Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation State Claim Kit

Wisconsin

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.

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

bhhcpolicyholder.bhhc.com/Client/External/Claims

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to (608) 267-0394.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave.
P.O. Box 7901
Madison, WI 53707
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
https://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

(**Please read the instructions on page 2 for completing this form**)

EMPLOYEE

Employee Name (First, Middle, Last)	Social Security Number* - -	Sex ☐ M ☐ F	Employee Home Telephone No. ( ) -

Employee Street Address	City	State	Zip Code	Occupation

Birthdate	Date of Hire	County and State Where Accident or Exposure Occurred?

EMPLOYER

Employer Name	WI Unemployment Ins. Acct No.	Self-Insured? ☐ Yes ☐ No	Nature of Business (Specific Product)

Employer Mailing Address	City	State	Zip Code	Employer FEIN

Name of Worker's Compensation Insurance Co. or Self-Insured Employer	Insurer FEIN
Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer	TPA FEIN

WAGE INFORMATION

Wage at Time of Injury	Specify per hr., wk., mo., yr., etc.	In Addition to Wages, Check Box(es) if Employee Received:		
$	Per:	☐ Meals	No. of Meals/wk.	
		☐ Room	No. of Days/wk	
		☐ Tips	Avg. Weekly Amt.	$

Is Worker Paid for Overtime? ☐ Yes ☐ No If Yes, After How Many Hours of Work Per Week?

For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.

No. of Weeks:	Gross Amount Excluding Tips: $	If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	: ☐ AM ☐ PM			
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:				

Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? ☐ Yes ☐ No If Yes, how many?	Number of **Full-Time** Employees Doing The Same Type Of Work:

INJURY INFORMATION

Injury Date	Time of Injury : ☐ AM ☐ PM	Last Day Worked	Date Employer Notified	☐ Date Returned to Work ☐ Estimated Date of Return

Did Injury Cause Death? ☐ Yes ☐ No	Date of Death	Was This a Lost Time or Other Compensable Injury? ☐ Yes ☐ No	Did Injury Occur Because of: ☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to Obey Rules

Was Employee Treated in an Emergency Room? ☐ Yes ☐ No Was Employee Hospitalized Overnight as an In-Patient? ☐ Yes ☐ No

Name and Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.

What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)

What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)

Report Prepared By	Work Phone Number ( ) -	Position	Date Signed

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

WAGE INFORMATION SUPPLEMENT*

Use this form (WKC-13-A-E) only for injuries occurring before April 10, 2022.

Insurers, including self-insured employers, must submit this form with the first **WKC-13 report** for each claim where TTD is less than the maximum rate in the year the injury occurred.

Read instructions on reverse carefully before completing.

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

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Employee Name	Employee Social Security Number*	Date of Injury

Employer Name

Name of Insurance Company or Self-Insured Employer (do not list adjusting company)

Claims Handling Address (number, city, state, zip code)

Complete Section 4 for part-time employees (include anyone working less than 35 hours per week) before completing Sections 1 and 2.)

1. Hourly Wage — Multiply — Equals — Add — Equals

a. Hourly rate at time of injury:
- ☐ Standard Base $_____
- ☐ Piece Rate (if higher than the standard rate)
- ☐ Standard base rate plus tips

Tip Rate only: $_____

Base + Tip $_____

x

b. Hours per week: (fill in "usual scheduled hours," check the box you use to set the wages)
- ☐ **Normal scheduled hours:** _____ Includes those hours paid at time-and-a-half: **(See Instructions)** _____
- ☐ Actually Worked: (use with piece rate, or tips in Section 1a.) _____
- ☐ Expand to: (See Section 4) 24
- ☐ Expand to Normal Full-time: _____
- ☐ Seasonal: (See instructions) 44

=

c. Base weekly rate: (See reverse for computing rates for time and a half employees)

$_____

+

d. Additional weekly compensation from Section 3 below: (exclude tips)

$_____

=

e. Average weekly earnings: (hourly)

$_____

2. Gross Wage — Divide — Equals — Add — Equals

a. Gross taxable wages in 52-week period prior to date of injury: (Exclude tips)
$_____

÷

b. Number of weeks worked in 52-week period prior to injury:
__

=

c. Base Gross Wage:
$_____

+

d. Additional weekly compensation from Section 3 below:
$_____

=

e. Actual average weekly earnings:
$_____

3. Additions to Cash Wage Received by Employee Per Week (Mark any that apply)

- ☐ Free meals (Number/week) _____ Weekly Amount $_____
- ☐ Room (Number of days/wk) _____ Weekly Amount $_____
- ☐ Tips Amount/Week $_____ (Add only to Section 2d., not 1d.)
- ☐ House or Apartment Weekly Amt $_____ ☐ Check if this is continued during disability
- ☐ Fuel Weekly Amount $_____
- ☐ Lights Weekly Amount $_____
- ☐ Other Weekly Amount $_____
- **Total Weekly Value:** $_____

