Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation State Claim Kit

Minnesota

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 methods listed to the right.

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

bhhcpolicyholder.bhhc.com/Client/External/Claims

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation Posting Requirements

Workers Compensation Poster

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

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

(Minnesota Statutes § 176.139)

Workers' compensation

If you are injured

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

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

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

Workers' compensation pays for

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

What the insurer must do

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

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

Fraud

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

Insurer name and contact information

Name -

Address - PO BOX 881716 San Francisco, CA 94188

Phone - 800-661-6029

DEPARTMENT OF LABOR AND INDUSTRY

(651) 284-5032 • 1-800-342-5354 • dli.workcomp@state.mn.us • www.dli.mn.gov

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

August 2017

Nyiaj raug mob ntawm hauj lwm

Yog hais tias koj raug mob

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

  Txoj cai cia cov chaw them nyiaj rau kev raug mob ntawm hauj lwm mus muab cov ntaub ntawv qhia txog kev kho mob uas muaj feem rau qhov koj raug mob ntawm hauj lwm uas tsis tas tau kev tso cai los ntawm koj, tiam sis lawv yuav tsum tau xa ib tsab ntawv tuaj qhia rau koj thaum lawv thov cov ntaub ntawv no.

  Lub chaw them nyiaj yuav muab tsis tau lwm cov ntaub ntawv kho mob tshwj tsis yog tias koj tau kos npe rau ib tsab ntawv tso cai lawm tso.
- Mus kom kws kho mob sau ib tsab ntawv tso cai rau koj los so hauj lwm. Tsab ntawv yuav tsum tau sau lub ntsiab kom meej li meej tau.

Nyiaj raug mob ntawm hauj lwm yuav them rau dab tsi

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

Lub chaw them nyiaj yuav tsum tau ua dab tsi

- Lub chaw them nyiaj yuav tsum tau tshawb fawb txog qhov koj thov kom them nyiaj kom sai. Yog hais tias koj muaj kev tsis taus mus ntev tshaj peb hnub, lub chaw them nyiaj yuav tsum tau pib them nyiaj rau koj los sis xa ib tsab ntawv tsis kam them nyiaj ntawd tuaj rau koj ua ntej 14 hnub tom qab koj lub chaw hauj lwm paub tias koj tsis mus ua hauj lwm los sis tsis tau nyiaj ua hauj lwm vim tias koj raug mob.
- **Yog hais tias lub chaw them nyiaj lees them rau qhov koj thov kom them nyiaj pab rau ib feem ntawm koj qhov nyiaj ua hauj lwm uas koj tsis tau thiab koj muaj kev tsis taus mus ntev tshaj peb hnub:** Lub chaw them nyiaj yuav qhia rau koj thiab yuav tsum tau pib them nyiaj pab rau ib feem ntawm koj qhov nyiaj ua hauj lwm uas koj tsis tau ua ntej 14 hnub li tau hais los saud. Lub chaw them nyiaj yuav tsum tau them nyiaj kom ncav sij hawm. Cov nyiaj them rau qhov uas tsis tau nyiaj ua hauj lwm lawm yuav them tib lub sij hawm li lub chaw ua hauj lwm them nyiaj rau koj.
- **Yog hais tias lub chaw them nyiaj tsis kam them nyiaj pab rau ib feem ntawm koj qhov nyiaj ua hauj lwm uas koj tsis tau thiab koj tau muaj kev tsis taus mus ntev tshaj peb hnub:** Lub chaw them nyiaj yuav xa ib tsab ntawv tuaj qhia rau koj ua ntej 14 hnub. Tsab ntawv yuav tsum tau tshab txhais meej meej txog cov lus qhia tseeb thiab yog vim li cas lawv ntseeg tias qhov koj raug mob los sis tus mob ntawd nws tsis yog los ntawm qhov koj ua hauj lwm los sis yog vim li cas qhov kev thov kom them nyiaj pab rau ib feem ntawm koj qhov nyiaj ua hauj lwm uas koj tsis tau ntawd tsis muaj feem rau qhov koj raug mob.

