Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation State Claim Kit

Missouri

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

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

Dear Policyholder:

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

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

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

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

bhhcpolicyholder.bhhc.com/Client/External/Claims

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation Posting Requirements

Form WC-106 – Roles and Responsibilities for Employers and Employees Poster

- Post in one or more conspicuous places at all business locations
  - Employees that primarily work off the premises must receive notice of the posting in writing
- Print each page of the Poster on 11" x 17" paper

To complete the form, please enter the name of your designated insurance carrier, and the name & phone number of a company representative to receive notices of injury. For your convenience, our other contact information has been entered on the poster.

(Missouri Revised Statutes § 287.127)

DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Employee Information

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

Insurance Company, Third Party Administrator, Service Company, or Designated Individual If Self-Insured

Name _____

Address P.O. Box 881716
San Francisco, CA 94188

Phone (800) 661-6029

Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the accident/or 30 days after the diagnosis of any occupational disease or repetitive trauma) by contacting

   _____, _____.
   employer representative *phone number*

   Failure to do so may jeopardize your ability to receive benefits
2. **Ask your employer to provide medical treatment (your employer/insurer is responsible for providing medical treatment and paying the medical fees and charges unless you choose to treat with another doctor at your own expense without your employer/insurer's approval).**
3. Get more information about the benefits available under the Workers' Compensation Program or about the steps you may take to get the benefits you need. **Visit www.labor.mo.gov/DWC or call 800-775-COMP.**

Benefits for Injured Employees

Medical Care:
The employer or insurer is required to provide medical treatment and care that is reasonably required to cure and relieve the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately**. The employer/insurer has the right to choose the healthcare provider or treating physician. You may select a different healthcare provider or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages:
- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:
If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:
If a work-related injury causes an employee's death, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage along with funeral expenses up to $5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC.

Additional Benefits for Occupational Diseases Due to Toxic Exposure - Permanent Total Disability and/or Death:
For information relating to additional benefits available, please refer to the Division's website at www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

**Make sure your data is turned on and scan the QR Code with your smartphone's camera to go to the Division of Workers Compensation's Website for more information. If you are not redirected, you may need to update your smartphone's operating system or download a QR Code reader app.

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

With some exceptions, all employers with five or more employees, and construction industry employers with one or more employees, are required to insure their workers' compensation liability, either by purchasing a policy or obtaining self-insurance authority. Workers' compensation insurance provides benefits to workers injured on the job. Employers also are required to post this notice in the workplace for employees to view. This poster is required by section 287.127, RSMo, and is available to employers and insurers free of charge by contacting the Division at 800-775-Comp.

Steps to Take When an Injury Occurs

1. Be sure first aid is administered and the employee is taken to a physician or hospital for further medical care, if necessary.
2. Report the injury to the insurance company or Third Party Administrator (TPA) within five days of the date of injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. The insurer, TPA, or Division approved self-insurer is responsible for filing a First Report of Injury with the Division of Workers' Compensation **within 30 days** of knowledge of the injury.
3. Pay medical bills related to the work injury for treatment reasonably required to cure and relieve the employee of the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. The employer has the right to choose the healthcare provider or treating physician. (The employee may select a different healthcare provider or treating physician, but if the employee does so, it may be at his/her own expense.)
4. For more liability and insurance information relating to the Workers' Compensation Program, visit www.labor.mo.gov/DWC or call 800-775-COMP.

Workers' Safety

Developing and implementing a comprehensive safety and health program can reduce occupational injuries and help lower workers' compensation costs. Insurance carriers in the state of Missouri must provide safety assistance at the request of the insured employer. The Missouri Department of Labor evaluates these services and provides additional assistance through its Missouri Workers' Safety Program.
Visit www.labor.mo.gov/MWSP or call 573-751-4231 for more information about these programs or for a registry of independent consultants who are certified in the state of Missouri to provide safety assistance.

Fraud/Noncompliance

Employee Fraud – knowingly making a claim for workers' compensation benefits to which an employee knows he/she is not entitled or knowingly presenting multiple claims for the same occurrence with intent to defraud is a class E felony, punishable by a fine of up to $10,000, or double the value of the fraud, whichever is greater. A subsequent violation is a class D felony.

Employer Fraud – knowingly misrepresenting an employee's job classification or any other fact to obtain insurance at less than the proper rate is a class A misdemeanor. A subsequent violation is a class E felony. An employer who knowingly makes a false or fraudulent statement regarding an employee's entitlement to benefits to discourage the worker from making a legitimate claim or who knowingly makes a false or fraudulent material statement or material representation to deny benefits to a worker is guilty of a class A misdemeanor punishable by a fine of up to $10,000. A subsequent violation is a class D felony.

Insurer Fraud – knowingly and intentionally refusing to comply with workers' compensation obligations to which an insurance company or self-insurer knows an employee is entitled is a class E felony, punishable by a fine of up to $10,000 or double the value of the fraud, whichever is greater. A subsequent violation is a class D felony.