4. Part-Time Employment (Worked less than 35 hrs/wk)

Part of Class Determination (What percentage of the workforce is part-time employees)	1. Normal number of hours scheduled per week:	2. Number of part-time employees doing same work on same schedule:	3. Number of full-time employees doing the same type of work:	4. _____% Divide 2 by (2 + 3) ☐ No, not part of class (If #4 quotient is less than 10%) ☐ Yes, part of class (If #4 quotient is more than 10%)
	_____	_____	_____	

(Choose a, b or c that applies)

a ☐ Employee worked **less** than 24 hrs/week, **is part of a class and does not restrict** availability for work. Check the box listed as "expand to" in Section 1b above with number of scheduled hours shown as 24.

b ☐ Employee worked less than 35 hours/week, but **is not part of a class and does not restrict** availability for work. Check the box in Section 1b listed as "Expand to Normal full-time" and enter the number of hours which full-time employees normally work for the employer in this occupation.

c ☐ Employee works less than 27 hours/week, and **restricts availability** for work. Check the box in Section 1b listed as "Normal Scheduled Hours" and enter the number of normal scheduled hours. If the employee does not have "normal scheduled hours", leave Section 1b blank and complete all parts of Sections 2 and 5 using the 100% option of the result in Section 2e in Section 5b. **Attach the self-restriction statement**. See instructions on reverse for an **exception to using 100% in Section 5b.**

Important: These options are the only circumstances for which you will use a number other than the "normal hours scheduled" to compute weekly hourly wages. Use normal hours scheduled or actual hours worked (piece rate, time and 1/2 or tip rate) in Section 1b unless 4a, 4b or 4c applies.

5. Weekly Wage and TTD Rate Computation — Multiply — Equals

a. Weekly Wage (Greater of #1 or #2 above)
$_____

X

b. ☐ 66.67% **OR** ☐ 100% (see 4.c)

=

c. Weekly TTD Rate:
$_____

Insurance Claim Representative	Telephone Number
	( ) -

Instructions for Completing the Wage Information Supplement, Form WKC-13-A

These instructions will help you complete the WKC-13-A and compute the TTD rate correctly. If more help is needed, please contact a wage specialist at (608) 266-1340 or send an e-mail to **wcpendrpt@dwd.wisconsin.gov.** Section DWD 80.02(2)(c) of the Wis. Admin. Code requires insurers, including self-insured employers, to submit this form within 30 days after the injury. It must be submitted for every claim where the TTD rate is less than the maximum rate for the year the injury occurred. For a reference to the maximum rates, see our website at: **https://dwd.wisconsin.gov/dwd/publications/wc/WKC-9572-P.pdf**

Section 1a- Hourly Rate at Time of Injury: Enter the standard base rate at the time of injury. Include in the hourly rate any additional hourly amounts which the employee received at the time of injury, e.g., shift differentials. For employees receiving time-and-a-half, enter the standard base rate, not time and a half rate. If this employee did not have an hourly rate but had a weekly, bi-weekly or monthly salary and has scheduled hours of work, divide the salary by the number of hours worked in the pay period to arrive at the hourly rate. If an employee is paid solely by commission or by mileage or some other method where scheduled hours are not used, the TTD rate will be based only on gross earnings. In such a case, enter "NA" in Section 1 and go on to Section 2. For employees paid on a piece work basis, compute the hourly piece work rate by dividing the earnings from piece work by the number of hours actually worked while on piece rate. Exclude time and a half earnings and hours in this computation. Use the piece rate amount only if the resulting rate is higher than the standard hourly rate. If the employee received tips, compute the additional hourly amount of tips. Enter that amount next to **"tip rate"** and add the hourly tip rate to the standard hourly rate to get the "standard base rate plus tips". Compute the tip rate by dividing total tip earnings (only the earnings received in tips) by total hours actually worked on a tip basis. The total hourly rate must be at least the legal minimum hourly wage.

Section 1b- Hours Per Week: Enter the normal number of hours scheduled (regular fixed schedule) at the time of injury). Include the number of hours the employee is paid at the time and a half rate. If the employee does not have regular scheduled hours, enter the number of hours which full-time employees normally work for the employer in this occupation. Include scheduled hours paid at a time-and-a-half rate in the number of "normally scheduled hours". If scheduled hours vary by more than 5 hours from week to week during the 90-day period immediately preceding the injury, use the number of hours that is normal for full time employees for this occupation. Check the box "Actually Worked" in Section 1b and enter the hours actually worked if the hourly rate in Section 1a is piece rate or includes tips. Check the "seasonal" box with **44** hours entered for employees who meet the definition of **"seasonal"** employees in s.102.11(1)(b) Wis. Stats. Seasonal employment cannot exceed 14 weeks. For part time employees, follow the instructions in Section 4.

Section 1c- Base Weekly Rate: Multiply the hourly rate in Section 1a times the hours used in Section 1b. For employees who worked a time and a half schedule at the time of injury and at least 13 consecutive weeks immediately prior to the injury, use the following formula: multiply the standard rate times the normal scheduled hours excluding those hours paid at the time-and-a-half rate; then multiply the time and a half rate times the time and a half hours, and add the two results to get the Base Weekly Rate.

