Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

# Workers Compensation State Claim Kit

*Colorado*

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.

Colorado state law requires employers report every industrial injury or occupational disease claim to their workers compensation carrier as soon as possible or within 10 days of employer knowledge of injury. BHHC recommends that employers report all potential claims within five days of their knowledge to allow enough time to fully investigate the claim while meeting state reporting deadlines.

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

bhhc.com/workers-compensation/claim-services/report-a-claim/

### Phone

(800) 661-6029

### Fax

(800) 661-6984

### E-mail

newclaim@bhhc.com

Berkshire Hathaway HOMESTATE COMPANIES
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# Workers Compensation Posting Requirements

## Form WC-50 – Notice to Employer of Injury Poster (Revised August 10, 2022)

- Post in one or more conspicuous places at all business locations and work sites
- As of 8.10.22 CO law requires this poster size to be 27'x40" in size. Due to this size requirement BHHC will not be printing or mailing out this poster.
- To print this yourself:
  - Complete the fillable text box with the name and contact information of your insurance carrier.
  - Poster text must be a minimum of 0.5" high. Poster has already been sized to meet this standard which is 27"x40".
  - You can find the poster file here at codwc.app.box.com/s/v0mr2xp8jvxkbfjbgb23vk1if18pi0xz.
  - You are only required to print out the English version of the poster. Additional versions of the poster have been provided in full color, black and white, and Spanish.
  - You can also send poster file to a local print shop or online printing service.

(Colorado Revised Statutes § 8-43-102(1)(b))

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
*DIVISION OF WORKERS' COMPENSATION*

# NOTICE

**IF YOU ARE INJURED ON THE JOB, YOU HAVE RIGHTS UNDER THE COLORADO WORKERS' COMPENSATION ACT. YOUR EMPLOYER IS REQUIRED BY LAW TO HAVE WORKERS' COMPENSATION INSURANCE. THE COST OF THE INSURANCE IS PAID ENTIRELY BY YOUR EMPLOYER. IF YOUR EMPLOYER DOES NOT HAVE WORKERS' COMPENSATION INSURANCE, YOU STILL HAVE RIGHTS UNDER THE LAW.**

**IT IS AGAINST THE LAW FOR YOUR EMPLOYER TO HAVE A POLICY CONTRARY TO THE REPORTING REQUIREMENTS SET FORTH IN THE COLORADO WORKERS' COMPENSATION ACT. YOUR EMPLOYER IS INSURED THROUGH:**

**(Please write or type your insurance carrier name and contact information here.)**

**IF YOU ARE INJURED ON THE JOB, NOTIFY YOUR EMPLOYER AS SOON AS YOU ARE ABLE, AND REPORT YOUR INJURY TO YOUR EMPLOYER IN WRITING WITHIN 10 DAYS AFTER THE INJURY. IF YOU DO NOT REPORT YOUR INJURY PROMPTLY, YOU MAY STILL PURSUE A CLAIM.**

**ADVISE YOUR EMPLOYER IF YOU NEED MEDICAL TREATMENT. IF YOU OBTAIN MEDICAL CARE, BE SURE TO REPORT TO YOUR EMPLOYER AND HEALTH-CARE PROVIDER HOW, WHEN, AND WHERE THE INJURY OCCURRED.**

**YOU MAY FILE A WORKER'S CLAIM FOR COMPENSATION WITH THE DIVISION OF WORKERS' COMPENSATION. TO OBTAIN FORMS OR INFORMATION REGARDING THE WORKERS' COMPENSATION SYSTEM,THE CUSTOMER SERVICE CONTACT INFORMATION FOR THE DIVISION OF WORKERS' COMPENSATION IS:**

**Division of Workers' Compensation**
**633 17th Street, Suite 400**
**Denver, CO 80202**

**303-318-8700**
**1-888-390-7936 (Toll-Free)**
**cdle.colorado.gov/dwc**

WC50 Rev 08/22

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
*DIVISION OF WORKERS' COMPENSATION*