Employer Noncompliance – knowingly failing to insure workers' compensation liability under the law is a class A misdemeanor punishable by a fine of up to three times the annual premium the employer would have paid had it been insured or up to $50,000, whichever is greater. A subsequent violation is a class E felony. An employer who willfully fails to post the notice of workers' compensation at the workplace is guilty of a class A misdemeanor punishable by a fine of $50 to $1,000 or by imprisonment or both fine and imprisonment.

WC-106 (07-19) AI

DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Información del empleado

La División de Compensación al Trabajador de Missouri (DWC en inglés) administra programas para trabajadores que han sido lesionados en el trabajo o han sido expuestos a una enfermedad ocupacional que son como consecuencia del trabajo y durante el mismo. Los Jueces de la Ley Administrativa de la División tienen la autoridad de aprobar acuerdos o conceder indemnizaciones después de una audiencia relacionada a los derechos de prestaciones por lesiones a un trabajador.

Aseguradora, administrador externo, compañía de servicios o individuo designado si es autoasegurado

Nombre _____

_____

Dirección P.O. Box 881716

San Francisco, CA 94188

_____

Teléfono (800) 661-6029

Pasos a seguir si se lesiona en el trabajo

1. Notifique a su empleador inmediatamente (se debe proporcionar aviso por escrito en un plazo de 30 días a partir de haber ocurrido la lesión o 30 días cuando se esté bastante consciente de la enfermedad ocupacional relacionada con el trabajo) poniéndose en contacto con

   _____, _____.
   representante del empleador *número de teléfono*

   No hacerlo puede poner en peligro su capacidad para recibir los beneficios
2. **Busque atención médica (su empleador/aseguradora es responsable de proporcionar tratamiento médico y pagar las cuotas y cargos médicos a menos que elija usted buscar atención con otro médico bajo su propia cuenta sin aprobación previa de su empleador/aseguradora).**
3. Obtenga más información de los beneficios disponibles bajo el programa de compensación de trabajadores o de los pasos que puede tomar para recibir los beneficios que necesita.

Visite www.labor.mo.gov/DWC o llame al 800-775-2667.

Beneficios para trabajadores lesionados

Cuidados médicos:
El empleador o la aseguradora tienen la obligación de proporcionar tratamiento médico y cuidado para curar o aliviar los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. No hay deducibles y todos los costos los paga su empleador o la aseguradora de compensación al trabajador de su empleador. Si usted recibe una factura, **comuníquese con su empleador o con la aseguradora inmediatamente.** El empleador/la aseguradora tiene el derecho a elegir al proveedor del cuidados médicos o al médico que lo atienda. Puede elegir a otro proveedor de cuidados médicos o médico que lo atienda, pero de hacerlo, puede ser a su propia cuenta.

Pago por pérdida de ingresos:

- Si el médico dice que usted no puede regresar a trabajar debido a sus lesiones o para recuperarse de una cirugía, puede que tenga derecho a beneficios por **discapacidad total temporal** (TTD en inglés). Si el médico indica que usted puede realizar un trabajo ligero o modificado y su empleador le ofrece ese trabajo, es posible que no sea elegible para los beneficios de TTD. Los beneficios de TTD deben continuar hasta que el médico diga que usted puede regresar a trabajar o cuando su tratamiento concluya porque su condición ha alcanzado la "máxima mejoría médica", lo que ocurra primero.
- Si usted regresa a un trabajo ligero o modificado por menos del pago completo, puede tener derecho a beneficios por **discapacidad parcial temporal**.

Beneficios por discapacidad permanente:
Si la lesión o enfermedad resulta en una discapacidad permanente, usted puede tener el derecho a recibir beneficios permanentes por discapacidad parcial o discapacidad total.

Beneficios de sobreviviente:
Si un empleado muere en el trabajo, los dependientes sobrevivientes pueden recibir beneficios semanales por muerte pagados a 66 2/3% del salario semanal promedio del empleado fallecido junto con los gastos de funeral hasta $5,000 por parte del empleador o de la aseguradora. Para recibir más información sobre los beneficios de sobreviviente, incluyendo oportunidades de becas universitarias para niños sobrevivientes, por favor visite www.labor.mo.gov/DWC.

Beneficios adicionales para las enfermedades ocupacionales causadas por exposición a sustancias tóxicas – discapacidad total permanente y/o muerte:
Para recibir más información relacionada con los beneficios adicionales disponibles, por favor consulte el sitio web de la División a www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

**Asegure que sus servicio de datos está activado y escanee el código QR Code con la cámara de su teléfono inteligente para ir al sitio web de la División de Compensación para Trabajadores para obtener más información. Si no es reorientado, puede que necesite actualizar el sistema operativo de su teléfono inteligente o descargar una aplicación de Lector de Códigos QR.