Sections 1d & 1e- Hourly Wages/Additions to Base Average Weekly Wages and Average Weekly Earnings: Enter here and in Section 2d (except for tips) the weekly value of any other type of compensation the employee received, as shown in Section 3.

Section 2a-e Gross Wages and Average Weekly Earnings Enter the gross wages and the number of weeks the employee worked on that job (same type of work) in the 52-week period prior to the date of injury. When counting weeks for Section 2b, do not Include the week of injury in the 52-week period. Count partial weeks as whole weeks. Include tips and additions to wages from Section 3 in section 2e. For employees who worked less than 6 weeks, TTD will be determined solely by the hourly rate in Section 1 or, if the employee does not have an hourly rate, by wages paid in a "same or similar" occupation. Enter "same or similar" wages in Section 2e and skip 2a, 2c and 2d. Complete the computations in Sections 2c, d and e for all others.

Section 3- Additions to Cash Wages: Enter the weekly value of any additional compensation paid to the employee. This value is added to the computations in Sections 1 and 2. The standard value of **"meals"** and **"room"** is set in Wis. Admin. Code DWD 80.29 and DWD 272. The value of all other items is set by common marketplace value to the employee.

Section 4- Part-Time Employment: Complete this Section for all workers at less than the maximum TTD rate if they were scheduled to work less than 35 hours per week at the time of injury.

Part of Class Determination: Complete this part before choosing and checking the applicable Section 4a, 4b or 4c. If the employee's regular work schedule varies by more than 5 hours per week during the 90-day period immediately preceding the injury, always consider the employee as "not part of class". Choose Section 4a, 4b or 4c that applies to the employee before doing the computations in Sections 1 or 2 to set the wage for the employee. If you check Section 4b, you will need to check the box in Section 1b "expand to normal full-time" and enter the number of normal full-time hours there for this occupation. Use the number of hours that are normally considered as full-time for that employer for that occupation to compute the wage.
Self Restriction: An employee "self restricts" employment if he/she limits his/her availability on the labor market to part-time work only and was not employed elsewhere. If you indicate that the worker self-restricts in Section 4c and wages are set at 100%, you must attach a copy of a self-restriction statement signed by the employee, stating the limitation to part-time and that he/she was not working elsewhere at the time of injury. A sample statement can be found at **https://dwd.wisconsin.gov/dwd/forms/WKC/wkc-12698-e.htm**

Section 5-- Wage and Rate Computation: Enter the wage used to compute the TTD rate (the higher amount from Section 1e or 2e). The rate in Section 5c is computed by multiplying the wage by either 66.67% or by 100% (see Section 4c).
Exception to using 100% in Sections 4c and 5b: If using 100% in Section 4c exceeds 66.67% of the wages of a full-time employee doing this job, use 66.67% of wages (higher of 1e or 2e) after expanding the hours in Section 1b to full-time.
Exception Note: If this employee's employment situation is unique and you cannot use the computation formulas in Sections 1 and 2, indicate the wage and TTD rate in Section 5, and attach an explanation of how you computed the wage and TTD rate to this request.

Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation Posting Requirements

Form WKC-12698 – Statement of Self-Restriction to Part-Time Work

The attached form is needed to calculate the workers' compensation benefits for part-time workers. Please have all injured workers that are part-time employees complete and sign the attached form when an injury is reported. Please send the completed form to us while reporting the claim.

(Wisconsin Statutes § 102.11 and Wisconsin Administrative Code DWD 80.51)

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STATEMENT OF SELF-RESTRICTION TO PART-TIME WORK

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
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EMPLOYEE NAME:

EMPLOYEE S.S. #*:

DATE OF INJURY:

This form is needed to properly compute the wage for your Worker's Compensation benefits. Please answer the following questions, sign, date and return to your insurance carrier or self-insured employer.

1. At the time of your injury, did you limit your availability in the labor market to part-time work or to work only with the employer where you were injured?
☐ Yes ☐ No

   If Yes, explain your limitation:

2. At the time of your injury, were you also employed by another employer or self-employed?
☐ Yes ☐ No

   If Yes, please provide us with the name and address of your other employer below:

   Employer Name:

   Employer Address:

Signed Dated _____

Phone Number: _____

Departamento de Desarrollo Laboral
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P.O. Box 7901
Madison, WI 53707
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Servidor de fax para imágenes: (608) 260-2503
FAX: (608) 267-0394
https://dwd.wisconsin.gov/wc
Correo: DWDDWC@dwd.wisconsin.gov

DECLARACIÓN DE AUTORESTRICCIÓN AL TRABAJO A TIEMPO PARCIAL

*Facilitar su número de seguro social (Social Security Number, SSN) es voluntario. No facilitarlo puede causar un retraso en el trámite.
El Departamento de Desarrollo de la Fuerza Laboral (DWD) administra la Ley de Compensación al Trabajador, Capítulo 102 Wis. Stats. El propósito de este formulario es ayudar con la obtención de información relacionada con o requerida por el Capítulo 102. La cumplimentación de este formulario es voluntaria y la no cumplimentación de dicho formulario puede dar lugar a un retraso en la administración del Capítulo 102. El Departamento de Desarrollo de la Fuerza Laboral (DWD) puede utilizar la información de identificación personal (PII) que obtiene de usted en este formulario para fines distintos de aquellos para los que se está recogiendo.