# AVISO

**SI SE LESIONA EN EL TRABAJO, TIENE DERECHOS BAJO LA LEY DE COMPENSACIÓN DE TRABAJADORES DE COLORADO. SU EMPLEADOR ESTÁ OBLIGADO POR LEY A TENER UN SEGURO DE COMPENSACIÓN PARA TRABAJADORES. EL COSTO DEL SEGURO ES PAGADO EN SU TOTALIDAD POR SU EMPLEADOR. SI SU EMPLEADOR NO TIENE SEGURO DE COMPENSACIÓN PARA TRABAJADORES, USTED TODAVÍA TIENE DERECHOS BAJO LA LEY.**

**ES CONTRA LA LEY QUE SU EMPLEADOR TENGA UNA PÓLIZA CONTRARIA A LOS REQUISITOS DE INFORMES ESTABLECIDOS EN LA LEY DE COMPENSACIÓN DE TRABAJADORES DE COLORADO. SU EMPLEADOR ESTÁ ASEGURADO A TRAVÉS DE:**

**(Escriba aquí el nombre de su compañía de seguros y la información de contacto.)**

**SI SE LESIONA EN EL TRABAJO, NOTIFIQUE A SU EMPLEADOR TAN PRONTO COMO PUEDA E INFORME SU LESIÓN A SU EMPLEADOR POR ESCRITO DENTRO DE LOS 10 DÍAS POSTERIORES A LA LESIÓN. SI NO INFORMA SU LESIÓN CON PRONTITUD, AÚN PUEDE PRESENTAR UN RECLAMO.**

**INFORME A SU EMPLEADOR SI NECESITA TRATAMIENTO MÉDICO. SI OBTIENE ATENCIÓN MÉDICA, ASEGÚRESE DE INFORMAR A SU EMPLEADOR Y PROVEEDOR DE ATENCIÓN MÉDICA CÓMO, CUÁNDO Y DÓNDE OCURRIÓ LA LESIÓN.**

**PUEDE PRESENTAR UN RECLAMO DE COMPENSACIÓN DEL TRABAJADOR ANTE LA DIVISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES. PARA OBTENER FORMULARIOS O INFORMACIÓN SOBRE EL SISTEMA DE COMPENSACIÓN DE TRABAJADORES, LA INFORMACIÓN DE CONTACTO DE SERVICIO AL CLIENTE PARA LA DIVISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES ES:**

**Division of Workers' Compensation**
**633 17th Street, Suite 400**
**Denver, CO 80202**

**303-318-8700**
**1-888-390-7936 (Llame Gratis)**
**cdle.colorado.gov/dwc**

WC50 Rev 08/22

Berkshire Hathaway HOMESTATE COMPANIES

# Colorado Medical Provider Panels

Treating physicians can have a significant impact on a claim's medical cost. A key component to controlling these costs and reaching a satisfactory resolution of a claim for all parties involved is ensuring that the claimant receives quality medical care from a competent physician. In the state of Colorado, when an employer has notice of an on-the-job injury, the employer shall provide the employee with a written list of designated providers from which the employee may select a physician or corporate medical provider. Pursuant to 7 CCR 1101-3 Rule 8-2, this list will be referred to as the designated provider list.

This document contains a summary of the essential elements for the creation and maintenance of a designated provider list. **Our staff is available to assist in this process.** We can provide a list of qualified, reputable physicians and medical providers that are experienced in providing treatment of industrial injuries, familiar with workers' compensation, and strong advocates of a safe and expedient return to work.

## GENERAL REQUIREMENTS

**Notice to Workers-** A copy of the written designated provider list must be given to the employee in a verifiable manner within seven business days following the date the employer has notice of the injury. The list must include contact information for the insurer, including address, phone number, and claims contact information.

**Included Physicians-** The designated provider list may include any combination of physicians and/or corporate medical providers so long as at least one physician or corporation medical provider is at a distinct location without common ownership. If there are not at least two physicians or corporate medical providers at distinct locations without common ownership within 30 miles of the employer's place of business, the list may be comprised of providers at the same location or with common ownership.