Ley de Compensación al Trabajador

Funciones y responsabilidades para empleadores y trabajadores

INFORMACIÓN DEL EMPLEADOR

Con algunas excepciones, se requiere a todos los empleadores con cinco o más trabajadores, y empleadores de la industria de la construcción con un trabajador o más, para garantizar la compensación al trabajador, ya sea a través de la compra de una póliza de seguro o por adquirir autoridad de autoasegurarse. El seguro por compensación al trabajador proporciona beneficios a los trabajadores lesionados en el trabajo. A los empleadores también se les requiere publicar este aviso en el lugar de trabajo a la vista de todos los empleados. Se requiere poner este cartel de acuerdo a la sección 287.127, RSMo, y el mismo está disponible para todos los empleadores y aseguradoras sin cargo alguno al comunicarse con la División al 800-775-2667.

Pasos a tomar cuando ocurre una lesión

1. Asegúrese de que se administren los primeros auxilios y que se lleve al empleado al médico o al hospital para recibir atención médica adicional, si es necesario.
2. Reporte la lesión a la aseguradora o un Administrador tercero (TPA en inglés) dentro de los cinco días siguientes a la fecha de la lesión o dentro de los cinco días siguientes a la fecha en que fue reportada la lesión al empleador por el trabajador, lo que ocurra después. La Aseguradora, TPA, o autoaseguradora aprobado por la División es responsable para entregar un Informe primero de lesión con la División de Compensación al Trabajador **en un plazo de 30 días** a partir de haberse hecho a conocer la lesión.
3. Pague las cuentas relacionadas a la lesión en el trabajo para curar y aliviar al trabajador de los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. El empleador tiene derecho a elegir al proveedor de cuidado de la salud o al médico que lo atienda. (Usted como el trabajador puede elegir otro proveedor de cuidados médicos o médico de tratamiento, pero de hacerlo, puede ser por su propia cuenta.)
4. Para obtener más información sobre la responsabilidad o el seguro relacionados con el Programa de compensación al trabajador, viste www.labor.mo.gov/DWC o llame al 800-775-2667.

Seguridad del trabajador

Desarrollar e implementar un programa integral de seguridad y salud puede reducir las lesiones ocupacionales y ayudan a reducir los costos de compensación al trabajador. Las compañías de seguro en el estado de Missouri deben proporcionar ayuda de seguridad a petición del empleador asegurado. El Departamento del Trabajo de Missouri evalúa estos servicios y proporciona ayuda adicional a través de su Programa de Seguridad del Trabajador de Missouri.
Visite www.labor.mo.gov/MWSP o llame al 573-751-4231 para obtener más información acerca de estos programas o para un registro de asesores independientes certificados en el estado de Missouri para proporcionar ayuda de seguridad.

Fraude/no cumplimiento

Fraude del trabajador – deliberadamente presentar un reclamo para beneficios de compensación al trabajador a los cuales un empleado sabe que él o ella no tiene derecho o deliberadamente presentar múltiples reclamos por el mismo evento con el intento de defraudar es un delito mayor clase E, castigado con una multa de hasta $10,000, o el doble de la cantidad del fraude, lo que sea mayor. Una violación posterior es un delito mayor clase D.

Fraude del empleador – deliberadamente distorsionar una clasificación del trabajo del empleado para conseguir seguro por debajo de la tarifa apropiada es un delito menor clase A. Una violación posterior es un delito mayor clase E. Un empleador que deliberadamente hace una declaración falsa o fraudulenta relacionada con el derecho del trabajador a beneficios para disuadir que el trabajador haga un reclamo legítimo o quien deliberadamente hace una declaración de material fraudulento o representación fraudulenta a negar beneficios a un trabajador es culpable de un delito menor clase A, castigado con una multa de hasta $10,000. Una violación posterior es un delito mayor clase D.

Fraude de la aseguradora – deliberadamente e intencionalmente rehusar cumplir con las obligaciones de compensación al trabajador a las cuales sabe la aseguradora o la autoaseguradora tiene derecho un empleado es un delito mayor clase E, castigado con una multa de hasta $10,000 o el doble del valor del fraude, lo que sea mayor. Una violación posterior es un delito mayor clase D.

No cumplimiento del empleador – Faltar a propósito a asegurar la obligación legal de la compensación al trabajador es un delito menor clase A y también se castiga con una multa civil de hasta tres veces la prima anual que el empleador habría tenido que pagar de estar asegurado, o hasta $50,000, lo que sea mayor. Una violación posterior es un delito mayor clase E. Un empleador que intencionalmente no publica el aviso de compensación al trabajador en el lugar del trabajo es culpable de un delito menor clase A, castigado con una multa de $50 a $10,000, o con prisión o con ambos multa y prisión.