NOMBRE DEL EMPLEADO:

NÚMERO DE SEGURO SOCIAL:

FECHA DE LA LESIÓN:
(mm/dd/yyyy)

Este formulario es necesario para calcular correctamente el salario con miras a su indemnización por accidente en el lugar de trabajo.

Responda las siguientes preguntas, firme, coloque la fecha y devuelva este formulario a su compañía de seguros o empleador auto asegurado.

1. Al momento de lesionarse, ¿limitó su disponibilidad en el mercado laboral al trabajo a tiempo parcial o al trabajo solo con el empleador donde se lesionó?
   ☐ Sí ☐ No

   En caso afirmativo, explique en qué consiste su limitación:

2. Al momento de lesionarse, ¿también estaba empleado por otro empleador o por cuenta propia?
   ☐ Sí ☐ No

   En caso afirmativo, indíquenos el nombre y la dirección del otro empleador:

   Nombre:

   Dirección:

Firma: _____ Fecha de firma: _____

Número de teléfono: _____
con código de área

Voluntary and Informed Consent for Disclosure of Health Care Information

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
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By law, all health care providers must provide to any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time-consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker than if you refuse to authorize the release of medical information.

Health Care Provider Name		Street Address	
P.O. Box	City	State	Zip Code
Patient (Employee) Name	Employer Name		
Patient Social Security Number*	Patient Birth Date	WC Claim No.	

The patient named above hereby authorizes the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment and evaluation to:

Name and Address of Party Authorized to Receive Protected Information

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes *all* records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

CHECK ONE:

☐ **A.** **Physical Only**. Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 146.81 and 146.82, and 45 C.F.R. § 164.508.

☐ **B.** **Physical and Other**. Release all records, correspondence, and any other information from whatever source regarding the patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, hospital or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited Wis. Stat. §§ 51.30, 146.025, 146.81 and 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 and 45 C.F.R. § 164.508.

Patient Signature (or Person Authorized to Sign for Patient) — for Option B

Patient Signature (or Person Authorized to Sign for Patient)	Date Signed

In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by written request to the party authorized above to receive information. However, I understand that my revocation is not effective with respect to actions a covered entity took in reliance on this authorization or as needed for an insurer to contest a claim/policy authorized by law if signing the authorization was a condition to obtaining insurance coverage.
- I may obtain a copy of the disclosed records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

If you have any questions about this document, you should contact the Worker's Compensation Division at (608) 266-1340. You should not sign this document if the name of the health care provider is blank.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy copy shall be as valid as the original.

Patient Signature (or Person Authorized to Sign for Patient)	Date Signed
If not signed by patient, authority/designation to sign is based on the fact that the patient is ☐ A minor ☐ Incompetent ☐ Disabled ☐ Deceased ☐ Other:	

Kev Zoo Siab thiab To Taub Txog Kev Tso Cai Muab Ntaub Ntawv Kho Mob Hais Qhia Tawm

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 266-1340
Fax: (608) 267-0394
https://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

*Ntawm kev muab koj tus Social Security Naj Npawb (SSN) yog nyob ntawm siab yeem. Yog tsis muab ces tej zaum yuav ua rau txoj kev lis cov ntaub ntawv mus qeeb
Chav Hauj Lwm Txhim Kho Cov Ceeg Ua Hauj Lwm (DWD) tswj hwm Cov Neeg Ua Hauj Lwm Txoj Cai Pab Cuam Nyiaj Txiag, Tshooj 102 Wis. Stats. Lub hom phiaj ntawm daim foos no yog los pab nrog kev yuav cov ntaub ntawv ntsig txog los sis raws li kev xav tau los ntawm Tshooj 102. Kev ua kom tiav daim foos no yog kev yeem thiab yog tias ua tsis tiav daim foos uas tau hais los ntawv ces yuav ua rau ncua sij hawm hauv kev tswj hwm ntawm Tshooj 102. Chav Hauj Lwm Txhim Kho Cov Ceeg Ua Hauj Lwm (DWD tuaj yeem siv cov ntaub ntawv qhia txog tus kheej (PII) nws tau txais los ntawm koj nyob ntawm daim foos no txhawm rau lub hom phiaj uas tsis yog cov ntaub ntawv uas nws raug sau lo ntawv.

Raws li kev cai lij choj, txhua qhov chaw kho mob yuav tsum hais qhia rau tus neeg ua hauj lwm uas raug mob, qhov chaw ua hauj lwm, lub worker's compensation insurer los yog cov neeg sawv cev rau lawv txog tej yam mob uas yog ntawm txoj hauj lwm. Tiam sis, kev txheeb cov ntaub ntawv kho lwm yam mob thiab tus mob uas yog los ntawm txoj hauj lwm tsis yooj yim thiab yuav siv sij hawm ntau heev. Yog li, yuav kom pab txo cov sij hawm txheeb ntaub ntawv no kom sai, daim ntawv tso cai no yog muab rau lub chaw kho mob kom lawv muab koj cov ntaub ntawv uas teev txog kev tshuaj ntsuam ntawm koj tus mob, uas lawv thiaj tsis tau mus tshawb nrhiav seb cov ntaub ntawv twg thiaj yog cov teev koj tus mob los ntawm kev raug mob tom hauj lwm los.

