Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation State Claim Kit

Delaware

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.

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

bhhcpolicyholder.bhhc.com/Client/External/Claims

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation Posting Requirements

Requirements for Labor Law Poster

- Post in one or more conspicuous places readily accessible to all employees at all business locations
- Print each page of the Poster on 8.5" x 14" (legal size) paper

(19 Delaware Code § 2306(c))

Fox Valley Offices
4425 North Market Street- 3rd Floor
Wilmington, DE 19802
(302) 761-8200

Georgetown American Job Center
8 Georgetown Plaza, Suite 2
Georgetown, DE 19947
(302) 856-5230

DELAWARE DEPARTMENT OF LABOR
DIVISION OF INDUSTRIAL AFFAIRS

Blue Hen Corporate Center
655 S Bay Road, Ste. 2H
Dover, DE 19901
(302) 422-1134

University Office Plaza
252 Chapman Road, 2nd Floor
Newark, DE 19702
(302) 761-8200

Email: wages@delaware.gov | Email: workpermits@delaware.gov | Website: Labor.delaware.gov

PAYMENT OF WAGES

EMPLOYERS OF FOUR (4) OR MORE EMPLOYEES ARE REQUIRED TO:

- **Notify employees in writing at the time of hire:**
  1. Rate of Pay
  2. Day, hour, and place of payment
  3. Employer's fringe benefits policies
- Notify employees in writing of any reductions in the rate of pay, and any changes in the day, hour, or place of payment or benefits.
- Furnish each employee with a pay statement showing:
  1. Amount of wages due;
  2. Pay period covered by the payment;
  3. Amounts of deductions (separately specified) which have been made from the wages;
  4. Total number of hours worked in the pay period (for employees who are paid at an hourly rate).

PAYMENT OF WAGES

- Wages must be paid at least once each month.
- Employees must be paid all wages within seven (7) days from the close of each pay period [with some exceptions, see §1102(b)].
- If the payday falls on a non-work day, payment shall be made on the preceding work day.
- If an employee is not present on the regular payday, payment shall be made on the next regular workday that the employee is present or by mail (only if requested by the employee).
- Wages may be paid to a bank account designated by an employee(upon the employee's written request).
- Wages may be paid in cash or by check (provided that suitable arrangements are made by the employer for cashing at a bank or other business establishment convenient to the workplace).
- Whenever an employee quits, resigns, is discharged, suspended or laid off, the wages earned shall be paid on the next regularly scheduled payday(s) either through the usual pay channels or by mail (if requested by the employee) as if employment had not been suspended or terminated.

UNLAWFUL DEDUCTIONS

Employers are not permitted to deduct or withhold wages for:

1. Cash or inventory shortages;
2. Cash advances or charges for goods and services (unless there is a signed agreement specifying the amount owed and the repayment schedule);
3. Damaged Property
4. Failure to return employer's property

MINIMUM WAGE

Regular Rate:

effective: 06-01-15 - $8.25/hour
effective: 01-01-19 - $8.75/hour
effective: 10-01-19 - $9.25/hour
effective: 01-01-22- $10.50/hour
effective: 01-01-23 - $11.75/hour
effective: 01-01-24 - $13.25/hour
effective: 01-01-25 - $15.00/hour

EMPLOYEES WHO RECEIVE TIPS

The minimum cash wage payable to employees who receive tips is $ 2.23 per hour, effective 10/1/96.

The employer must be able to prove that the employee received the balance of the full minimum rate in tips.

MINIMUM WAGE (continued)

NOTE: Delaware's minimum cash wage for tipped employees is greater than the cash wage required by federal law. Employers must pay Delaware's higher rate.

Tips may not be taken or retained by an employer except as required by law. Tip-pooling is permitted (under certain conditions) in an amount not to exceed 15% of the actual tips received by the employee.

MINIMUM WAGE EXEMPTIONS:

- Employees in agriculture.
- Employees in domestic service in or about private homes.
- Employees of the United States Government.
- Outside commission paid salespeople.
- Bona fide executives, administrators, and professionals.
- Employees engaged in fishing and fish processing at sea.
- Volunteer workers (for educational, religious or non-profit organizations).
- Junior camp counselors employed by non-profit summer camp programs.

RECORD KEEPING REQUIREMENTS:

✦ **Employers must keep records(including the rate of pay, hours worked, and amount paid for each employee for three (3) years.**

BREAKS

All employees must be offered a meal break of at least 30 consecutive minutes if the employee is scheduled to work 7.5 or more hours per day.

Must be after the first 2 hours of work and before the last 2 hours of work.

This rule does not apply when:

- The employee is a professional employee certified by the State Board of Education and employed by a local school board to work directly with children.
- There is a collective bargaining agreement or other employer-employee written agreement which provides otherwise.