**Number of Physicians-** The number of physicians or corporate medical providers required on the designated provider list is determined by the number of physicians or corporate medical providers willing to treat an employee within 30 miles of the employer's location:

| AVAILABLE PROVIDERS WITHIN 30 MILES: | REQUIRED NUMBER OF DESIGNATED PROVIDERS TO BE LISTED: |
|---|---|
| THREE OR LESS | ONE |
| AT LEAST FOUR BUT LESS THAN NINE | TWO |
| NINE OR MORE | FOUR |

If the employer fails to supply the required designated provider list, the employee may select an authorized treating physician or chiropractor of his/her choosing.

**Emergency Situation-** In an emergency situation, the employee shall be taken to any physician or medical facility that is able to provide the necessary care. When emergency care is no longer required, the above will apply. Additionally, if the employee is away from the usual place of employment at the time of the injury, the employee may be referred to a physician in the vicinity where the injury occurred. Within 7 business days following the date the employer has notice of the injury, the employer shall comply with the above.

**Change in Provider-** Within 90 days following the date of injury but before reaching maximum medical improvement, an employee may request a one-time change of authorized treating physician pursuant to §8-43-404(5)(a)(III). The new physician must be a physician on the designated provider list or provide medical services for a designed corporate medical provider on the list. To make a change the employee must complete and sign Form WC3- Notice of One-Time Change of Physician provided by the Colorado Division of Workers' Compensation. The employee shall submit the form by mailing or hand-delivering the completed form to the person designated by the employer to receive the form. The person designated is listed on the designated provider list given to the employee as the respondents' representative. The employee may, but is not required to, provide the form to the impacted physicians. In any event, the respondents' representative shall notify the impacted physicians and the individual adjusting the claim of the change, unless an objection is submitted. If the insurer or employer believes the notice provided does not meet statutory requirements and does not accept the change of physician, the insurer or employer must provide written objection to the employee within 7 business days following receipt of the form. The written objection shall set out the reason(s) that the notice does not meet statutory requirements.

**Additional Changes in Provider-** In addition and separately from the above, an employee may submit a written request to change physicians to the insurer. Such a request must be on Form WC197- Request for Change of Physician provided by the Colorado Division of Workers' Compensation. The insurer has 20 days to either grant permission for the requested change of physician or object in writing on the form prescribed by the Colorado Division of Workers' Compensation. Failure to timely object shall be deemed a waiver of objection.

**Continuance of Care-** The originally authorized treating physician shall continue as the authorized treating physician for the employee until the employee's initial visit with the newly authorized treating physician. The opinion of the originally authorized treating physician regarding work restrictions and return to work shall control unless such opinion is expressly modified by the newly authorized treating physician.

Berkshire Hathaway HOMESTATE COMPANIES

# Acknowledgement of Receipt and Notice of Designated Provider List

By signing this document, I am certifying that my employer,_____, provided me with a copy of the designated provider list on_____.

I understand that I must select a medical provider from the designated provider list to provide medical care for any work injuries that I have sustained.

I further understand that, if I am not satisfied with the first provider that I select from the panel, I have the right to request a one-time change within the first 90 days of treatment to another provider on the designated provider list. I may do so by submitting Form WC3 from the Colorado Division of Workers' Compensation to the designated representative. Once I have submitted this change, I am unable to make a change without a written request to the insurance carrier on Form WC197 provided by the Colorado Division of Workers' Compensation.

I understand that the originally authorized provider shall continue treatment until I have my initial visit with the newly authorized treating physician. I further understand that the opinion of the originally authorized treating physician shall control unless it is expressly modified by the newly authorized treating physician.

I have read this acknowledgment and fully understand the entire content. 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 acknowledgement at my request.

**PRINTED NAME** _____

**SIGNATURE**_____

**DATE** _____

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

# Medical History Request

Employee Name

Date of Injury

Employer Name

Completion Date

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

Thank you for your cooperation.