Koj tsis tas yuav kos npe rau daim ntawv no los tau. Koj muaj cai tsis kam kos npe rau daim ntawv no yam li yuav tsum tsis muaj kev cuam tshuam nrog rau koj cov cai uas tau worker's compensation benefits. Tiam sis, yog muab kev koom tes nrog kev tshawb nrhiav txog koj qhov mob no, tej zaum koj yuav tau cov kev pab cuam sai dua qhov koj tsis kam tso cai muab koj cov ntaub ntawv kho mob qhia tawm.

Lub Npe Chaw Kho Mob		Chaw Nyob	
P. O. Box	Lub Zos	Lub Xeev	Zip Code
Tus Neeg Muaj Mob Lub Npe		Lub Npe Chaw Ua Hauj Lwm	
Tus Neeg Muaj Mob tus Social Security Naj Npawb*	Tus Neeg Muaj Mob Lub Hnub Yug	WC Claim No.	

Tus neeg muaj mob uas lub npe teev saum toj no tso cai rau lub chaw kho mob uas teev npe saud muab nws cov ntaub ntawv kho mob raws li khij hauv qab txog nws kev tshuaj ntsuam mob, thiab kho nws tus mob mus rau:

Lub Npe thiab Chaw Nyob ntawm qhov chaw uas tau cai txais cov ntaub ntawv qhia txog kev tshuaj ntsuam mob

los yog cov raug xaiv los sawv cev rau lawv, thiab yuav tau muab cov qauv ntawm cov ntaub ntawv teev meej uas muaj pov thawj, teev txog tus mob, tej kev tshuaj ntsuam thiab cov x-rays. Kev tso cai no yog yuav *tas nrho* cov ntaub ntawv, cov ntawv sau txog, los yog lwm cov ntaub ntawv ntawm qhov chaw kho mob uas tau kev tso cai muab tso tawm. Txawm hais tias lub chaw kho mob teev hauv daim ntawv no tsis yog qhov chaw tshawb pom tau tus mob los nws yuav tsum muab cov ntaub ntawv uas nws muaj xa tuaj raws li teev hauv daim ntawv tso cai no. Kev tso cai no yuav muab los siv rau txoj kev tshawb nrhiav, npaj, ntsuam, thiab/los yog sib hais txog worker's compensation claim raws li hais los saud.

CHECK ONE (KHIJ IB NQE):

☐ **A.** **Physical Only**. Tso tas nrho cov ntaub ntawv, cov ntawv teev txog, thiab tej yam yuav qhia txog tus neeg mob ntawd kev noj qab hauv huv, kev kho thiab kev tshuaj ntsuam nrog rau kws kho mob, nurse, chiropractor, osteopath, dentist, physical therapist, lub tsev kho mob, los yog lwm lub chaw muab kev tshuaj ntsuam mob.
Txoj kev tso cai no yuav muab tej cai uas lub xeev thiab tseem fwv tau tsim, tau muab kev soj ntsuam, los yog lwm cov cai, uas tsis tas rau ntawm tus cai Wis. Stat. §§ 146.81 thiab 146.82, thiab 45 C.F.R. § 164.508 tshem tseg.

☐ **B.** **Physical and Other**. Tso tas nrho cov ntaub ntawv, cov ntawv teev txog, thiab lwm cov ntaub ntawv hais txog tus neeg mob tej kev mob ntawm cev nqaij daim ntawv thiab kev meej pem, kev quav yeeb quav tshuaj thiab quav cawv, kev tshuaj ntsuam HIV thiab AIDS, kev kho, thiab kev ntsuam xyuas nrog rau, xws li tej yam uas kws kho mob, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, tsev kho mob los yog ib qho chaw uas muab kev tshuaj ntsuam tshawb pom los yog yuav muab tau los hais qhia.
Txoj kev tso cai no yuav muab tej cai uas lub xeev thiab tseem fwv tau tsim, tau muab kev soj ntsuam, los yog lwm cov cai, uas tsis tas rau ntawm tus cai Wis. Stat. §§ 51.30, 146.025, 146.81 thiab 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 thiab 45 C.F.R. § 164.508.