WC-106-S (7-19) AI

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

REPORT OF INJURY

P.O. Box 58
Jefferson City, MO 65102-0058

(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*

CARRIER ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)*

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*

POLICY PERIOD

to

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR *(NAME, ADDRESS & PHONE NO.)*

CARRIER FEIN

INSURANCE POLICY NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)*

DATE OF BIRTH

SOCIAL SECURITY #

DATE HIRED

STATE OF HIRE

ADDRESS *(INCLUDE ZIP)*

SEX
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS
☐ UNMARRIED
SINGLE DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION JOB TITLE

EMPLOYMENT STATUS

PHONE #

OF DEPENDENTS

NCCI CLASS CODE

WAGE

RATE

PER ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER

OF DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY / ILLNESS

TIME OF OCCURRENCE ☐ 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

ZIP CODE OF THE LOCATION WHERE THE 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 TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*

HOSPITAL *(NAME & ADDRESS)*

INITIAL TREATMENT
☐ 0 - NO MEDICAL TREATMENT
☐ 1 – MINOR: BY EMPLOYER
☐ 2 – MINOR CLINIC HOSPITAL
☐ 3 – EMERGENCY CASE
☐ 4 – HOSPITALIZED > 24 HOURS
☐ 5 – FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

NOTE: This form constitutes the detailed report of injury required by §287.380, RSMo, and rules applicable thereto. An injury that requires immediate first aid, but does not result in further medical treatment or lost time from work, need not be reported to the Division. Employers should report all injuries to their workers' compensation insurance carrier or third-party administrator (TPA) within five days of the date of the injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. See §287.380, RSMo. If the employer has been granted self-insurance authority by the Division pursuant to §287.280, RSMo, and rules applicable thereto, please report all injuries to your TPA or Service Company to enable them to file this report with the Division.

PRINT QUALITY: All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division MUST be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

Data Element Dictionary for Hard Copy Report of Injury

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Employer (Name & Address)	The name of the employer where the employee was employed at the time of the injury.	This is the name the employer does business under followed by the FULL address including mailing address, city, state and zip code.	M
Industry Code	The code which represents the nature of the employer's business which is contained in the North American Industry Classification System Manual published by the Federal Office of Management and Budget. See implementation note below: The industry code selected should represent the primary nature of the employer's business. If the employer is assigned multiple industry codes, use the code that relates to the specific business operation for which the employee was employed at the time of the injury. The data element may contain an SIC code or NAICS Code. SIC code will be identified with the characters 'SC' as the last two characters of the data element. If SC is not present, the code is presumed to be NAICS.	This is the Standard Industrial Classification Code for the employer. SIC/NAICS codes can be found at www.census.gov/epcd/www/naics.html	M
Employer FEIN	The FEIN of the employer where the employee was employed at the time of the injury.	Must be the primary FEIN for the Employer listed above.	M
Report Purpose Code (RPC)	Defines the specific purpose of the report being filed with the state of Missouri. 00 = Original FROI 02=Change CO=Correction AQ=Acquired Report of Injury AU=Acquired Unallocated Report of Injury	The Report of Injury that the employer is required to file with the Division of Workers' Compensation (Division) through the insurance carrier or third party administrator (TPA).	M
Claims Administrator's Number	Identifies a specific claim within a claim administrator's claims processing system.	Number used by the organization adjusting the claim (insurance company, third party administrator, etc.).	M
Jurisdiction	The governing body or territory whose statute applies.	This must always be Missouri.	M
Jurisdiction Claim Number		The injury number assigned by the Division upon receipt of the First Report of Injury with all mandatory information provided. The reporting entity is to leave this field blank.	

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Insured Report Number	A number used by the insured to identify a specific claim.		O
Employer's Location Address	List the physical address of where the employee sustained the accident or illness if that location is different from where the employer wishes to have correspondence sent.		O
Insured Location Number	A code defined by the insurer/employer, which is used to identify the employer's location of the accident.		O
Phone Number	List a phone number of the employer location where the employee worked at the time of the accident.		O
Carrier (insurer) Name & Address	The name and mailing address of the carrier or self-insured entity assuming the employer's financial responsibility for the workers' compensation claim.	If the employer is **individually** self-insured, the **individual** self-insured employer's name and mailing address would be indicated in this field. The FEIN and Name must match. **If the employer is self-insured by a trust, the trust's name would be submitted in this field.**	M
Carrier (insurer) FEIN Number	The FEIN of the carrier or self-insured assuming the employer's financial responsibility for the workers' compensation claim(s).		M
Carrier Policy Number	The number assigned to the contract/policy for the employer or association group.	A number assigned by the **insurance company, *(Not a number assigned by a TPA)*** for the specific workers' compensation policy for that employer. Not a required field for Division approved self-insureds.	M
Policy Period	List the effective and expiration dates of the contract/policy.	The date that the policy became effective and the date the policy expires or is no longer in effect. No date is required in this field if the injury falls within the Division approved self-insurer's self-insurance period.	M
Self-Insured Indicator	An indicator that identifies the employer as one who is authorized by the state of Missouri to retain the risks arising from their operations and bears the financial responsibility. Y=Yes, N=No	Condition – Must indicate Y(Yes) ONLY for an individual employer or a member of a self-insured trust authorized by the Missouri Division of Workers' Compensation to self-insure under § 287.280, RSMo. It does not include uninsured employers or employers under deductible insurance policies.	C
Claim Administrator (TPA) Name & Address	The name and mailing address of the Third Party Administrator (TPA), independent administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	Name and mailing address of the Third Party Administrator (TPA), independent adjuster, contracted to adjust the claim and phone number of the office adjusting the claim. If there is not a TPA, independent adjuster/administrator, contracted to adjust the claim please leave blank.	C