Rules have been issued granting exemptions when:

- Compliance would adversely affect public safety.
- Only one (1) employee may perform the duties of a position.
- An employer has fewer than five (5) employees on a shift at one location (the exception would only apply to that shift).
- The continuous nature of an employer's operations, such as chemical production or research experiments, requires employees to respond to urgent or unusual conditions at all times and the employees are compensated for their meal breaks.

Where exemptions are allowed, employees must be allowed to eat meals at their work stations or other authorized locations and use restroom facilities as reasonably necessary.

DELAWARE DEPARTMENT OF LABOR

Revised 01/17/2023
Revised 9/28/2018

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CHILD LABOR

General Provisions

- The minimum age for employment is 14.
- Work Permits are required for all employed minors under the age of 18.
- Employers are required to keep Work Permits on file for each employed minor.
- A new Work Permit is required when the employer of a minor change**s**.

Provisions for Individuals 14 and 15 Years of Age:

MINORS 14-15 YEARS OF AGE SHALL NOT WORK:

- Before 7:00 a.m. or after 7:00 p.m. - except from June 1st through Labor Day when the evening hour shall be extended to 9:00 p.m.
- More than four (4) hours per day on school days
- More than eight (8) hours per day on non-school days
- More than eighteen (18) hours in any week when school is in session for five (5) days
- More than six (6) days in any week
- More than forty (40) hours per week; and
- More than five (5) hours continuously without a non-work period of at least thirty (30) consecutive minutes.

Specific Provisions for Individuals 16 and 17 Years of Age:

- Not more than twelve (12) hours in a combination of school and work hours per day
- Must have at least eight (8) consecutive hours of non-work, non-school time in each twenty-four (24) hour period
- May not work more than five (5) hours continuously without a non- work period of at least thirty (30) consecutive minutes.

For a list of Prohibited Occupations, contact:

The Delaware Department of Labor, Division of Industrial Affairs, Office of Labor Law Enforcement at any of the addresses listed.

This poster provides only general information regarding the provisions of Delaware's Child Labor Laws. The requirements of state law do not affect an employer's obligation to comply with any provisions of federal law.

WAGE THEFT

An employer may not do any of the following:

- Employ an individual without reporting the individual's employment to all appropriate government agencies and paying all applicable taxes and fees for the individual.
- Fail to properly withhold state and federal taxes from an employee.
- Fail to forward money withheld from an employee's wages to the appropriate state or federal agency within 7 days of the applicable pay period.
- Pay an employee wages that are less than the minimum wage established under state and federal law for the work performed.
- Misclassify a worker as an independent contractor for purposes of avoiding wage, tax, or workers' compensation obligations under this title.
- Knowingly conspire to assist, advise, or facilitate a violation of this section.

PENALTIES

- Following an investigation in which the Department makes an initial determination that an employer has violated one or more provisions of subsection (a) of this section, the Department may decide to impose a civil penalty.
- An employer who violates this section is subject to a civil penalty of not less than $2,000 and not more than $20,000 for each violation.
- Each instance of a violation of subsection (a) of this section per employee is a separate violation.
- The Department may also refer cases to the Department of Justice for criminal prosecution consistent with § 841D of Title 11

RETALIATION

An employer is subject to a civil penalty of not less than $20,000 and not more than $50,000 for each violation if the employer discharges or in any manner retaliates or discriminates against an individual because that individual does any of the following under this section:

a. Made a complaint or provided information to the Department.
b. Caused, or is going to cause, an investigation to be instituted.
c. Testified, or is going to testify, in a hearing.

It is unlawful to retaliate against an employee because (s)he has made a complaint or given information to the Dept of Labor about possible labor law violations.

Employers Are Required By Law To Display This Official Poster In A Place Accessible To Employees And Where They Regularly Pass

Violations of Delaware Labor Laws could result in fines of up to $20,000 per violation.

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PAGO DE SALARIOS

A LOS EMPLEADORES CON CUATRO (4) O MÁS EMPLEADOS SE LES EXIGE:

- Notificar a los empleados por escrito al momento de la contratación:
  1. Tarifa de pago
  2. Día, hora y lugar de pago
  3. Políticas sobre límites en los beneficios del empleador
- Notificar a los empleados por escrito sobre cualquier reducción en la tarifa de pago y cualquier cambio en el día, la hora o el lugar de pago o en los beneficios.
- Proporcionar a cada empleado una declaración de pago que indique:
  1. Importe de salarios adeudados.
  2. Período de pago cubierto por el pago.
  3. Montos de las deducciones (definido por separado) que se realizaron en los salarios.
  4. Cantidad total de horas trabajadas en el período de pago (para los empleados pagados a una tarifa por hora).