Tus Neeg Mob Kos Npe (los yog Tus Neeg Tau Kev Tso Cai Kos Npe rau Tus Neeg Mob) — rau Option B:

Tus Neeg Mob Kos Npe (los yog Tus Neeg Tau Kev Tso Cai Kos Npe rau Tus Neeg Mob)	Hnub Kos Npe

Kev kos npe rau daim ntawv no, kuv lees paub tias kuv to taub tias:

- kuv tso cai muab kuv cov ntaub ntawv raws li teev saud tso tawm.
- Kuv muab kev zam rau tej yam uas tej zaum yuav txwv tau kev muab kuv tej ntaub ntawv tso tawm raws li teev saud.
- Kuv to taub hais tias lub chaw muab kev tshuaj ntsuaj mob uas teev npe saud, yog lub chaw kuv tso cai kom muab kuv cov ntaub ntawv qhia tawm txog ntawm kuv kev noj qab haus huv, yam li yuav tsis txwv kuv kev kho mob, kev them nqi, kev zwm npe los yog muaj feem tau kev pab cuam txawm kuv kos npe thiab tsis kos rau daim ntawv no, tswj xeeb: (1) yog hais tias kuv kev kho mob yog ib qho kev tshuaj ntsuam mus rau kev kawm, los yog (2) cov kev pab cuam hauv kev kho mob tsuas muab rau kuv kom tsim kev tiv thaiv ntawm ib cov ntaub ntawv txog kev kho mob uas yuav muab mus rau ib qho chaw twg uas yog lwm tus sab nraud (third party).
- Kuv muaj cai sau ntawv mus thim kev tso cai muab kuv cov ntaub ntawv tso tawm li hais saud, tshwj tias qhov chaw uas tau teev saud twb ho xub txais cov ntaub ntawv ua ntej kuv thim no lawm.
- Kuv muaj cai hais kom qhov chaw uas kuv tau tso cai tau kuv cov ntaub ntawv luam ib co qauv rau kuv yam li tsis raug nqi dab tsi rau kuv them.
- Cov ntaub ntawv qhia txog kuv kev noj qab hauv huv yuav muab qhia tawm raws li kev tso cai hauv daim ntawv no tej zaum yuav tsis tau kev tiv thaiv raws li kev cai lij choj hauv tseem fwv lawm. Kuv cov ntaub ntawv qhia txog kuv kev noj qab hauv huv yuav muab hais mus qhia rau xws li: qhov chaw ua hauj lwm, lub worker’s compensation insurer, lub Department of Workforce Development, lwm cov chaw uas muaj feem nrog rau qhov teeb meem no los yog cov kws lij choj; hauv Labor and Industry Review Commission; kev sib foob hauv lub tsev hais plaub los yog tej yam yuav sib hais txog qhov teeb meem no; tej tus kws uas paub zoo txog tej yam no uas ib tog twg tau ntiav los yog tau sab laj nrog; thiab tej tug agents, cov neeg ua hauj lwm, los yog cov sawv cev rau lawv. Kuv yeej tso cai meej meej kom muab cov ntaub ntawv li teev hauv daim ntawv no hais qhia.
- Kuv muaj cai tau ib daim qauv ntawm daim ntawv no tom qab kuv kos npe rau.

Yog koj muaj lus dab tsi nug txog daim ntawv no, koj yuav tsum hu mus nug huav Worker's Compensation Division ntawm tus xov tooj (608) 266-1340. Yog tsis teev qhov chaw muab kev tshuaj ntsuam mob lub npe rau hauv daim ntawv no, koj yuav tsum tsis txhob kos npe rau daim ntawv no.

Yuav muab daim ntawv tso cai no rhuav thim thaum twg los tau. Yog tsis muab thim, daim ntawv tso cai no yuav siv tau mus li ob (2) lub xyoos txij hnub kos npe. Daim ntawv tso cai no yuav tshem tej cai uas yuav tsum siv raws sij hawm li cov hnub tom qab hnub kos npe, los yog yuav tsum teev ib lub sij hawm tseg rau kev siv ua ntej hnub yuav pib siv tau. Txoj kev tso cai nov kuj yuav ncua sij hawm mus rau cov ntaub ntawv kho mob uas tseem yuav muaj rau yav tom ntej, uas yog tom qab hnub kos npe rau daim ntawv tso cai no lawm, tsuas kom kev kho yuav tsum tshwm sim nyob hauv lub sij hawm uas kev tso cai no tseem siv tau. Ib daim qauv yuav tsum saib muaj nuj nqis tib yam li daim tseem.

Tus Neeg Mob Kos Npe (los yog Tus Neeg Tau Kev Tso Cai Kos Npe rau Tus Neeg Mob)	Hnub Kos Npe
Yog tsis yog tus neeg mob kos npe, tus neeg muaj cai/raug taw kom kos npe yog los ntawv qhov muaj tseeb yog hais tias tus neeg mob ntawd: ☐ Tsis tau muaj hnub nyoog ☐ Tsis muaj peev xwm ☐ Xiam hoob qhab ☐ Tas sim neej lawm ☐ Lwm yam:	

Departamento de Desarrollo de la Fuerza Laboral
División de Compensación de Trabajadores
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Teléfono: (608) 266-1340
Fax: (608) 267-0394
https://dwd.wisconsin.gov/wc/
e-mail: DWDDWC@dwd.wisconsin.gov

Consentimiento Voluntario e Informado para la Divulgación de Información de Atención Médica

*La provisión del número de seguro social (SSN, Social Security Number) es voluntaria. No proporcionarlo puede provocar una demora en el procesamiento de la información.
El Departamento de Desarrollo de la Fuerza Laboral (DWD) administra la Ley de Compensación al Trabajador, Capítulo 102 Wis. Stats. El propósito de este formulario es ayudar con la obtención de información relacionada con o requerida por el Capítulo 102. La cumplimentación de este formulario es voluntaria y la no cumplimentación de dicho formulario puede dar lugar a un retraso en la administración del Capítulo 102. El Departamento de Desarrollo de la Fuerza Laboral (DWD) puede utilizar la información de identificación personal (PII) que obtiene de usted en este formulario para fines distintos de aquellos para los que se está recogiendo.

