحديث هذا الإشعار ونشره وإعادة توزيعه عند حدوث تغييرات على المعلومات.**

روجع في يونيو/ حزيران 2024

# AVISO PA FUNCIONÁRIUS

## DEPARTAMENTU DI ACIDENTIS INDUSTRIAL DI COMMONWEALTH DI MASSACHUSETTS

## SI BU SUFRI UM ACIDENTI DI TRABADJU:

- **Notifica imediatamenti bu empregador ma bu sufri um acidenti.**

Contactu di RH/Compensazon di Trabadjadores di Empregador ______________________ Número de telefoni ______________________

- **Informa provedor médico ma bu sufri um acidenti di trabadju e das kes informazons abaixu:**

Nomi de seguru Direson Número de telefoni

______________________________________________

Empregador Direson

______________________________________________

- **Si empregador ka comunica acidenti pa seguradora, funcionáriu pode presenta um Reclamason di Funcionáriu (Formulário 110).**
- **Informazons adicionais sobre bus direitus e elegibilidade pa benefícius di acordo ku lei de Indenizason di Trabadjadores podi ser obtidu ntrandu em contatu ku Departamentu di Acidenti Industrial pa telefoni 617.727.4900 ou pa site www.mass.gov/dia.**

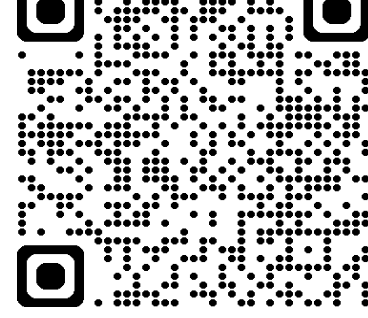
## SI TRATAMENTU MÉDICO FOR NECESSARIU:

**Trabadjadores acidentadus podi scodji se própriu provedor médico. Custus di tratamentu médico ki for razoável, necessariu e relacionadus a acidenti di trabadju ta ser pagus pa seguradora mencionadu diriba.**

**Si informazons sobri estabelecimentu médico for fornecidus abaixu, seguradora mencionadu diriba tem um acordu di provedor preferencial e seguradora providencia si tratamentu inicial na:**

Instalazons médicus: ______________________ Direson: ______________________

Número de telefoni: ______________________



**EMPREGADOR: ES AVISU DEVI SER PREENCHIDU E AFIXADU NA UM LOCAL UNDI FUNCIONÁRIUS PODI LÊL, DI ACORDU KU M.G.L. C. 152, SEKSONS 21, 22, 30 i 75B (2). EMPREGADORES KA PODI RITALIA, DISCRIMINA (DI ACORDU KU KUALKUER LEI ESTADUAL OU FEDERAL APLICÁVEL, KI TA INCLUI STATUS DI IMIGRASON) OU FORNICE INFORMASONS FALSUS SOBRI PROCESSU DI INDENIZASON DI TRABADJADORIS A SES FUNCIONÁRIUS. ES AVISU DEVI SER ATUALIZADU, PUBLICADU E REDISTRIBUÍDU HORAS KI OUVER ALTERASONS NAS INFORMASONS.**

REVISED JUNE 2024

# AVI POU TOUT ANPLWAYE

## THE COMMONWEALTH OF MASSACHUSETTS
## DEPATMAN AKSIDAN ENDISTRYÈL (DIA)

## SI OU VIKTIM YON AKSIDAN PANDAN OU NAN TRAVAY OU :

- **Fè anplwayè w konnen touswit ke ou sot viktim yon aksidan.**

Reponsab Resous Imèn (HR) Anplwayè a/Kontak Konpansasyon Travayè ______________________ Nimewo Telefòn ______________

- **Di pèsonèl medikal kap ba w swen a ke se pandan ou te nan travay ke ou te fè yon aksidan ki andomaje w; epi tou, ba l enfòmasyon ki anba yo:**

Konpayi Asirans ______________ Adrès ______________ Nimewo Telefòn ______________

Anplwayè ______________ Adrès ______________

- **Si anplwayè a pa rapòte aksidan an oswa andomajman an bay konpayi asirans la, travayè a ta dwe ranpli yon Fòm Reklamasyon Anplwaye (Fòm 110).**
- **Ou ka jwenn plis enfòmasyon konsènan dwa w ak kondisyon ki nesesè pou kalifye pou benefis an akò ak lwa sou Konpansasyon Travayè, si w kontakte Depatman Aksidan Endistriyèl la (DIA) nan nimewo 617.727.4900 oswa si w vizite sit entènèt www.mass.gov/dia la.**