PAGO DE SALARIOS

- Los salarios deben pagarse al menos una vez por mes.
- A los empleados se les deben pagar los salarios dentro de los siete (7) días del cierre de cada período de pago [con algunas excepciones, consulte §1102(b)].
- Si el día de pago cae en un día no laborable, el pago se deberá realizar el día laborable anterior.
- Si un empleado no está presente en el día de pago regular, el pago se realizará el siguiente día laborable regular que el empleado esté presente o se realizará por correo (solo si así lo solicita el empleado).
- Los salarios pueden pagarse en una cuenta bancaria designada por un empleado (si lo solicita por escrito el empleado).
- Los salarios pueden pagarse en efectivo o cheque (siempre que el empleador tome las disposiciones adecuadas para el cobro en un banco u otro establecimiento comercial conveniente para el lugar de trabajo).
- Cuando un empleado renuncia o se le desvincula, suspende o despide, los salarios recibidos se pagarán en el siguiente día de pago programado de forma regular ya sea a través de los medios de pago usuales o por correo (si el empleado lo solicita) como si el empleo no se hubiera suspendido o finalizado.

DEDUCCIONES ILEGALES

A los empleadores no se les permite deducir ni retener los salarios por lo siguiente:

1. Falta de dinero en efectivo o inventario
2. Anticipos de dinero en efectivo o cargos por bienes y servicios (excepto que haya un acuerdo firmado que especifique el monto adeudado y el cronograma de pago)
3. Propiedad dañada
4. Incumplimiento en la devolución de propiedad del empleador.

SALARIO MÍNIMO

Tarifa regular:

Vigencia: 01-06-15 - $8.25/hora
Vigencia: 01-01-19 - $8.75/hora
Vigencia: 01-10-19 - $9.25/hora
Vigencia: 01-01-22 - $10.50/hora
Vigencia: 01-01-23 - $11.75/hora
Vigencia: 01-01-24 - $13.25/hora
Vigencia: 01-01-25 - $15.00/hora

EMPLEADOS QUE RECIBEN PROPINAS

El salario mínimo en efectivo pagadero a los empleados que reciben propinas es de $2.23 por hora, a partir del 1/10/96.

El empleador debe poder comprobar que el empleado recibió el saldo del porcentaje mínimo total en propinas.

SALARIO MÍNIMO (continuación)

NOTA: El salario mínimo en efectivo de Delaware para empleados que reciben propinas es mayor que el salario en efectivo requerido por la ley federal. Los empleadores deben pagar la tarifa más alta de Delaware.

Un empleador no puede quitar ni retener las propinas excepto que lo requiera la ley. La acumulación de propinas está permitida (bajo ciertas condiciones) en un monto que no supere el 15% de las propinas reales recibidas por el empleado.

EXCENCIONES EN LOS SALARIOS MÍNIMOS:

- Empleados del sector agrícola.
- Empleados del servicio doméstico en hogares privados.
- Empleados del Gobierno de los Estados Unidos.
- Vendedores pagados fuera de la comisión.
- Ejecutivos, administradores y profesionales con credenciales.
- Empleados involucrados en el sector pesquero y procesamiento de peces en alta mar.
- Trabajadores voluntarios (para organizaciones educativas, religiosas o sin fines de lucro).
- Orientadores en campamentos juveniles empleados por programas de campamentos de verano sin fines de lucro.

REQUISITOS PARA EL MANTENIMIENTO DE REGISTROS:

- Los empleadores deben llevar el mantenimiento de registros, incluida la tarifa de pago, las horas trabajadas y el monto pagado por cada empleado durante tres (3) años.

RECESOS

Todos los empleados deben recibir un receso para las comidas de al menos 30 minutos consecutivos si el empleado tiene programado trabajar 7.5 o más horas por día.

Debe realizarse después de las primeras 2 horas de trabajo y antes de las últimas 2 horas de trabajo.

Ésta regla no se aplica cuando:

- El empleado es un empleado profesional certificado por el Consejo de Educación del Estado y está empleado por la junta escolar local para trabajar directamente con niños.
- Existe un acuerdo de negociación colectiva u otro acuerdo por escrito entre empleador y empleado que dispone de otro modo.

Se han emitido reglas que otorgan exenciones cuando:

- El cumplimiento afectaría de forma negativa la seguridad pública.
- Solo un (1) empleado puede llevar a cabo las responsabilidades de un puesto.
- Un empleador tiene menos de cinco (5) empleados en un turno en una ubicación (la excepción solo se aplicaría a ese turno).
- La naturaleza continua de las operaciones de un empleador, tales como la producción química o los experimentos de investigación, requiere que los empleados respondan a las condiciones urgentes o inusuales en todo momento y que los empleados reciban compensación por los recesos para comidas.

Cuando se permiten exenciones, los empleados deben tener permitido comer en sus estaciones de trabajo o en otras ubicaciones autorizadas y usar las instalaciones sanitarias como sea razonablemente necesario.