  Yog hais tias koj tsis pom zoo txog qhov uas tsis kam them nyiaj ntawd, nrog lub chaw tuav pov hwm tus neeg tuav koj cov ntaub ntawv thov kom them nyiaj tham tau. Yog hais tias koj tsis txaus siab thiab tseem tsis pom zoo txog qhov uas tsis kam them nyiaj ntawd, **hu rau Minnesota Tuam Tsev Xyuas Txog Kev Ua Hauj Lwm (Department of Labor) thiab Tus Xov Tooj Pab Txog Chaw Hauj Lwm Kev Them Nyiaj Raug Mob Ntawm Hauj Lwm (Industry's Workers' Compensation Hotline) ntawm 1-800-342-5354.**

Kev Dag

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

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

Name -

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

Lub 8 hlis xyoo 2017

Magadhowga Shaqaalaha

Haddii aad dhaawacanto

- U soo sheeg horjoogahaada dhaawac kasta sida ugu dhaqsiyaha badan, iyadoo aan loo eegin sida uu u yaryahay. Waxaa laga yaabaa in aad lumiso waxtarrada ah xaqa magdhowga shaqaalaha haddii aanad waqtiga habboon dhaawaca u soo sheegin loo shaqeeyahaaga. Xadka waqtiga wuxuu noqon karaa ugu yaraan 14 cisho.
- Loo shaqeeyahaaga u sheeg macluumaad badan ee ku saabsan dhaawacagaada hadba sida suurtagalka ah.
- Qaado daawo kasta oo lagama maarmaana sida ugu dhaqsiyaha badan. Haddii caafimaadkaadku aanu daboolayn urur maamul daryeel oo shati haysta (CMCO), waxa aad iska daawayn kartaa hadba dhaqtarka aad doorato. Loo shaqeeyahaagu waa inuu qoraal kugu soo wargeliyaa haddii CMCO uu kaa daboolayo.
- Gacan ku sii codsiyada idil ee ku saabsan macluumaadka quseeya dalabyadaada.

  Sharcigu waxa uu u fasaxayaa caymiyaha maqdhowga shaqaalaha in ay helaan macluumaadka caafimaadka oo la xariira dhaawaca shaqadaada adiga oo aan u fasaxin, laakiin waa in ay qoraal kugu soo wargaliyaan marka ay codsanayaan macluumaadka.

  Caymiyuhu ma heli karo xog kale ee caafimaad haddii aadan saxiixin oggolaasho qoran.
- Ka qaado dhaqtarkaada hubaal-celin qoraala wixii ku saabsan fasax kasta ee shaqada looga tagayo. Ogaysiisku waa inuu qeexnaadaa hadba sida suurtagalka ah.

Shaqaalaha magdhowgiisa wuxuu bixinayaa

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

Maxaa caymiyaha laga doonayaa in uu sameeyo

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

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

Magaca Caymiyaha Khiyaamada

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

Magaca shirkadda caymiska iyo macluumaadka xiriirka

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

Agoosto 2017

Compensación laboral

Si usted se lesiona

- Informe cualquier lesión a su supervisor tan pronto le sea posible; no importa qué tan leve le pueda parecer. Usted podría perder el derecho a los beneficios de compensación laboral si no presenta a tiempo un informe de la lesión a su empleador. El tiempo límite puede ser tan corto como 14 días.
- Provea a su empleador la mayor cantidad de información posible sobre su lesión.
- Obtenga el tratamiento médico que necesite lo más pronto posible. Si no está cubierto por una organización de atención médica certificada, (CMCO), usted puede recibir tratamiento con el doctor que usted elija. Su empleador debe notificarle por escrito si tiene cobertura con un CMCO.
- Colabore con todas las solicitudes de información relacionadas con su reclamo.

  La ley permite que la aseguradora de compensación laboral obtenga la información médica relacionada con su lesión sin su autorización, pero le debe enviar una notificación por escrito cuando solicite la información.

  La compañía aseguradora no puede obtener otros expedientes médicos a menos que usted firme una autorización por escrito.
- Obtenga una confirmación por escrito de su médico sobre cualquier autorización para ausentarse del trabajo. La nota debe ser lo más específica posible.