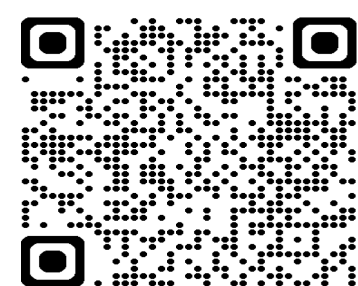
## SI YON TRETMAN MEDIKAL NESESÈ:

**Travayè ki viktim yon aksidan ka chwazi pwòp founisè sèvis medikal yo. Depi depans pou trètman medikal la rezonab, li nesesè, epi li gen rapò ak aksidan moun nan te sibi nan travay la, konpayi asirans li te deklare anwo nan fòm la ap peye pou yo.**

**Si nan etablisman sante ki liste anba a, konpayi asirans ou te deklare nan fòm la gen yon aranjman ki pi favorab ak youn ladan yo, konpayi asirans la gen pou notifye w ke li deja fè aranjman pou kòmanse tretman ou a nan etablisman sa a:**

Etablisman Medikal: ______________ Adrès: ______________

Nimewo Telefòn: ______________



ENFÒMASYON MIZAJOU AN JEN 2024

**ANPLWAYÈ: AN KONFÒMITE AK SEKSYON 21, 22, 30, AK 75B (2) NAN M.G.L. C. 152 AVI SA A FÈT POU RANPLI EPI AFICHE KOTE TOUT TRAVAYÈ YO KA WÈ L. ANPLWAYÈ YO PA GEN DWA PRAN VANJANS SOU TRAVAYÈ YO, DISKRIMINE KONT YO (SOU BAZ ANKENN LWA ETA A, OSWA LWA FEDERAL KI GEN POU WÈ AK KESYON SITIYASION IMIGRASYON), NI TOU BAYO MOVE ENFÒMASYON SOU PWOSESIS KONPANSASYON POU TRAVAYÈ. ANPLWAYÈ YO DWE FÈ MIZAJOU AVI SA A, AFICHE L EPI REDISTRIBYE L CHAK FWA GEN CHANJMAN NAN ENFÒMASYON AN.**

# ការជូនដំណឹងដល់និយោជិត

## នាយកដ្ឋានឧស្សាហកម្មឧប្បត្តិហេតុនៃរដ្ឋ MASSACHUSETTS

## ប្រសិនបើអ្នករងរបួសនៅកន្លែងធ្វើការ៖

- ជូនដំណឹងដល់និយោជករបស់អ្នកភ្លាមៗថាអ្នកបានរងរបួស។

លេខទូរស័ព្ទទំនាក់ទំនង

និយោជកប្រភពមនុស្ស (HR)/ ប្រាក់សំណងរបស់កម្មករ

- ប្រាប់អ្នកផ្តល់សេវាវេជ្ជសាស្ត្រ ថាអ្នកត្រូវបានរងរបួសនៅកន្លែងធ្វើការ និងផ្តល់ព័ត៌មានខាងក្រោម៖

ឈ្មោះ

អាសយដ្ឋាន

លេខទូរស័ព្ទអ្នកធានារ៉ាប់រង

អាសយដ្ឋាន

និយោជក

- ប្រសិនបើនិយោជកមិនបានរាយការណ៍អំពីការរងរបួសទៅអ្នកធានា និយោជិតដាក់ការប្តឹងទាមទាររបស់និយោជិត (ទម្រង់ 101)។
- ព័ត៌មានបន្ថែមទាក់ទងនឹងសិទ្ធិ និងសិទ្ធិទទួលបានអត្ថប្រយោជន៍របស់អ្នកដោយយោងតាមច្បាប់ ស្តីពីសំណងរបស់កម្មករអាចទទួលបានដោយទាក់ទងនាយកដ្ឋានគ្រោះថ្នាក់ឧស្សាហកម្មតាមរយៈលេខ 617.727.4900 ឬចូលទៅកាន់ www.mass.gov/dia.