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Email: wages@delaware.gov | Email: workpermits@delaware.gov | Website: Labor.delaware.gov

TRABAJO INFANTIL

Disposiciones Generales:

- La edad mínima para trabajar es 14 años.
- Se requieren permisos laborales a todos los empleados menores de 18 años.
- Se exige a todos los empleadores conservar archivados los permisos laborales de cada empleado menor.
- Se exige un nuevo permiso laboral cuando un menor cambia de empleador.

Disposiciones para individuos de 14 y 15 años:
LOS MENORES DE 14-15 AÑOS NO DEBEN TRABAJAR:

- Antes de las 7:00 a. m. ni después de las 7:00 p. m. - excepto desde el 1.° de junio hasta el Día del trabajo cuando la hora vespertina se extiende hasta las 9:00 p. m.
- Más de cuatro (4) horas por día los días de escuela
- Más de ocho (8) horas por día en días que no hay escuela
- Más de dieciocho (18) horas en cualquier semana en que hay clases durante cinco (5) días
- Más de seis (6) días en cualquier semana
- Más de cuarenta (40) horas por semana y
- Más de cinco (5) horas de forma continua sin un período no laborable de al menos treinta (30) minutos consecutivos.

Disposiciones específicas para individuos de 16 y 17 años:

- No deben trabajar más de doce (12) horas en una combinación de horas de escuela y laborables por día
- Deben tener al menos ocho (8) horas consecutivas de tiempo no laborable fuera de la escuela en cada período de veinticuatro (24) horas
- No pueden trabajar más de cinco (5) horas continuas sin un período no laborable de al menos treinta (30) minutos consecutivos.

Para obtener una lista de Actividades prohibidas, comuníquese con:

Departamento de Trabajo de Delaware, División de Asuntos Industriales, Oficina de Cumplimiento de la Ley de Trabajo en cualquiera de las direcciones enumeradas

Este póster solo brinda información general en relación con las disposiciones de las leyes laborales infantiles de Delaware. Los requisitos de la ley estatal no afectan la obligación de un empleador de cumplir con cualquier disposición de la ley federal.

ROBO DE SALARIOS

Un/a empleador/a no puede hacer nada de lo siguiente:

- Emplear a una persona sin informar de su empleo a todas las agencias gubernamentales apropiadas y sin pagar todos los impuestos y tasas aplicables a dicha persona.
- No retener adecuadamente los impuestos estatales y federales de un/a empleado/a.
- No enviar el dinero retenido del salario de un/a empleado/a a la agencia estatal o federal correspondiente en un plazo de 7 días luego del período de pago aplicable.
- Un/a empleador/a no puede hacer nada de lo siguiente:
- Pagar a un/a empleado/a un salario inferior al salario mínimo establecido por las leyes estatales y federales para el trabajo realizado.
- Clasificar de forma incorrecta a un/a trabajador/a como contratista independiente con el fin de eludir las obligaciones salariales, tributarias o de compensación de los/las trabajadores/as en virtud de este título.
- Conspirar a sabiendas para ayudar, asesorar o facilitar una infracción de esta sección.

PENALIDADES

- Luego de una investigación en la que el Departamento haga una determinación inicial de que un/a empleador/a ha infringido una o más disposiciones de la subsección (a) de esta sección, el Departamento puede decidir imponer una penalidad civil.
- Un/a empleador/a que infrinja este artículo estará sujeto/a a una penalidad civil no inferior a $ 2000 y no superior a $20.000 por cada infracción.
- Cada instancia de infracción de la subsección (a) de esta sección constituye una infracción independiente por empleado/a.
- El Departamento también puede derivar casos al Departamento de Justicia para su enjuiciamiento penal de conformidad con la sección 841D del Título 11.

RETALIACIÓN

Un/a empleador/a está sujeto/a a una penalidad civil de no menos de $ 20.000 y no más de $ 50.000 por cada infracción si el/la empleador/a despide o de cualquier forma toma represalias o discrimina a una persona porque esa persona hace cualquiera de los siguientes bajo esta sección:

a. Presentar una queja o facilitar información al Departamento.
b. Haber causado o causar la apertura de una investigación.
c. Haber testificado o testificar en una audiencia.

Es ilegal tomar represalias contra un empleado porque este ha presentado una queja o ha informado al Departamento de Trabajo acerca de posibles violaciones de la ley laboral.

Los empleadores están obligados por ley a mostrar este póster oficial en un lugar accesible a los empleados y por donde estos pasen en forma regular

Las infracciones de la Ley laboral de Delaware pueden ocasionar multas de hasta $20.000 por infracción.