Compensación laboral paga por lo siguiente

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

Lo que la aseguradora debe hacer

- La compañía aseguradora deberá investigar su reclamo con prontitud. Si usted ha estado incapacitado por más de tres días calendario, la aseguradora debe iniciar el pago de beneficios o enviarle un aviso de negación de responsabilidades dentro de los 14 días después que su empleador se enteró de su ausencia laboral o había perdido parte de su salario debido a su reclamo por lesión.
- **Si la compañía aseguradora acepta su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días calendario:** La aseguradora le notificará y deberá iniciar el pago de los beneficios por pérdida de salario dentro de los 14 días mencionados anteriormente. La aseguradora deberá pagar los beneficios puntualmente. Los beneficios por pérdida de salario se pagan en los mismos intervalos que sus cheques de nómina.
- **Si la compañía aseguradora deniega su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días calendario:** La aseguradora le enviará una notificación dentro de los 14 días. La notificación debe explicar claramente los hechos y motivos por los cuales ellos consideran que su lesión o enfermedad no fue resultado de su trabajo o por qué los beneficios por pérdida de salarios que reclama no están relacionados con su lesión.

  Si usted no está de acuerdo con la denegación, hable con el ajustador de reclamos de la aseguradora a cargo de su reclamo. Si usted no está satisfecho y aún está en desacuerdo con la denegación, **comuníquese con el teléfono gratuito para Compensación para Trabajadores del Departamento de Trabajo e Industria de Minnesota (Minnesota Department of Labor and Industry) al 1-800-342-5354.**

Fraude

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

Nombre e información de contacto de la compañía aseguradora

Name -

Address - PO BOX 881716 San Francisco, CA 94188

Phone - 800-661-6029

DEPARTAMENTO DE TRABAJO E INDUSTRIA

(651) 284-5032 • 1-800-342-5354 • dli.workcomp@state.mn.us • www.dli.mn.gov

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

Agosto de 2017

MN Department of Labor and Industry
Workers' Compensation Division
(651) 284-5032 or 1-800-342-5354

First Report of Injury

See Instructions on Reverse Side

Reset

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

FRO1

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm	
4. DATE OF CLAIMED INJURY	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)
7. EMPLOYEE Name (last, suffix, first, middle)		8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried

10. Home address		11. Home phone #	12. Date of birth / 13. Date hired
City	State Zip Code	14. Occupation	15. Regular department / 16. Apprentice ☐ Yes ☐ No

17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week	Normal work schedule Sun - Sat (S M T W T F S) ☐ ☐ ☐ ☐ ☐ ☐ ☐	21. Employment status (check all that apply) ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No Name and address of the place of the occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI	
	28. Date employer notified of injury	29. Date employer notified of lost time	
	30. Return to work date	31. RTW same employer ☐ Yes ☐ No	32. RTW with restrictions ☐ Yes ☐ No
33. Treating physician (name)	34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated		
35. Certified Managed Care Organization (if any)			

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)	
38. **Mailing** address	39. Employer FEIN	40. Unemployment ID #
City State Zip Code	41. Employer's contact name and phone #	
42. **Physical** address (if different)	43. Witness (name and phone) - if more than 1 attach a separate sheet	
City State Zip Code	44. NAICS code	45. Date form completed

46. **INSURER** name	51. **CLAIMS ADMIN COMPANY (CA)** name (check one) ☐ Insurer ☐ TPA		
47. Insured legal name and FEIN	52. CA address		
48. Policy # (including effective dates) or self-insured certificate #	City State Zip Code		
49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. CA claim #

55. To be completed by the **CA**:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

Employer: Send copies to Insurer (or Workers' Compensation Division if no insurer), employee, and employee's union (if applicable)

GENERAL INSTRUCTIONS TO THE EMPLOYER

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

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

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

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

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

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

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

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

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

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

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

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

Minnesota workers' compensation system employee information sheet

What does workers' compensation pay for?

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

How are workers' compensation benefits paid?

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

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

- The insurer will send you a copy of the Notice of Insurer's Primary Liability Determination form stating your claim is accepted.

- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

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

- The insurer will send you a copy of the Notice of Insurer's Primary Liability Determination form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.

- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.

  Insurer name: Phone:

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

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

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

Additional information is available at www.dli.mn.gov/workers/workers-compensation-workers.