## Past Injuries, Disabilities, or Other Medical Conditions

## Hospitalizations

| Hospital Name & Address | Phone | Date(s) Adimitted |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Treating Physicians or Groups

| Doctor or Group Name, Address | Phone | Dates of Treatment |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

RESET FORM

PRINT THIS FORM

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

*Go to Form*

## Instructions for Completing the

# First Report of Injury

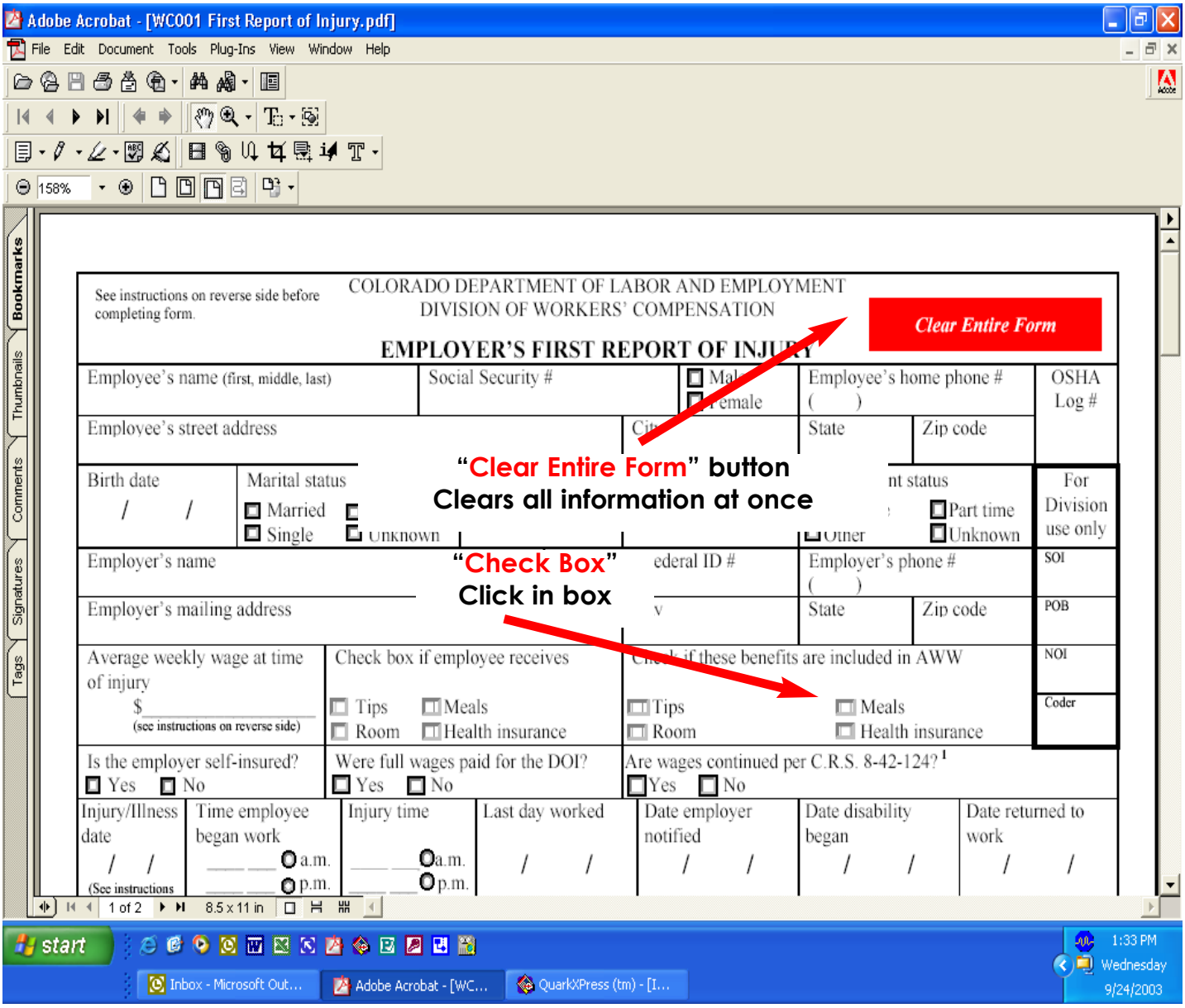