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Claim Administrator (TPA) FEIN Number	The FEIN of the Third Party Administrator (TPA), independent adjuster/administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	FEIN number for the company hired as a TPA. Note: If there is no Third Party Administrator, please leave blank.	C
Agent Name & Code Number	List the name and code number of the carrier or claim administrator agent who administers the workers' compensation claims for the employer.		O
Employee Name	The injured worker's legally recognized name which is used on legal documents, employment, Social Security, banking, records, etc.	Name to include last, first and middle initial.	M
Employee Date of Birth	The date the injured worker was born.	Must be a valid date.	M
Social Security Number	A number assigned by the Social Security Administration used to identify the employee.	If a SSN is not available please call 573-526-3542.	M
Date of Hire	The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.	Must be valid date.	O
State of Hire	List the state where the employer hired the employee.		O
Employee Address	The mailing address used by the injured worker.	The address should not be listed as unknown. Please include the last known address provided by the injured worker that is on file with the employer.	M
Employee Phone	A telephone number where the injured worker can be reached.	This is an optional field, although if the employer or insurance company has this information, **please** report it to the Division. This will improve communication between the parties. This will be a numeric field only *5736367777.*	O
Gender Code	The code which indicates the sex of the employee. Gender of employee F=Female M=Male U=Unknown		M
Number of Dependents	The number of dependents as defined by the administrating jurisdiction.	Spouse, minor children or others if known. Required if date of death is entered. Numeric field 0-9.	C
Marital Status Code	The code, which indicates the marital status of the employee. U = Widowed, divorced, single, unmarried, M = Married, S = Separated, K = Unknown		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Occupational/ Job Title or Description	Identifies the primary occupation of the employee at the time of the accident or injurious exposure.		O
Employment Status Code	Indicate the employee's primary work code status at the time of the injury with the covered employer.		O
NCCI Class Code	A code, which, corresponds to the primary occupation in which the employee was engaged at the time of the accident/injury or injurious exposure.	MO uses NCCI codes.	M
Wage	The reported employee's pre-injury wage for the wage period. Implementation Note: This amount may include commission, piecework earnings, and other forms of income converted to a normal scheduled work week, plus the estimated value of lodging, food, laundry and other payments in kind; and concurrent employment earnings, as prejurisdictional requirement.	"Gross Wages" includes, in addition to money paid by the employer for services rendered by the employee, the reasonable value of board, rent, housing, lodging or similar advance by the employer, except if it continues to be provided to the employee for the period of disability, it is not included in calculating the average weekly wage. "Wages" also includes gratuity received in the course of employment from individuals other than the employer that are reported for income tax purposes. "Wages" does not include fringe benefits such as retirement, pension, health and welfare, life insurance, training, Social Security or other employee or dependent benefit plan provided by the employer. **Please See Special Notes #1**	M
Wage Period	A code indicating the time period during which the wage was earned.	Please use the weekly wage rate paid to the employee.	M
Number of Days Worked	The number of the employee's regularly scheduled workdays per week.		O
Full Wages Paid for the Date of Injury Indicator	Indicates whether full wages for the date of the accident/injury or illness were paid by the employer.		O
Salary Continued Indicator	The employer has paid or is paying the employee's salary in lieu of compensation during an absence caused by a work-related injury.	Did the employer continue to pay salary to the employee after the injury? N=No Y=Yes	O
Time Employee Began Work	Time at which the employee began work on the day of the accident/injury or illness.		O
Date of Injury/Illness	For traumatic injury, the date on which the accident occurred. For occupational disease or cumulative injury, the date of injury is the date of last injurious exposure to the cause or substance creating the condition, unless otherwise defined by statute.	Date that injury/illness occurred or became known to employee; whichever is later.	M

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Time of Occurrence	The time at which the accident occurred.	To the extent that the time of the occurrence of the accident/injury is available, you should provide it to the Division. Please indicate a.m. or p.m.	O
Date Last Day Worked	The last paid workday prior to the initial date of disability as defined by jurisdiction.	Must be valid date.	O
Date Employer Notified	The date that the injury was reported to a representative of the employer.		M
Date Disability Began	The first day on which the employee originally lost time from work due to the occupational injury or disease or as otherwise defined by jurisdiction.	**Date of disability must be greater than Date of Injury.** First date employee starts losing time from work after the date of injury. This is the day after the date of injury or the first day of work missed, if later. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days. **Please See Special Notes #2**	C
Contact Name & Phone Number	List the name and phone number for a representative of the employer.		C
Type of Injury/Illness	List the type of injury/illness sustained by the employee.		O
Part of Body Affected	List the part of body to which the employee sustained injury.		O
Employer Premises Indicator	An indicator to denote whether the accident occurred at the employer's address provided.	If the injury/illness occurred on the employer's property indicate "YES." If it occurred elsewhere indicate "NO."	M
Type of Injury/Illness Code	The code, which corresponds to the nature of the injury sustained by the employee.	Choose from the list of code numbers, which corresponds with the nature of the injury. A list of codes with description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx **Please See Special Notes #2**	M
Part of Body Affected Code	The code, which corresponds to the part of the body to which the employee sustained injury.	Choose from the list of code numbers, which corresponds with the part of body injured. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx	M