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

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

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

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

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

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

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

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

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

Nombre de Aseguranza: Número de teléfono:

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

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

Ciudades gemelas el area Sur de Minnesota: 651-284-5005 or 800-342-5354
Duluth y el area norte de Minnesota: 218-733-7810 or 800-342-5354

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

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

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

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

Claim Number/Número de Reclamo

Date of Injury / Fecha de la Lesión

Employee/Empleado

Date of Birth / Fecha de Nacimiento

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

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

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

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

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

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

The released information is required for the following reasons:

La información liberada es requerida por las siguientes razones:

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

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

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

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

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

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

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

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

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

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

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

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

A copy or fax is as valid as the original.

Una copia o fax es tan válida como el original.

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

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

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

Signature/Firma

Date/Fecha

PRINT THIS FORM/ IMPRIMIR FORMULARIO

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Medical History Request

Employee Name

Date of Injury

Employer Name

Completion Date

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

Thank you for your cooperation.

Past Injuries, Disabilities, or Other Medical Conditions

Hospitalizations

Hospital Name & Address	Phone	Date(s) Adimitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

RESET FORM

PRINT THIS FORM

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Employee Incident Report

This form should be filled out by the injured employee.

Name

Employer Name

Date of Incident

Time of incident

Time you began work on day of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)
Yes or No

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

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

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

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

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

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

What did you do after the incident occurred?

The above form is true and correct.

Signature

Date Completed

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 Accident

Employee Name

Employer Name

Date of Accident

Time of accident

Time you began work on day of accident

Did the employee report the accident immediately?

Address of Accident

City, State

Zip

Offsite? (Y/N)
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 accident occurred (including self)?

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

Supervisor's Report of Employment Accident

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

- ☐ Unused/unavailable lifting equipment
- ☐ 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 accident
- ☐ 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

RESET FORM

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Informe de Incidente del Supevisor

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente? Si/No

Dirección del Incidente

Ciudad, Estado

Código Postal

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

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

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

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

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

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

Informe de Incidente del Supevisor

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

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

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

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración:

RESTABLECER FORMULARIO

IMPRIMIR FORMULARIO

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Witness' Report/Statement of Employee Incident

Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)
Yes or No

Date of Incident

Time of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)
Yes or No

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

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

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

What did the employee do after the incident occurred?

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

The above form is true and correct.

Witness' Signature

Date Completed

RESET FORM

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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)

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.

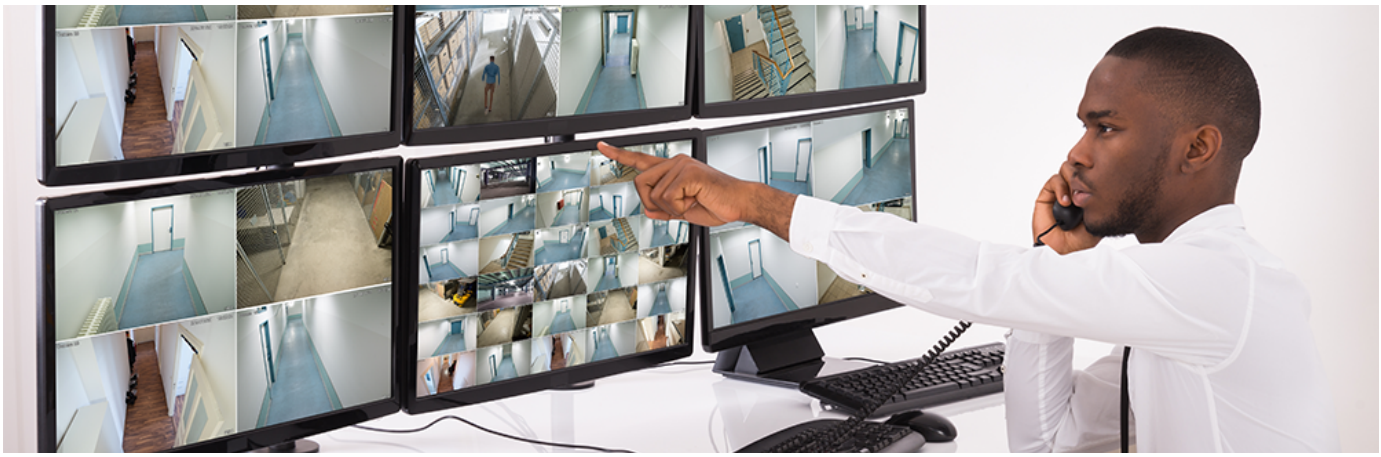
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

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.