**Please read all pages**

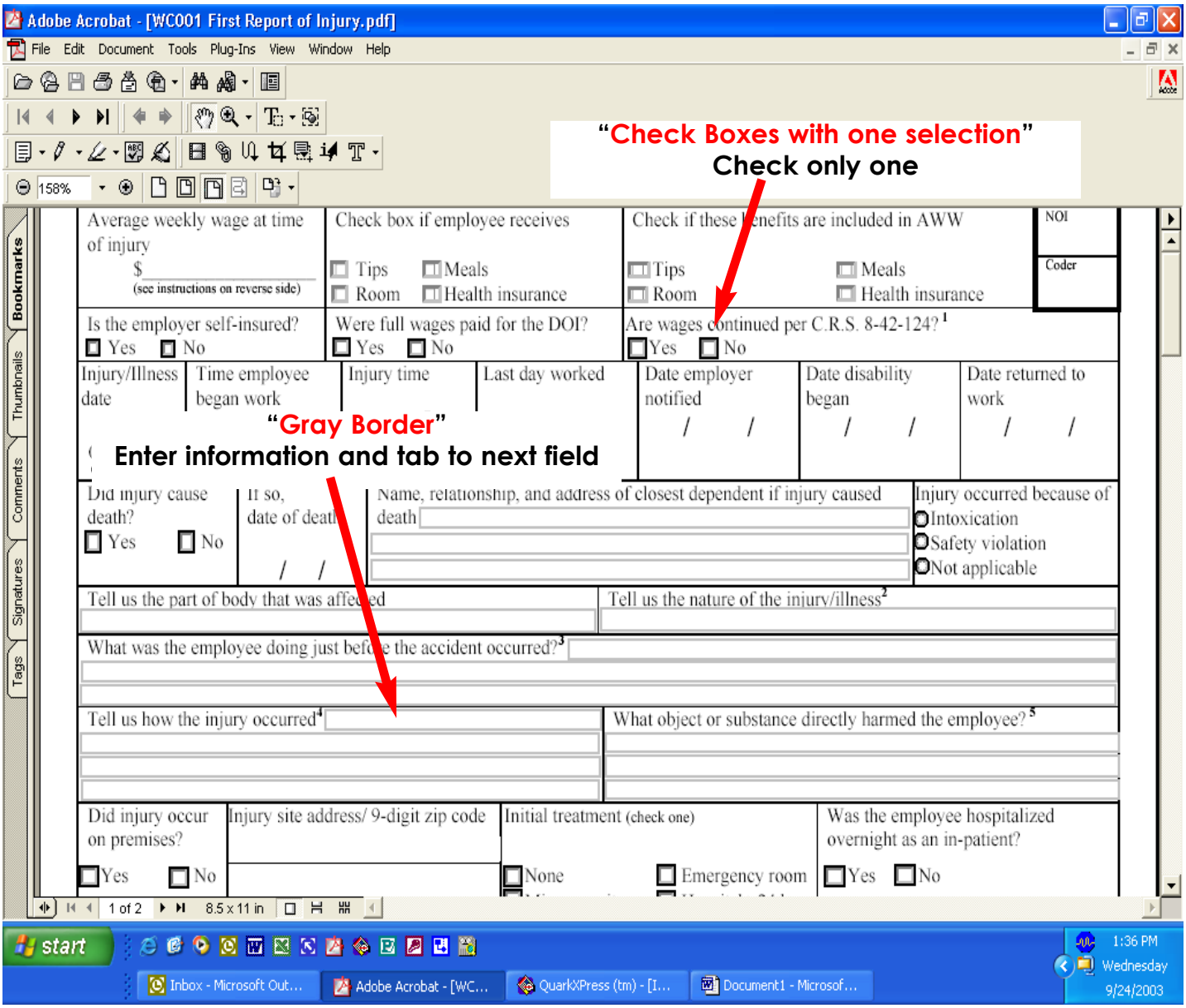
**This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will *not* be able to save the form onto your computer's hard drive.**

**When you open the form, click in the "Employee's Name" box (field), complete the information, and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you *cannot* continue to type information into a field if it doesn't fit into the space provided.**