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Zip Code of the Location Where Accident or Illness Exposure Occurred	The zip (postal code) that corresponds to the location where the injury occurred.	The code is required to assist with docket setting if needed.	M
All Equipment Using	List all the equipment; materials or chemicals the employee was using at the time of the accident/injury or illness exposure occurred.		O
Specific Activity Engaged In	Describe the specific activity that the employee was doing at the time the accident/injury or illness exposure occurred.		O
Work Process Engaged In	Describe the work process the employee was doing when the accident/injury or illness exposure occurred.		O
How the Injury or Illness Occurred	A free form description of how the accident occurred and the resulting injuries.	Describe how the injury/illness occurred. Please include the events that led to the injury/illness and any objects or substances that directly injured the employee or made the employee ill. Maximum of 150 characters, including spaces. *For example: Employee was on ladder putting away product, fell on chemical barrel breaking lower arm; arm lacerations; exposed to chemical liquid and fumes (141 characters).*	M
Cause of Injury Code	The code which corresponds to the cause of injury.	Choose from the list of code numbers, which corresponds with the cause of the injury. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx (Struck by, fell, auto accident, exposure, etc.)	M
Date Returned to Work	The first date on which the employee returned to work following the injury.	Must be a valid date. Must be entered if employee lost days of work and returned to work before first report of injury is filed.	C
Employee Date of Death	The date the injured worker died.	Must be a valid date.	C
Safeguards	Indicate whether safeguards or safety equipment was provided by checking “Yes” or “No.”		O
Were They Used	Indicate whether the safeguards or safety equipment was used by the employee by checking “Yes” or “No.”		O
Physician/Health Care Provider	List the name and address of the physician or health care provider who provided initial medical treatment to the injured employee after the accident/injury or illness.		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Hospital	List the name and address of the hospital where the employee received initial medical treatment.		O
Initial Treatment	A code used to identify the extent of medical treatment received by the employee immediately following the accident. 0= No medical treatment 1= Minor on-site remedies by employer medical staff 2= Minor clinic/hospital medical remedies and diagnostic testing 3= Emergency evaluation, diagnostic testing, and medical procedures 4= Hospitalization > 24 hours 5= Future major medical/lost time anticipated	First Aid includes the administration of immediate and temporary medical aid to the employee that a lay person may provide, such as the application of Band-Aid to treat a minor scratch or the removal of a splinter that would not result in the need for a referral to a doctor or other health care professional for additional medical treatment or would not result in further lost-time from work. The on-site company nurse or physician may be the individual that provides the first aid. If the company nurse or physician provides service beyond first aid, then the injury must be reported even if the treatment occurs on-site. **Please see Special Notes #2**	M
Witness	List the name and address of all witnesses who were present when the employee sustained the accident/injury or illness.		O
Date Reported to Claims Administrator	The date the claim administrator who is processing the claim received notice of the loss or occurrence.		M
Date Prepared	List the date that the representative for the claims administrator prepared this report of injury.		O
Preparer's Name and Title	List the name and title of the claims administrator's representative who prepared this report of injury.		C
Phone Number	List the phone number of the representative preparing this report of injury.		C

M – Mandatory – Cases missing mandatory information will NOT be accepted by the Missouri Division of Workers' Compensation system.

C – Conditional – Data Elements with Conditional fields indicate a value is required based on another Data Element or pre-existing condition.

Examples: When a death case is reported then the death date would be required.
If the employee has returned to work prior to the report being filed, the date of return to work would be entered.

O – Optional – Data Elements identified as Optional may be entered but are not required.

Special Notes

1) Wage Instructions

A) Missouri Notes: Report the wage information as the average weekly wage (AWW) of the employee. These rules apply for calculating the average weekly wage.

1) If the employee's wage is fixed by the year, the AWW is the yearly wage divided by 52;

2) If the employee's wage is fixed by the month, the AWW is the monthly wage multiplied by 12 and divided by 52;

3) If the employee's wage is fixed by the week, that amount is the AWW;

4) If the employee's wages are fixed by the day, hour or output, the numerator is the actual gross wages earned by the employee in the last thirteen calendar weeks immediately preceding the week in which the injury occurred; and the denominator is 13 to calculate the AWW.

i) The formula is: Actual gross wages earned in prior 13 weeks/13=AWW. *For example, the employee's hourly wage is $9.00/hour. The overtime rate is $13.50/hour. The employee works 40 hours per week at $9.00 an hour plus occasional overtime. Employee worked overtime of 44 hours in the 13-week period immediately preceding the week of the injury. The employer has employed the employee for 2 years.*

The gross wages are $9.00 X 40 hours X 13 weeks = $4,680. You also need to include the overtime 44 hours. Therefore, $13.50 X 44 hours = $594. The total wages are $4,680 plus $594 = $5,274. The AWW is $5,274/13=$405.69.