Según la ley, todos los proveedores de atención médica deben proporcionarle a todo empleado, empleador, asegurador de compensación de trabajadores o sus representantes cualquier tipo de información razonablemente relacionada con cualquier tipo de lesión laboral que se haya alegado. Sin embargo, determinar la relación de las fichas médicas anteriores con una lesión laboral puede ser difícil y llevar tiempo. Por consiguiente, para ayudar a que se lleve a cabo la investigación de su reclamo de manera oportuna, este documento autoriza que el proveedor de atención médica divulgue información médica sin intentar determinar la medida en que se relaciona con la lesión laboral que se ha alegado en su caso.

No se le requiere que firme este documento. Puede rehusarse a firmar este documento sin poner en peligro su derecho de cobrar beneficios de compensación de trabajadores. Sin embargo, al ayudar en la investigación de su reclamo, es probable que reciba beneficios con mayor rapidez que si se rehúsa a autorizar la divulgación de información médica.

Nombre del Proveedor de Atención Médica		Dirección de la Calle	
Apartado Postal	Ciudad	Estado	Distrito Postal
Nombre del Paciente (Empleado)	Nombre del Empleador		
Número de Seguro Social del Paciente*	Fecha de Nacimiento del Paciente	No. de Reclamo de CT	

El paciente cuyo nombre aparece arriba autoriza por medio del presente documento a que el proveedor de atención médica cuyo nombre aparece arriba le divulgue todas las fichas que se han marcado a continuación y que se encuentren en su posesión y tengan que ver con la salud, el tratamiento y la evaluación del paciente a:

Nombre y Dirección de la Parte Autorizada a Recibir la Información Protegida

o a sus representantes designados, y a que les suministre duplicados legibles y certificados de todas las fichas, escritos, informes, resultados de pruebas y rayos x que se encuentren en su posesión y contengan esa información. Esta autorización incluye *todas* las fichas, informes, correspondencia u otros materiales que el proveedor de atención médica autorizado tenga en su posesión, incluso si el proveedor de atención médica no generó esos materiales, y el volver a divulgar esos materiales se autoriza por medio del presente documento. Este permiso de divulgación puede utilizarse en la investigación, preparación, evaluación, y/o la audiencia del reclamo de compensación de trabajadores que se describe arriba.

MARQUE UNA DE LAS SIGUIENTES OPCIONES:

☐ **A.** **Salud Física Únicamente**. Divulgue todas las fichas, correspondencia y cualquier otra información de cualquier procedencia que tenga que ver con la salud física, el tratamiento y la evaluación del paciente, incluyendo sin limitación, las hechas o provistas por cualquier médico, enfermera, quiropráctico, osteópata, dentista, terapeuta físico, hospital, o cualquier otro proveedor de atención médica.

Este consentimiento constituye la renuncia de cualquier privilegio creado por estatutos, normas, reglas o cualquier otro tipo de autoridad estatal o federal, incluyendo sin limitación el Estat. de Wis. §§ 146.81 y 146.82, y 45 C.F.R. § 164.508.

☐ **B.** **Salud Física y de Otras Clases**. Divulgue todas las fichas, correspondencia y cualquier otra información de cualquier procedencia que tenga que ver con la salud física y mental, el abuso de drogas y alcohol, las pruebas de VIH y SIDA, el tratamiento y la evaluación del paciente, incluyendo sin limitación, las hechas o provistas por cualquier médico, psiquiatra, psicólogo, enfermera, quiropráctico, osteópata, dentista, terapeuta físico, hospital, o cualquier otro proveedor de atención médica.

Este consentimiento constituye la renuncia de cualquier privilegio creado por estatutos, normas, reglas o cualquier otro tipo de autoridad estatal o federal, incluyendo sin limitación el Estat. de Wis. §§ 51.30, 146.025, 146.81 y 146.82, 42 C.F.R., Cap. 1, subparte C, § 2.31 y 45 C.F.R. § 164.508.