**Use numbers *only* to fill in the fields for Social Security #, phone numbers and dollar amounts. If a dollar amount contains cents, *do* type the period. To fill in a check box, click inside the box with your mouse. Some check boxes require you to select only one answer; you cannot check both. The "Injury Description", "Name of Witness", and "Name of Doctor" fields have a gray border to indicate how many lines you have to type in. Use the tab key to navigate to the next field.**

**To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To change the information in one field, use the backspace or delete key.**


Adobe Acrobat - [WC001 First Report of Injury.pdf]
File Edit Document Tools Plug-Ins View Window Help
158%
Bookmarks
Thumbnails
Comments
Signatures
Tags
See instructions on reverse side before completing form.
COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
Clear Entire Form
EMPLOYER'S FIRST REPORT OF INJURY
Employee's name (first, middle, last)
Social Security #
Employee's home phone #
OSHA Log #
Employee's street address
State
Zip code
Birth date
Marital status
Married
Single
Unknown
Part time
Unknown
For Division use only
Employer's name
Employer's phone #
SOI
Employer's mailing address
State
Zip code
POB
NOI
Coder
Average weekly wage at time of injury
$
(see instructions on reverse side)
Check box if employee receives
Tips
Meals
Room
Health insurance
Tips
Meals
Room
Health insurance
Is the employer self-insured?
Yes
No
Were full wages paid for the DOI?
Yes
No
Are wages continued per C.R.S. 8-42-124?
Yes
No
Injury/Illness date
(See instructions
Time employee began work
a.m.
p.m.
Injury time
a.m.
p.m.
Last day worked
Date employer notified
Date disability began
Date returned to work
"Clear Entire Form" button
Clears all information at once
"Check Box"
Click in box
1 of 2
8.5 x 11 in
start
Inbox - Microsoft Out...
Adobe Acrobat - [WC...
QuarkXPress (tm) - [I...
1:33 PM
Wednesday
9/24/2003


Adobe Acrobat - [WC001 First Report of Injury.pdf]
File Edit Document Tools Plug-Ins View Window Help
"Check Boxes with one selection"
Check only one
"Gray Border"
Enter information and tab to next field
Average weekly wage at time of injury
$
(see instructions on reverse side)
Check box if employee receives
Tips Meals
Room Health insurance
Check if these benefits are included in AWW
Tips Meals
Room Health insurance
NOI
Coder
Is the employer self-insured?
Yes No
Were full wages paid for the DOI?
Yes No
Are wages continued per C.R.S. 8-42-124? 1
Yes No
Injury/Illness date
Time employee began work
Injury time
Last day worked
Date employer notified
Date disability began
Date returned to work
Did injury cause death?
Yes No
If so, date of death
Name, relationship, and address of closest dependent if injury caused death
Injury occurred because of
Intoxication
Safety violation
Not applicable
Tell us the part of body that was affected
Tell us the nature of the injury/illness 2
What was the employee doing just before the accident occurred? 3
Tell us how the injury occurred 4
What object or substance directly harmed the employee? 5
Did injury occur on premises?
Yes No
Injury site address/ 9-digit zip code
Initial treatment (check one)
None
Emergency room
Was the employee hospitalized overnight as an in-patient?
Yes No
Bookmarks
Thumbnails
Comments
Signatures
Tags
1 of 2
8.5 x 11 in
start
Inbox - Microsoft Out...
Adobe Acrobat - [WC...
QuarkXPress (tm) - [I...
Document1 - Microsof...
1:36 PM
Wednesday
9/24/2003

See instructions on reverse side before completing form.

Back to Instructions

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Clear Entire Form

# EMPLOYER'S FIRST REPORT OF INJURY

| | | | | |
|---|---|---|---|---|
| Employee's name (first, middle, last) | Social Security # | ☐ Male ☐ Female | Employee's home phone # ( ) | OSHA Log # |
| Employee's street address | City | State | Zip code | |
| Birth date / / | Marital status ☐ Married ☐ Separated ☐ Single ☐ Unknown | Date of hire / / | Occupation | Employment status ☐ Full time ☐ Part time ☐ Other ☐ Unknown |
| Employer's name | Employer's Federal ID # | Employer's phone # ( ) | | For Division use only |
| Employer's mailing address | City | State | Zip code | SOI |
| Average weekly wage at time of injury $_____ (see instructions on reverse side) | Check box if employee receives ☐ Tips ☐ Meals ☐ Room ☐ Health insurance | Check if these benefits are included in AWW ☐ Tips ☐ Meals ☐ Room ☐ Health insurance | | POB |
| | | | | NOI |
| | | | | Coder |