ii) If the employee misses nonconsecutive workdays during the 13-week period in multiples of 5 those days shall be subtracted from the denominator. *For example: if the employee misses 5 days, one week is subtracted from 13 and the denominator becomes 12; if the employee misses 10 days, two weeks are subtracted from 13 and the denominator becomes 11; and so on.*

iii) Partial weeks of time missed by the employee do not count to change the denominator. *For example: if the employee misses 4 days, the denominator is 13; if the employee misses 6 days, one week is subtracted from 13 and the denominator becomes 12; and so on.*

iv) If the employee works less than 13 weeks but more than 2 weeks, the AWW is the same formula with the numerator as the gross wages calculated for the number of weeks of employment and the denominator is the number of weeks of employment. *For example, the employee worked for the employer 8 weeks prior to the week of the injury. The employee was paid $9.00 per hour and worked 40 hours per week. The employee worked 13 hours of overtime. The overtime rate is $13.50. The gross wages are $9.00 X 40 hours X 8 weeks plus $13.50 X 13 hours = $3,055.50. The AWW is $3,055.50/8=$381.94.*

5) If the employee works less than two weeks the AWW shall be equivalent to the AWW for the same or similar employment. However, if the employer has agreed to a certain hourly wage, then the hourly wage agreed upon multiplied by the number of weekly hours scheduled shall be the employee's AWW.

B) **When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.**

C) When Initial Treatment Code is reported as equal to 00, 01 or 02, the case will be considered as a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed. When the Initial Treatment Code is reported as equal to 03, 04 or 05, the case will be considered as an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

2) Initial Treatment Code, Date Disability Began and Date Returned to Work:

A) When Initial Treatment Code is reported as 00, 01 or 02, the case will be considered a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed.

B) When the Initial Treatment Code is reported as 03, 04 or 05, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

1) When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

C) The following are examples of First Aid treatment:

a) Use of non-prescription medication at non-prescription strength.

b) Cleaning, flushing or soaking wounds on the surface of the skin.

c) Using wound coverings such as bandages, Band-Aids, gauze pads, etc. or using butterfly bandages or Steri-Strips. (Other wound closing devises such as sutures, staples, glues, etc. are considered medical treatment.)

d) Use of any non-rigid means of support such as an elastic bandage, wrap, or non-rigid belt. (The use of devices with rigid stays or other systems designed to immobilize body parts is considered medical treatment.)

e) Use of temporary immobilization devices (e.g., splints, slings, neck collars, etc.) while transporting an accident victim.

f) Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs, or other simple means.

g) Use of finger guards.

h) Drinking of fluids for relief of heat stress.

3) Mesothelioma Liability: Several changes to the Workers' Compensation Law went into effect January 1, 2014. Pursuant to §287.200.4, RSMo, employers may elect to accept mesothelioma liability in one of the following ways:

a. Insuring their liability by purchasing a workers' compensation policy;

b. Meeting the requirements of the Division of Workers' Compensation to qualify as a self-insurer;

c. Joining a Group Insurance Pool that complies with §287.223. (An employer may become a member of the Missouri Mesothelioma Risk Management Fund);

d. Rejecting *mesothelioma* liability under the Missouri Workers' Compensation Law.

Please note that if an employer has rejected *mesothelioma* liability coverage under the Workers' Compensation Law, the exclusive remedy provision of the Workers' Compensation Law, §287.120, RSMo, does not apply.

4) **Occupational diseases:** Occupational diseases due to toxic exposure have been defined effective January 1, 2014. The "occupational diseases due to toxic exposure" includes the following: asbestosis, berylliosis, coal worker's pneumoconiosis, bronchiolitis obliterans, silicosis, silicotuberculosis, manganism, acute myelogenous leukemia and myelodysplastic syndrome. The reporting requirements relating to other occupational diseases such as carpal tunnel syndrome, etc. remains the same.

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

DIVISION OF WORKERS' COMPENSATION

REPORT YOUR WORKPLACE INJURY/OCCUPATIONAL DISEASE OR REPETITIVE TRAUMA INJURY

800-775-2667
www.labor.mo.gov/DWC

- If your employer does **not** provide you with a form to complete to report your injury, you may use this form to provide the employer with written notice of your accident or injury;
- If you choose to use this form it **does not** replace the incident or accident form that your employer may require you to complete;
- **If you choose to use this form, PLEASE DO NOT send it to the state or to the Missouri Division of Workers' Compensation (Division);**
- **This is not a Claim for Compensation form**;
- Under Missouri law you are required to report your injury to your employer in writing within 30 days of the injury. Failure to report your injury to your employer within 30 days **may** jeopardize your ability to receive workers' compensation benefits **UNLESS** the Division or Commission finds that the employer is not prejudiced by failure to receive the notice;
- Under Missouri law, your employer or its workers' compensation insurance company or third-party administrator should arrange for you to receive the medical treatment as may be reasonably required to cure and relieve you from the effects of the injury.
- **Under Missouri law, the employer files a separate First Report of Injury with the Division pursuant to §287.380, RSMo.**

Your written notification to the employer should include the following information:

Date Written Notice Given: _____

Name of Person Injured: _____

Address of Person Injured: _____

Date of Injury: ____/____/_____

Time of Injury: _____:_____ ☐ a.m. / ☐ p.m.