## បើការព្យាបាលខាងវេជ្ជសាស្ត្រគឺត្រូវការចាំបាច់៖

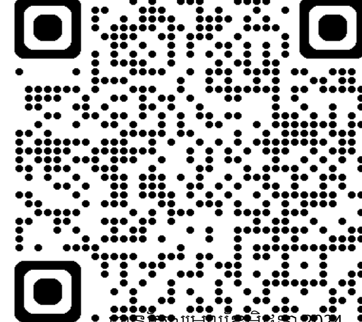
កម្មកររងរបួសអាចជ្រើសរើសអ្នកផ្តល់សេវាវេជ្ជសាស្ត្ររបស់ខ្លួនផ្ទាល់។ ថ្លៃព្យាបាលដែលសមហេតុ ផលចាំបាច់ និងទាក់ទងនឹងរបួសការងារ នឹងត្រូវបង់ដោយក្រុមហ៊ុនធានារ៉ាប់រងដែលមានឈ្មោះខាងលើ។

ប្រសិនបើព័ត៌មានអំពីមណ្ឌលសុខភាពត្រូវបានផ្តល់ជូនខាងក្រោម អ្នកធានាដែលមាន ឈ្មោះខាងលើមានការរៀបចំអ្នកផ្តល់សេវា ដែលពេញចិត្ត ហើយក្រុមហ៊ុនធានារ៉ាប់រងបាន រៀបចំសម្រាប់ការព្យាបាលដំបូងរបស់អ្នកនៅ៖

ស្ថាប័នវេជ្ជសាស្ត្រ៖

អាសយដ្ឋាន៖

លេខទូរស័ព្ទ៖



និយោជក៖ សេចក្តីជូនដំណឹងត្រូវតែបានបំពេញ និងដាក់តាំងនៅទីកន្លែងដែលនិយោជិតទាំងឡាយអាចអានវា អនុលោម M.G.L. C. 152, SECTIONS 21, 22, 30, AND 75B (2). និយោជកមិនអាចសងសឹក រើសអើង (ស្របតាមរដ្ឋដែលអាចអនុវត្តបាន ឬច្បាប់សហព័ន្ធដែលរួមបញ្ចូលស្ថានភាពអន្តោប្រវេសន៍) ឬផ្តល់ព័ត៌មានមិនពិតអំពីសំណងរបស់កម្មករនិយោជិត។ សេចក្តីជូនដំណឹងនេះត្រូវតែមានបច្ចុប្បន្នភាពដាក់តាំង នឹងចែករំលែកម្តងហើយម្តងទៀត នៅពេលមានការផ្លាស់ប្តូរចំពោះព័ត៌មាន។

បានកែសម្រួលខែមិថុនា 2024

# THÔNG BÁO DÀNH CHO CÔNG NHÂN

**PHÒNG TAI NẠN CÔNG NGHIỆP CỦA COMMONWEALTH MASSACHUSETTS**

## NẾU BẠN BỊ THƯƠNG TẠI NƠI LÀM VIỆC:

- **Báo tin ngay cho người chủ nhân/công ty của bạn rằng mình bị thương.**

Liên lạc với văn phòng nhân sự / Bồi thường tai nạn của công ty Số điện thoại

- **Báo cho phòng khám bệnh biết rằng bạn bị thương tại nơi làm việc và cung cấp thông tin bên dưới:**

Tên hãng bảo hiểm | Địa chỉ | Số điện thoại

Tên chủ nhân/công ty | Địa chỉ

- **Nếu công ty không báo thương tích lên cho hãng bảo hiểm, công nhân có thể nộp hồ sơ mẫu 110 xin yêu cầu bồi thường.**
- **Thông tin bổ sung về quyền của bạn và khả năng hội đủ điều kiện nhận phúc lợi theo Quy định của luật bồi thường tai nạn, công nhân có thể nhận lấy thông tin bằng cách liên hệ với phòng tai nạn công nghiệp tại số 617.727.4900 hoặc truy cập www.mass.gov/dia.**

## NẾU CẦN ĐIỀU TRỊ Y TẾ:

**Người công nhân bị thương có thể chọn trung tâm khám bệnh, bác sĩ của họ. Các chi phí điều trị hợp lý, cần thiết và liên quan đến thương tích sẽ do hãng bảo hiểm của công ty nêu trên chi trả.**