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PEMAN SALÈ

PATWON KAT (4) OSWA PLIS ANPLWAYE YO GEN DEVWA POU:

- **Fè anplwaye yo konnen alekri nan moman rekritman an:**
  1. To Reminerasyon an
  2. Jou, lè ak kote peman an ap fèt
  3. Politik sou avantaj an nati anplwayè a
- Fè anplwaye yo konnen alekri tout rediksyon nan to reminerasyon an, ak tout chanjman nan jou, lè oswa lye peman an oswa avantaj yo.
- **Bay chak anplwaye yon deklarasyon salè ki montre:**
  1. Montan salè a;
  2. Peryòd peman salè a kouvri;
  3. Montan dediksyon (presize apa) ki te fèt sou salè yo;
  4. Kantite total èdtan travay nan peryòd peman (pou anplwaye yo peye pa èdtan travay).

PEMAN SALÈ

- Yo dwe peye salè yo omwen yon fwa chak mwa.
- Yo dwe peye anplwaye yo tout salè yo nan sèt (7) jou apati fen chak peryòd peman [ak kèk eksepsyon, gade §1102(b)].
- Si jou peman an tonbe nan yon jou ki pa jou travay, peman an dwe fèt nan jou travay anvan an.
- Si yon anplwaye pa prezan nan jou peman regilye a, yo pral fè peman nan pwochen jou travay regilye anplwaye a prezan an oswa pa lapòs (sèlman si anplwaye a mande sa).
- Yo ka peye salè a sou yon kont labank yon anplwaye bay (sou demann alekri anplwaye a).
- Yo ka bay salè a pa chèk oswa lajan kach (a kondisyon ke patwon an fè aranjman ki apwopriye pou touche nan yon bank oswa yon lòt etablisman biznis ki pa lwen espas travay la).
- Chak fwa yon anplwaye kite, demisyone, revoke, sispann oswa sou atant, salè ou merite a pral peye nan pwochen jou peman ki pwograme regilyèman swa atravè mwayen peman abityèl yo oswa pa lapòs (si anplwaye a mande sa) tankou si travay la pa te kanpe oswa fini.

DEDIKSYON ILEGAL YO

Patwon yo pa gen otorizasyon pou dedwi oswa kenbe salè pou:

1. Mank lajan oswa envantè;
2. Lajan an avans oswa frè pou machandiz ak sèvis (sòf si gen yon akò ki siyen ki espesifye montan lajan yo dwe ak orè ranbousman an);
3. Byen ki andomaje
4. Pa arive remèt byen patwon an.

SALÈ MINIMUM

To Regilye:

an vigè: 06-01-15 - $8.25/èdtan
an vigè: 01-01-19 - $8.75/èdtan
an vigè: 10-01-19 - $9.25/èdtan
an vigè: 01-01-22- $10.50/èdtan
an vigè: 01-01-23 - $11.75/èdtan
an vigè: 01-01-24 - $13.25/èdtan
an vigè: 01-01-25- $15.00/èdtan

ANPLWAYE KI RESEVWA TEP

Salè minimòm yon anplwaye ki resevwa tep ka touche se $2.23 pa èdtan, an vigè 10/1/96.

Patwon an dwe kapab pwouve ke anplwaye a te resevwa balans pou tout kantite salè minimòm lan nan tep.

SALÈ MINIMUM (ak swit)

AVI: Salè minimòm lajan kach nan Delaware pou anplwaye ki jwenn tep yo pi gwo pase salè lajan kach lalwa federal egzije. Patwon yo dwe peye to Delaware ki pi elve a.

Yon patwon pa ka pran oswa kenbe tep eksepte jan lalwa egzije sa. Yo pèmèt yo rasanble tep yo (nan sèten kondisyon) nan yon kantite lajan ki pa depase 15% tep anplwaye a resevwa nan moman an.

EKSEPSYON SALÈ MINIMUM YO:

- Anplwaye nan agrikilti.
- Anplwaye nan sèvis domestik nan oswa sou kay prive.
- Anplwaye Gouvènman Etazini.
- Vandè ki touche komisyon deyò.
- Dirijan, administratè, ak pwofesyonèl bòn fwa yo.
- Anplwaye ki angaje nan lapèch ak transfòmasyon pwason nan lanmè.
- Travayè volontè (pou òganizasyon edikasyon, relijye oswa òganizasyon ki pa pou pwofi).
- Konseye kan jinyò k ap travay pou pwogram kan dete san pwofi yo.

KONDISYON POU KONSÈVE DOSYE YO:

- **Patwon yo dwe kenbe dosye (ki gen ladan yo to reminerasyon, èdtan travay, ak montan lajan yo peye pou chak anplwaye pandan twa (3) ane.**

POZ

Yo dwe ofri tout anplwaye yo yon poz manje pou omwen 30 minit swivi si anplwaye a pwograme pou travay 7 èdtan edmi (7.5) oswa plis pa jou.