Firma del Paciente (o Persona Autorizada para Firmar de Parte del Paciente) — para la Opción B:

Firma del Paciente (o Persona Autorizada para Firmar de Parte del Paciente)	Fecha de Firma

Al firmar este impreso de consentimiento, reconozco y entiendo que:

- Estoy autorizando la divulgación de las fichas y la información enumeradas anteriormente.
- Renuncio cualquier privilegio que pueda haber evitado la divulgación de las fichas y la información enumeradas anteriormente.
- Entiendo que el proveedor de atención médica cuyo nombre aparece arriba, al que estoy autorizando a divulgar mi información médica protegida, no puede imponer la condición de que firme esta autorización para proporcionarme tratamiento, pago, inscripción o elegibilidad de beneficios (si es pertinente), excepto: (1) si mi tratamiento se relaciona con la investigación, o (2) los servicios de atención médica se me proporcionan únicamente con el propósito de crear información médica protegida para su divulgación a un tercero.
- Puedo revocar esta autorización en cualquier momento por medio de una solicitud escrita enviada a la parte autorizada arriba a recibir información, excepto que la parte autorizada arriba a recibir esa información puede contar con la información médica personal que haya recibido antes de la revocación de esta autorización.
- Puedo obtener copia de las fichas e información divulgadas previa solicitud escrita enviada a la parte autorizada arriba a recibir información sin costo alguno para mí.
- Mi información médica personal divulgada de acuerdo con esta autorización puede volver a divulgarse y puede que deje de estar protegida por la ley federal. Mi información médica personal puede divulgarse a cualquiera de los siguientes: el empleador, el asegurador de compensación de trabajadores, el Departamento de Desarrollo de la Fuerza Laboral, otras partes relacionadas con este asunto o sus abogados; la Comisión de Revisión Laboral e Industrial; cualquier tribunal o cualquier acción o proceso legal relacionados con este asunto; expertos contratados o consultados por cualquiera de las partes; y cualquiera de sus agentes, empleados, o representantes. Específicamente autorizo y consiento a cualquier tipo de divulgación y redivulgación de ese tipo.
- Tengo derecho a una copia de este impreso de consentimiento después de firmarlo.

Si tiene preguntas acerca de este documento, debe ponerse en contacto con la División de Compensación de Trabajadores llamando al (608) 266-1340. No firme este documento si el nombre del proveedor de atención médica está en blanco.

Este consentimiento está sujeto a revocación en cualquier momento. Si no se revoca, este consentimiento tiene efectividad por un periodo de dos (2) años a partir de la fecha de firma. Esta autorización renuncia expresamente cualquier requisito de que deba utilizarse antes de que pase un determinado número de días después de la fecha de firma, o de que deba ponerse la fecha dentro de un cierto periodo de tiempo antes de la fecha en que se utilice. Esta autorización aplicará también a las fichas de tratamiento que pueda proporcionarse en el futuro, después de la fecha de firma de esta autorización, siempre que ese tratamiento ocurra mientras esta autorización tenga todavía vigencia. Una copia fotocopiada será tan válida como el original.

Firma del Paciente (o Persona Autorizada para Firmar de Parte del Paciente):	Fecha de Firma
Si no está firmada por el paciente, la autoridad/designación de firmar se basa en que el paciente es: ☐ Menor de edad ☐ Incompetente ☐ Incapacitado ☐ Fallecido ☐ Otro:	

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.

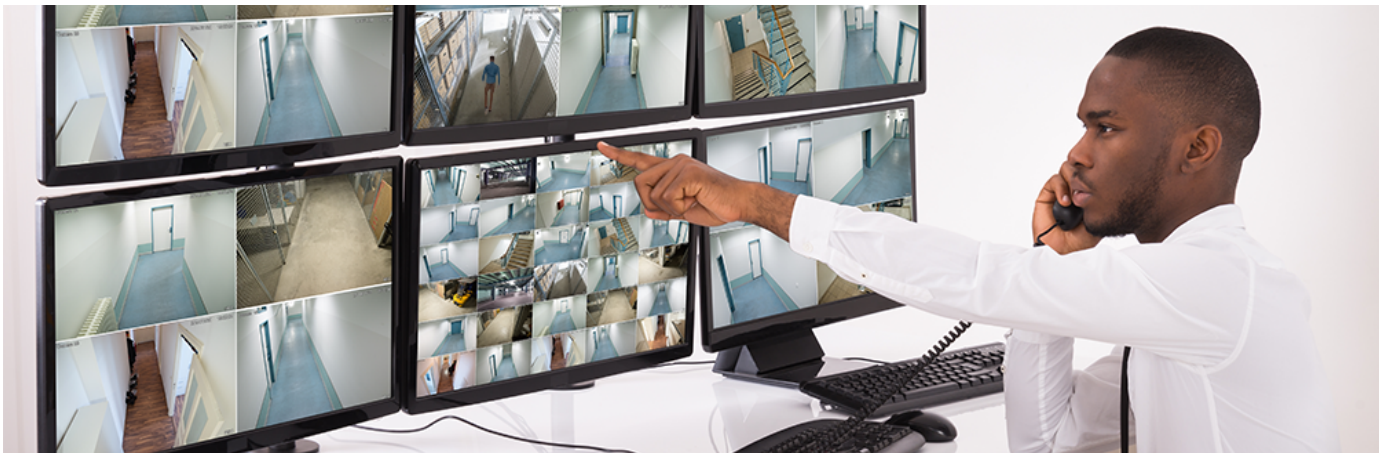
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

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.