**Nếu thông tin phòng khám bệnh được cung cấp dưới đây, hãng bảo hiểm ở trên có sự sắp xếp ưu tiên với phòng khám và hãng bảo hiểm đã sắp xếp việc điều trị ban đầu cho bạn tại:**

Phòng khám: | Địa chỉ:

Số điện thoại:

**: THÔNG BÁO NÀY PHẢI ĐƯỢC ĐIỀN VÀ ĐĂNG Ở NƠI NHÂN VIÊN CÓ THỂ ĐỌC THEO M.G.L. C. 152, MỤC 21, 22, 30 và 75B (2). CÔNG TY KHÔNG ĐƯỢC KHÔNG TRẢ ĐÁP, PHÂN BIỆT ĐỐI XỬ (PHÙ HỢP VỚI BẤT KỲ LUẬT LIÊN BANG HIỆN HÀNH NÀO BAO GỒM TÌNH TRẠNG DI CƯ), HOẶC CUNG CẤP THÔNG TIN SAI VỀ QUY TRÌNH BỒI THƯỜNG TAI NẠN CÔNG NGHIỆP DÀNH CHO NHÂN VIÊN CỦA HỌ. THÔNG BÁO NÀY PHẢI ĐƯỢC CẬP NHẬT, ĐĂNG VÀ PHÂN PHỐI LẠI KHI CÓ THÔNG TIN THAY ĐỔI.**

REVISED JUNE 2024

# WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

| EMPLOYER (NAME & ADDRESS INCL ZIP) | CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE |
|---|---|---|---|
| | JURISDICTION | JURISDICTION CLAIM NUMBER | |
| | INSURED REPORT NUMBER | | |
| | EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | | LOCATION # |
| INDUSTRY CODE / EMPLOYER FEIN | | | PHONE # |

## CARRIER/CLAIMS ADMINISTRATOR

| CARRIER (NAME, ADDRESS, & PHONE #) | POLICY PERIOD<br>TO<br>CHECK IF APPROPRIATE<br>☐ SELF INSURANCE | CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) |
|---|---|---|
| CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN |
| AGENT NAME & CODE NUMBER | | |

## EMPLOYEE/WAGE

| NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE |
|---|---|---|---|---|
| ADDRESS (INCL ZIP) | SEX<br>M MALE<br>F FEMALE<br>U UNKNOWN | MARITAL STATUS<br>U UNMARRIED SINGLE/DIVORCED<br>M MARRIED<br>S SEPARATED<br>K UNKNOWN | OCCUPATION/JOB TITLE<br>EMPLOYMENT STATUS | |
| PHONE | # OF DEPENDENTS | | NCCI CLASS CODE | |

| RATE PER: | ☐ DAY ☐ WEEK | ☐ MONTH OTHER: | DAYS WORKED/WEEK | FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO<br>DID SALARY CONTINUE? ☐ YES ☐ NO |
|---|---|---|---|---|

## OCCURRENCE/TREATMENT

| TIME EMPLOYEE BEGAN WORK | ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE<br>( ) CANNOT BE DETERMINED | ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN |
|---|---|---|---|---|---|---|---|

| CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED |
|---|---|---|
| DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE |

| DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED |
|---|---|
| SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED |

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

| DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO<br>WERE THEY USED? ☐ YES ☐ NO |
|---|---|---|

| PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS) | HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS) | INITIAL TREATMENT<br>0 NO MEDICAL TREATMENT<br>1 MINOR: BY EMPLOYER<br>2 MINOR CLINIC/HOSP<br>3 EMERGENCY CARE<br>4 HOSPITALIZED > 24 HOURS<br>5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED |
|---|---|---|

## OTHER

WITNESSES (NAME & PHONE #)

| DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER |
|---|---|---|---|

FORM IA-1(r 1-1-02) SEE BACK FOR IMPORTANT INFORMATION

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## EMPLOYER'S INSTRUCTIONS

**DO NOT ENTER DATA IN SHADED FIELDS**

DATES:
Enter all dates in MM/DD/YY format.

INDUSTRY CODE:
This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:
The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

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

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

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

EMPLOYMENT STATUS:
Indicate the employee's work status.  The valid choices are:

| | | | |
|---|---|---|---|
| Full-Time | On Strike | Unknown | Volunteer |
| Part-Time | Disabled | Apprenticeship Full-Time | Seasonal |
| Not Employed | Retired | Apprenticeship Part-Time | Piece Worker |

DATE DISABILITY BEGAN:
The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:
Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:
Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.