Dwe apre 2 premye èdtan travay yo epi anvan 2 dènye èdtan travay yo.

Règ sa pap aplike lè:
Anplwaye a se yon anplwaye pwofesyonèl ki sètifye pa Konsèy Edikasyon Eta a epi li anplwaye pa yon konsèy lekòl lokal pou travay dirèkteman ak timoun.

Yo te pibliye règ ki bay eksepsyon lè:

- Konfòmite ta pral gen yon efè negatif sou sekirite piblik la.
- Sèlman yon (1) anplwaye ta dwe ranpli fonksyon yon pozisyon.
- Yon patwon gen mwens pase senk (5) anplwaye nan yon woulman nan yon zòn (eksepsyon an ta pral aplike sèlman pou woulman sa).
- Nati pwogresis operasyon yon patwon, tankou pwodiksyon chimik oswa eksperyans rechèch, mande pou anplwaye yo reponn a kondisyon ijans oswa etranj an tout tan epi anplwaye yo jwenn konpansasyon pou poz manje yo.

Kote yo otorize ekzanpsyon, anplwaye yo dwe gen dwa pou manje nan pòs travay yo oswa lòt kote yo otorize pou fè sa epi sèvi ak twalèt yo lè sa nesesè nan yon mannyè rezonab.

DELAWARE DEPARTMENT OF LABOR

Fox Valley Offices
4425 North Market Street- 3rd Floor
Wilmington, DE 19802
(302) 761-8200

Georgetown American Job Center
8 Georgetown Plaza, Suite 2
Georgetown, DE 19947
(302) 856-5230

Depatman Travay Delaware Divizyon
Zafè Endistriyèl yo

Blue Hen Corporate Center
655 S Bay Road, Ste. 2H
Dover, DE 19901
(302) 422-1134

University Office Plaza
252 Chapman Road, 2nd Floor
Newark, DE 19702
(302) 761-8200

Imèl: wages@delaware.gov | Imèl: workpermits@delaware.gov | Sit Entènèt: Labor.delaware.gov

TRAVAY TIMOUN

Dispozisyon Jeneral yo:

- Pi piti laj pou travay se 14 zan.
- Pèmi Travay yo obligatwa pou tout minè ki gen mwens pase 18 lane ki ap travay.
- Patwon yo dwe kenbe Pèmi Travay nan dosye chak minè ki ap travay.
- Yon nouvo Pèmi Travay obligatwa lè yon minè chanje patwon.

Dispozisyon pou Endividi ki gen 14 ak 15 Lane:

MINÈ ki gen ant 14 ak 15 LANE PA DWE TRAVAY:

- Anvan 7:00 a.m. oswa apre 7:00 p.m. - eksepte soti 1ye jen jiska Jounen Travay (Labor Day) pandan lè aswè a pral pwolonje jiska 9:00 p.m.
- Plis pase kat (4) èdtan pa jou nan jou lekòl
- Plis pase uit (8) èdtan pa jou nan jou ki pa gen lekòl
- Plis pase dizwit (18) èdtan nan nenpòt semèn lè lekòl ap travay pandan senk (5) jou
- Plis pase sis (6) jou nan nenpòt semèn
- Plis pase karant (40) èdtan pa semèn; epi
- Plis pase senk (5) èdtan swivi san yon peryòd poz ki dire omwen trant (30) minit swivi.

Dispozisyon Espesifik pou Endividi 16 ak 17 Lane:

- Pa plis pase douz (12) èdtan nan yon konbinezon lè lekòl ak lè travay pa jou
- Dwe gen omwen uit (8) èdtan swivi san travay, san lekòl nan mitan chak peryòd vennkat (24) èdtan
- Pa dwe travay plis ke senk (5) èdtan swivi san yon peryòd poz ki dire omwen trant (30) minit swivi.

Pou yon lis Okipasyon ki Entèdi yo, kontakte:

Depatman Travay Delaware, Divizyon Zafè Endistriyèl, Biwo Aplikasyon Lwa Travay nan nenpòt nan adrès ki endike yo.

Afich sa a bay sèlman enfòmasyon jeneral konsènan dispozisyon Lwa Travay Timoun Delaware yo. Egzijans lwa eta a pa afekte obligasyon yon patwon pou li respekte dispozisyon lwa federal yo.

Li pa legal pou fè vanjans kont yon anplwaye paske li te fè yon plent oswa li te bay Depatman Travay enfòmasyon sou yon posib vyolasyon lalwa travay.