| | | | | | | |
|---|---|---|---|---|---|---|
| Is the employer self-insured? ☐ Yes ☐ No | Were full wages paid for the DOI? ☐ Yes ☐ No | Are wages continued per C.R.S. 8-42-124? [1] ☐ Yes ☐ No | | | | |
| Injury/Illness date / / (See instructions on reverse side) | Time employee began work ____ ___ ○ a.m. ____ ___ ○ p.m. | Injury time ○ a.m. ___ ___ ○ p.m. ○ unknown | Last day worked / / | Date employer notified / / | Date disability began / / | Date returned to work / / |
| Did injury cause death? ☐ Yes ☐ No | If so, date of death / / | Name, relationship, and address of closest dependent if injury caused death | | | Injury occurred because of ○ Intoxication ○ Safety violation ○ Not applicable | |
| Tell us the part of body that was affected | | Tell us the nature of the injury/illness [2] | | | | |
| What was the employee doing just before the accident occurred? [3] | | | | | | |
| Tell us how the injury occurred [4] | | What object or substance directly harmed the employee? [5] | | | | |
| Did injury occur on premises? ☐ Yes ☐ No | Injury site address/ 9-digit zip code | Initial treatment (check one) ☐ None ☐ Minor on-site ☐ Clinic/hospital ☐ Emergency room ☐ Hospital >24 hrs | | Was the employee hospitalized overnight as an in-patient? ☐ Yes ☐ No | | |
| Names of witnesses | | Name of employer representative notified | | | | |
| Name and address of treating doctor or other health care professional | | Name and address of facility where treated | | | | |
| Completed by (name) | Title | Phone # ( ) | Date completed / / | | | |

**The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.**

| | | | | |
|---|---|---|---|---|
| Name of insurance company | Address | | | |
| Name of third party administrator (if applicable) | Address | | | |
| Adjuster name | Adjuster phone # | | | |
| Policy # | Carrier claim # | Date insurer received first report / / | Block # | Adj. Code |

**INSTRUCTIONS**
**This form contains all items requested on OSHA Form No. 301,**
**"Injuries & Illnesses Incident Report"**

**General**

- All injuries no matter how trivial must be reported to your insurance company.
- All injuries or occupational diseases which result in lost time from work in excess of three shifts or calendar days, or in permanent physical impairment, must be reported to your insurance carrier on this form within ten days after notice or knowledge of the injury or disease. Fatalities must be reported to your insurance carrier immediately.
- Forms should be typed or printed legibly.
- All questions must be answered completely to meet requirements of the Colorado Workers' Compensation Act and to conform to the OSHA requirements for Form No. 301.
- The employer has the right in the first instance, to select the physician who attends the injured employee.

**Calculation of Average Weekly Wage**

- Determine the weekly wage rate.
- Add the average weekly amount of any overtime wages, tips or commissions.
- Add the average weekly value of any board, rent, housing, or lodging provided by the employer *if the employer will not be paying such benefit during the period of disability.*
- If the employee is covered by group health insurance *and* the employer does not continue the employee's health insurance coverage during the period of disability, add the employee's cost of conversion to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Compute the total from the above categories and insert in the *Average weekly wage at time of injury* field.

**Injury Date Information**

In the case of an occupational disease, use the date of the last injurious exposure.

**Notes**

Are Wages continued per C.R.S. 8-42-124?[1]
(Subject to application with and approval of the Director of the Colorado Division of Workers' Compensation)

**1** Any employer who, by separate agreement, working agreement, contract of hire, or any other procedure, continues to pay a sum in excess of the temporary total disability benefits to an employee temporarily disabled as a result of a work related injury or disease**,** and has not charged the employee with any earned vacation leave, sick leave, or other similar benefits, shall be reimbursed if insured by an insurance carrier or shall take credit if self-insured, to the extent of all moneys that such employee may be eligible to receive as compensation for temporary partial or temporary total disability subject to the approval of the Director of the Colorado Division of Workers' Compensation.