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## EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.


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FORM 127

# The Commonwealth of Massachusetts
# Department of Industrial Accidents

**Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750**
**Info. Line (800) 323-3249 Inside Mass. / (857) 321-7470 Outside Mass.**
**www.mass.gov/dia**

DIA USE ONLY

## AVERAGE WEEKLY WAGE COMPUTATION SCHEDULE

**Print or Type**

| 1. Employer's Name and Address: | 2. Insurer's Case File #: |
|---|---|
| | 3. DIA Board # (if known): |
| 4. Employee's Name and Address: | 5. # of dependent children: |
| | 6. # of other dependents: |

| 7. Date of Injury (mm/dd/yyyy): | 8. Date of Disability (mm/dd/yyyy): | 9. Date of Employment (mm/dd/yyyy): |
|---|---|---|

10. Has employee been certified by U.S. Veterans Administration for any type of disability? ☐ Yes ☐ No

**Indicate only those wages earned by the injured worker during the 52 week period immediately preceding the accident. If the injured employee has worked for less than 52 weeks, report wages from the time worked and, for the remaining weeks on this schedule, substitute wages of a fellow employee in the same class of employment who has worked for one year or more.**

| 11. Week No. | Year: Week Ending Month | Day | Gross Amount Before Taxes | Week No. | Year: Week Ending Month | Day | Gross Amount Before Taxes | Week No. | Year: Week Ending Month | Day | Gross Amount Before Taxes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | 19 | | | | 37 | | | |
| 2 | | | | 20 | | | | 38 | | | |
| 3 | | | | 21 | | | | 39 | | | |
| 4 | | | | 22 | | | | 40 | | | |
| 5 | | | | 23 | | | | 41 | | | |
| 6 | | | | 24 | | | | 42 | | | |
| 7 | | | | 25 | | | | 43 | | | |
| 8 | | | | 26 | | | | 44 | | | |
| 9 | | | | 27 | | | | 45 | | | |
| 10 | | | | 28 | | | | 46 | | | |
| 11 | | | | 29 | | | | 47 | | | |
| 12 | | | | 30 | | | | 48 | | | |
| 13 | | | | 31 | | | | 49 | | | |
| 14 | | | | 32 | | | | 50 | | | |
| 15 | | | | 33 | | | | 51 | | | |
| 16 | | | | 34 | | | | 52 | | | |
| 17 | | | | 35 | | | | **Total:** | | | |
| 18 | | | | 36 | | | | | | | |

| 12. Was room furnished to the employee? ☐ Yes ☐ No | 13. If tips or other benefits were earned, describe and state value per week: |
|---|---|

THIS IS A TRUE COPY OF THE PAYROLL RECORD OF THE ABOVE NAMED EMPLOYEE OR FELLOW EMPLOYEE IN THE SAME CLASS OF EMPLOYEMENT

| 14. Name of Fellow Employee (if applicable): | 15. Employer/Preparer Signature: | 16. Date Signed (mm/dd/yyyy): |
|---|---|---|

Make any comments on the reverse side of this form or on a separate sheet.



**Reproduce as needed.**

Comments:

# 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

# 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# Employee Incident Report

This form should be filled out by the injured employee.

Name

Employer Name

Date of Incident

Time of incident

Time you began work on day of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)

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

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

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

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

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

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

What did you do after the incident occurred?

The above form is true and correct.

Signature

Date Completed

# Informe de Incidente del Empleado

A ser completado por el trabajador lesionado.

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Hora en que usted empezó a trabajar el día del incidente

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

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

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

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

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

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

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

¿Qué hizo después de ocurrido el incidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario

# Supervisor's Report of Employment Incident

Employee Name

Employer Name

Date of Incident

Time of incident

Time the employee began work on day of incident

Did the employee report the incident immediately?

Address of Incident

City, State

Zip

Offsite? (Y/N)

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

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

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

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

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

# Supervisor's Report of Employment Incident

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

- Unused/unavailable lifting equipment
- 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

# 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?

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 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:

# 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

# 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!

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# 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!

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# $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.

BHHC has an AM Best Credit Rating of A++ as of February 22, 2024.
For the latest Best Credit Rating, access ambest.com.

# $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 o 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.

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For the latest Best Credit Rating, access ambest.com.