VÒLÈ SALÈ

Yon patwon pa dwe fè okenn nan sa yo:

- Anboche yon moun san ou pa rapòte sa bay tout ajans gouvènman ki konsène ak peye tout taks ak frè aplikab yo pou moun nan.
- Pa rive byen fè prelèvman taks eta ak federal sou yon anplwaye.
- Pa rive voye prelèvman lajan ki te fèt sou salè anplwaye a bay ajans leta oswa federal ki konsène, 7 jou apre peryòd pèman aplikab la.
- Yon patwon pa dwe fè okenn nan sa yo:
- Peye yon anplwaye yon salè ki pi ba ke salè minimòm ki etabli dapre lwa eta ak federal la pou travay yo te fè.
- Kategorize enjisteman yon travayè avèk yon tit antreprenè endepandan nan objektif pou evite obligasyon fiskal, salaryal, ak konpansasyon aksidan travay yo.
- Fè konplo pou fasilite, bay oswa asiste, ak tout volonte, yon vyolasyon nan seksyon sa a.

SANKSYON YO

- Apre yon ankèt kote Depatman an reyalize gen yon patwon ki te vyole youn oswa plizyè dispozisyon sou-seksyon (a) nan seksyon sa a, Depatman an ka deside bay yon sanksyon sivil.
- Yon patwon ki vyole seksyon sa ka sibi yon sanksyon sivil ki pa pi ba pase $2,000 epi ki pa plis pase $20,000 pou chak vyolasyon.
- Chak ka vyolasyon sou-seksyon (a) nan seksyon sa a pou chak anplwaye, se yon vyolasyon apa.
- Depatman an gendwa voye ka yo bay Depatman Jistis la pou pouswit kriminèl dapre atik § 841D Tit 11

REVANJ

Yon patwon ka sibi yon sanksyon sivil ki pa pi ba pase $20,000 epi ki pa plis pase $50,000 pou chak vyolasyon si patwon an revoke oswa nan nenpòt fason, fè vanjans oswa diskriminasyon kont yon moun paske moun sa a fè youn nan bagay sa yo ki anndan seksyon sa a:

a. Te pote plent oswa te bay Depatman an enfòmasyon.
b. Te lakòz oswa pral lakòz yon ankèt fèt.
c. Temwanye oswa pral temwanye nan yon odyans.

La lwa oblije patwon yo pou montre afich ofisyèl sa a nan yon kote anplwaye ka wè epi kote yo pase toutan.

Vyolasyon Lwa Travay Delaware yo kapab lakòz amann jiska $20,000 pou chak vyolasyon.

ALL COPIES OF THIS FIRST REPORT MUST BE TYPED OR PRINTED

Department of Labor
Office of Workers' Compensation (OWC)
4425 N. Market Street
Wilmington, DE 19802
Telephone 302-761-8200

STATE OF DELAWARE
FIRST REPORT
OF OCCUPATIONAL INJURY OR DISEASE

OWC Case File No. _____

ALL INFORMATION IS REQUIRED, unless not applicable where "if applicable" is noted.

1. EMPLOYEE: FIRST / MIDDLE / LAST			**2. EMPLOYEE SOCIAL SECURITY NO.**	
3. ADDRESS – INCLUDE COUNTY AND ZIP CODE			**4.** MALE ☐ FEMALE ☐	**5. EMPLOYEE PHONE NUMBER (INCLUDING AREA CODE)**
6. DATE OF BIRTH / /	**7. AGE**	**8. WAGE**	**9. WEEKLY HOURS WORKED**	
10. OCCUPATION (REGULAR)	**11. DEPARTMENT OR DIVISION REGULARLY EMPLOYED**		**12. HOW LONG EMPLOYED**	
13. EMPLOYER:			**14. PERSON MAKING OUT THIS REPORT**	
15. ADDRESS – INCLUDE COUNTY AND ZIP CODE			**16. EMPLOYER PHONE # (INCLUDE AREA CODE)**	
17. MAILING ADDRESS – IF DIFFERENT THAN ABOVE			**18. NATURE OF BUSINESS – TYPE OF MFG., TRADE, CONSTURCTION, SERVICE, ETC.**	
19. WORKERS' COMPENSATION INSURANCE CARRIER			**20. WORKERS' COMP. INS. CARRIER PHONE #, (INCLUDING AREA CODE**	
21. WORKERS' COMP. INSURANCE CARRIER ADDRESS			**22. POLICY NUMBER / CARRIER CASE NUMBER:** /	
23. THIRD PARTY ADMINISTRATOR (TPA), IF APPLICABLE	**24. TPA ADDRESS – INCLUDE CITY STATE AND ZIPCODE**			
DATES: **25. DATE OF REPORT** / /	**26. DATE OF INJURY** / /	**27. NORMAL STARTING TIME** ☐ AM ☐ PM	**28. IF EMPLOYEE BACK TO WORK GIVE DATE** / /	**29. AT SAME WAGE?** YES ☐ NO ☐
30. IF FATAL INJURY, GIVE DATE OF DEATH / /	**31. DATE EMPLOYER KNEW OF INJURY** / /	**32. DATE DISABILITY BEGAN** / /	**33. LAST FULL DAY PAID-DATE** / /	

INJURY OR DISEASE:

34. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.

35. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.

OCCURRENCE:

36. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE USED WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.

37. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, E.G. LIFTING A PATIENT.

38. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED.

39. NAME OF PHYSICIAN (IF APPLICABLE)	**40. PHYSICIAN'S ADDRESS**
41. HOSPITAL (IF APPLICABLE)	**42. HOSPITAL ADDRESS**

DISTRIBUTION OF THIS REPORT (1 original and 3 copies)

1. **ORIGINAL MUST BE SENT IMMEDIATELY TO THE WORKERS' COMPENSATION INSURANCE CARRIER.**
2. **COPY TO THE OFFICE OF WORKERS' COMPENSATION (use the address at the top left of this form)**
3. **EMPLOYER'S COPY – RETAIN AS RECORD**
4. **EMPLOYEE'S COPY**

WORKERS' COMPENSATION

IMPORTANT THINGS TO DO IN CASE OF INJURY

THE EMPLOYER SHOULD:

1. Provide all necessary medical, surgical and hospital treatment from the date of accident.
2. Every employer shall keep a record of all injuries received by employees and make a report within 10 days thereof in writing to the Office of Workers' Compensation
3. Ascertain the average weekly wages of the employee and provide compensation in accordance with the provisions of the law, for disability *beyond the third day* after the accident. All agreements as to compensation must be submitted to the Office of Workers' Compensation for approval.

THE EMPLOYEE SHOULD:

1. Immediately notify the employer in writing of accidental injury or occupational disease and request medical services. Failure to give notice or to accept medical services may deprive the employee of the right to compensation.
2. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the law, file application with the Industrial Accident Board for a hearing on the matters at issue within two years of the date of accidental injury or one year of knowledge of the diagnosis of an occupational disease or an ionizing radiation injury. All forms can be obtained from the Office of Workers' Compensation.

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 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

RESET FORM

PRINT THIS FORM

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Informe de Incidente del Supevisor

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente? Si/No

Dirección del Incidente

Ciudad, Estado

Código Postal

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

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

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

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

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

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

Informe de Incidente del Supevisor

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

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

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

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración:

RESTABLECER FORMULARIO

IMPRIMIR FORMULARIO

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Witness' Report/Statement of Employee Incident

Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)
Yes or No

Date of Incident

Time of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)
Yes or No

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

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

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

What did the employee do after the incident occurred?

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

The above form is true and correct.

Witness' Signature

Date Completed

RESET FORM

PRINT THIS FORM

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

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

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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

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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.

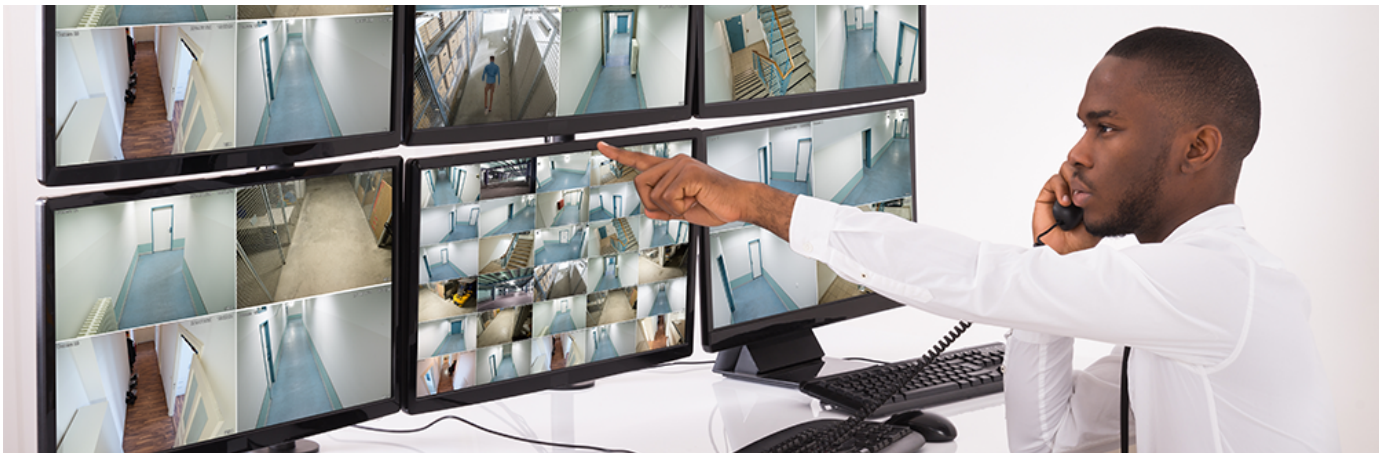
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

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.