Place of Injury: _____

Nature of the Injury: _____

NOTE:

Failure to provide written notice of your occupational disease or repetitive trauma injury to your employer within 30 days of the diagnosis of your condition may jeopardize your ability to receive workers' compensation benefits UNLESS the Division or Commission finds that the employer is not prejudiced by failure to receive the notice.

Make a copy of this written notice or the written notice your employer gives you to complete and keep a record of the date you provided your notice. If you hand-deliver your notice, keep a record of the date and time of the delivery along with the full name and title of the person you delivered it to.

To verify that your injury has been reported or to speak to an Information Specialist, please call the Division's toll free number 800-775-2667. If you experience difficulty in obtaining medical treatment or other benefits, call the number above and request Dispute Management Assistance.

DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

AUTHORIZATION TO INSPECT AND/OR COPY MEDICAL RECORDS

P.O. Box 58
Jefferson City, MO 65102-0058
573-751-4231
labor.mo.gov/DWC

Injury Number	Checked By

TO:

Employee	Employer

Insurer	Date of Accident

Place and County of Accident

Description of Injury *(Must include part of body affected)*

You are hereby authorized to permit _____
(NAME)

in behalf of _____, to inspect and/or copy any and all medical
(PARTY)

records you have in your possession in regard to the above captioned case, which is now pending before the Division of Workers' Compensation.

NOTE: The medical records which may be released according to this authorization are limited to medical treatment for the injury suffered on the date of accident listed above. **ONLY records that relate to the injury listed above,** as to the type of injury and the part of the body injured, **may be included.** Medical records from before the date of accident or medical records after the date of accident, which do not relate to ***this*** injury, may not be released pursuant to this authorization.

This authorization is made in accordance with Section 287.140.7, RSMo., which reads as follows:

> "Every hospital or other person furnishing the employee with medical aid shall permit its record to be copied by and shall furnish full information to the division or the commission, the employer, the employee or his dependents and any other party to any proceedings for compensation under this chapter, and certified copies of the records shall be admissible in evidence in any such proceedings."

Date	APPROVED BY: Administrative Law Judge Signature *(Division of Workers' Compensation)*

This form is effective twelve months from the date it is signed by an Administrative Law Judge.

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

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Witness' Report/Statement of Employee Incident

Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)
Yes or No

Date of Incident

Time of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)
Yes or No

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

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

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

What did the employee do after the incident occurred?

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

The above form is true and correct.

Witness' Signature

Date Completed

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Informe de Incidente del Testigo

Nombre del Empleado

Nombre del Testigo

Teléfono del Testigo

Dirección del Testigo

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/No)

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.

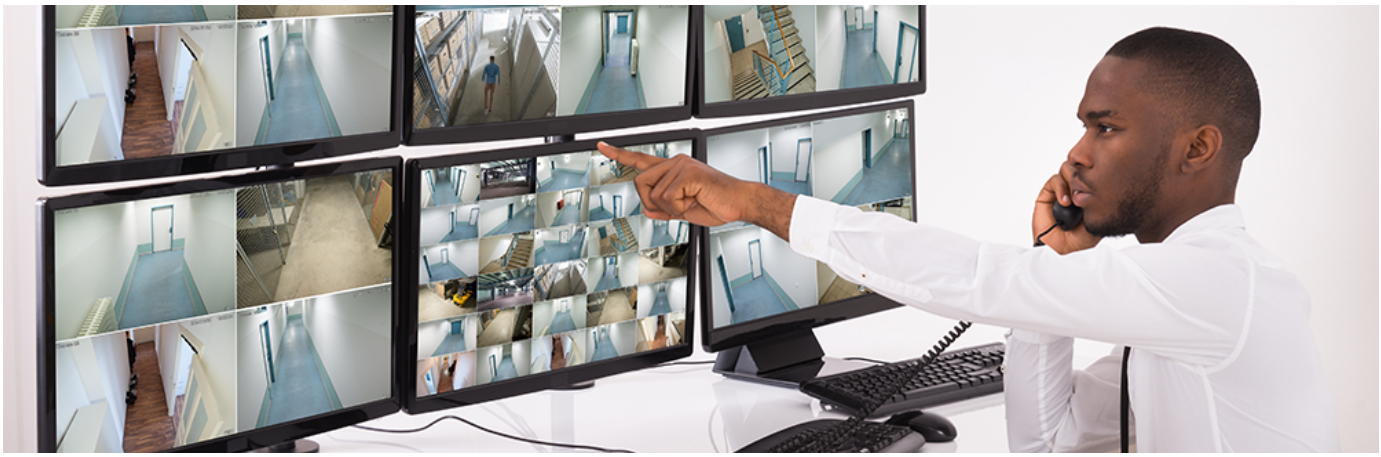
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

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.