Injury Description (Tell us the part of body that was affected. Tell us the nature of the injury/illness [2]; What was the employee doing just before the accident occurred? [3]; What happened? [4]; What object or substance directly harmed the employee?[5])

**2** Be more specific than ""hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
**3** Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."
**4** Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
**5** Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank

**Notices**

**You are hereby notified that if a child support obligation is owed, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S. YOU ARE FURTHER NOTIFIED that you must provide written notice of any award for social security, pension, disability or other source of income that might reduce your compensation benefits. This notice must be sent to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in suspension of your benefits pursuant to section 8-42-113.5, C.R.S.**

**C.R.S. Section 10-1-128(6) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."**

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

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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

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IMPRIMIR FORMULARIO

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# Supervisor's Report of Employment Incident

Employee Name

Employer Name

Date of Incident | Time of incident | Time the employee began work on day of incident

Did the employee report the incident immediately? Yes or No

Address of Incident | City, State | Zip | Offsite? (Y/N) Yes or No

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

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

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

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

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

# Supervisor's Report of Employment Incident

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

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

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

The above form is true and correct.

Prepared by

Signature

Date Completed

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Workers Compensation Division

# Informe de Incidente del Supevisor

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente? Si/No

Dirección del Incidente

Ciudad, Estado

Código Postal

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

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

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

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

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

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

# Informe de Incidente del Supevisor

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

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

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

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración:

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Workers Compensation Division

# Witness' Report/Statement of Employee Incident

Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)
Yes or No

Date of Incident

Time of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)
Yes or No

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

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

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

What did the employee do after the incident occurred?

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

The above form is true and correct.

Witness' Signature

Date Completed

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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

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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.

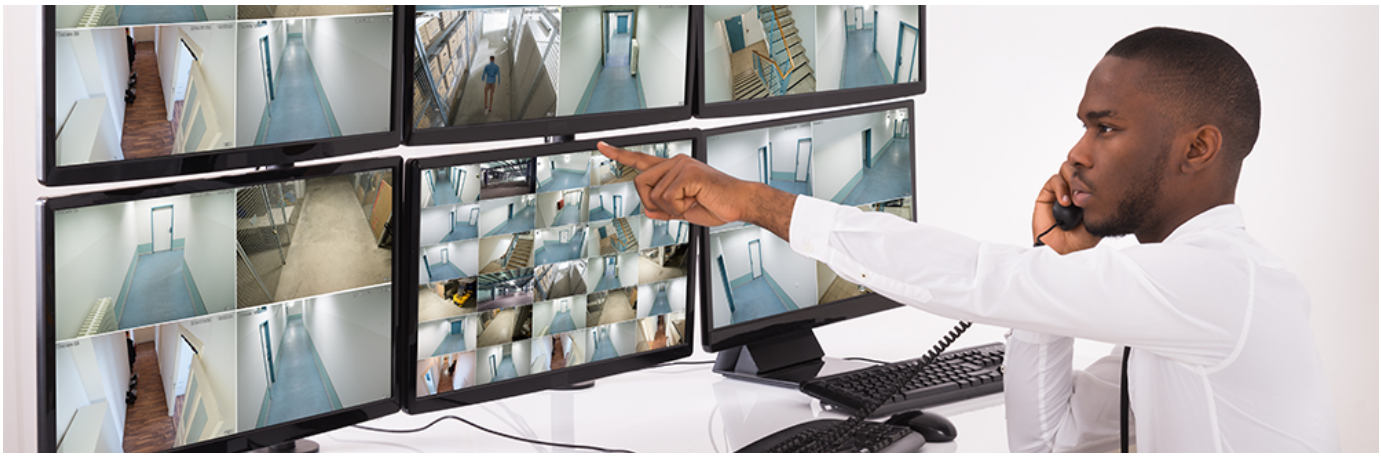
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

## 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.