Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation State Claim Kit

Hawaii

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

Table of Contents

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division ™

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

Dear Policyholder,

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

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

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

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

bhhcpolicyholder.bhhc.com/Client/External/Claims

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division ™

Workers Compensation Posting Requirements

Requirements for Notice to Employees RE Disability Compensation Law Poster

- Post in one or more conspicuous places readily accessible to all employees at all business locations.
- Enter the name of your designated workers' compensation insurer into the spaces provided at the bottom of the document. Our other contact information has been included for your convenience.

(Hawaii Revised Statutes § 386-99; Rule 12-10-68(a); Rule 12-10-92(a))

Requirements for WC-101 0 Highlights of the Hawaii Workers' Compensation Law Brochure

- A copy of WC-101 – Highlights of Hawaii Workers' Compensation Law Brochure must be provided to all injured workers within 3 days of notice of an injury.

(Rule 12-10-68(b))

Workers' Compensation - You have the right to receive workers' compensation benefits and medical care if you suffer a work-related injury. You must report the date, time and circumstance of your injury immediately to your employer or supervisor. Give the name of the insurer to your doctor so that your doctor will know where to send the physician's report. If your employer does not file a report of the injury, you may file a written claim with the Disability Compensation Division. You do not pay for the premium cost; your employer pays the entire amount.

You are entitled to all required medical, surgical and hospital services and supplies including medication; weekly benefits from the fourth day of disability to replace wage loss, representing 66 2/3% of your average weekly wage but not more than the maximum weekly benefit amount annually set by the Department; additional benefits if the injury results in permanent disability or disfigurement; vocational rehabilitation, if appropriate; funeral and burial expenses if the work injury results in death; and additional weekly benefits to the surviving spouse and other dependents.

Temporary Disability Insurance - You have the right to file a claim for temporary disability insurance benefits within 90 days from the date of disability if you suffer a disabling non-work-related injury/illness or inability to work because of your pregnancy. Your employer or insurance carrier should furnish you with a TDI-45 claim form or some other authorized claim form. You may receive TDI benefits if a physician properly certifies your inability to work. Generally, you must have worked for an employer in Hawaii at least two weeks before your disability. During the last 52 weeks, you must have: worked for at least 14 weeks; been paid for at least 20 hours per week; and earned at least $400.

After a 7 consecutive day waiting period, you will be paid 58% of your average weekly wage, not to exceed the maximum in the TDI law. Your employer may have an "equivalent" plan approved by the Department, which may provide different benefits. You should ask your employer for details if they have an "equivalent" plan.

You may be required by your employer to share in the premium cost. Your share cannot be more than one-half of the cost and should not exceed .5% of your weekly wages. Your employer pays the remaining portion exceeding the prescribed limitation. If you are not eligible for benefits (see second paragraph above), your employer cannot deduct any contributions from you to share in the premium cost.

Prepaid Health Care - You have the right to enroll in your employer's prepaid health care insurance plan after 4 consecutive weeks of employment where you have worked at least 20 hours each week. The Department of Labor & Industrial Relations must approve the health care plan and include insurance coverage for hospital, surgical, medical, diagnostic and maternity medical care.

You should claim benefits under this program if a non-work-related injury or illness requires medical care. Give your doctor or hospital the name of your employer's health care contractor and the plan name.

If you are required to share in the premium cost for your coverage, your share cannot be more than 1.5% of your monthly wages or one-half the premium cost (whichever is less). Your employer pays the balance.

Disability Compensation Division:

Oahu	586-9161 (Workers' Compensation)
	586-9188 (Temporary Disability Insurance and Prepaid Health Care)
Hilo	974-6464
Kona	322-4808
Maui	243-5322
Kauai	274-3351

This notice provides general background information on labor laws administered and enforced by DLIR's Disability Compensation Division and is not intended to serve as a substitute for legal counsel. For specific legal advice on individual situations, please consult an attorney.

Anne E. Eustaquio, Director
Department of Labor and Industrial Relations

***You may satisfy Hawaii Labor Laws' posting requirements by posting our official labor law poster.**
For more information: http://labor.hawaii.gov/labor-law-poster/

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-8866.

Revised 09/21/2020

☐ NEW
☐ AMEND

STATE OF HAWAII
DEPARTMENT OF LABOR & INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY
NOTE: COMPLETE THE FILLABLE-DARK SHADED BLOCKS

CASE NUMBER
DATE RECEIVED

Every work injury/illness to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury/illness. Failure to report promptly is a misdemeanor punishable by not more than a $5,000 fine. (Sec. 386-95, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY/ILLNESS RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

The law requires the employer to furnish the injured/ill employee a copy of this report.

IDENTIFICATION - SECTION 1

EMPLOYEE NAME – LAST	FIRST	M.I.	SUFFIX

SEX/GENDER	MARITAL STATUS	IDENTIFICATION TYPE	IDENTIFICATION NUMBER	DATE OF BIRTH
☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED	☐ SSN ☐ PASSPORT		

ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)

CITY	STATE	ZIP CODE	EMAIL ADDRESS

PHONE NUMBER	DATE HIRED	YEARS EMPLOYED CODE	OCCUPATION
( ) –			

DEPARTMENT	PAYROLL COMP CLASS CODE	SOC CODE	OCC CODE

REGISTERED EMPLOYER	DBA

ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER POINT OF CONTACT	PHONE NUMBER	EMAIL ADDRESS
	( ) –	

NATURE OF BUSINESS	PRE-FABRICATED	DEPARTMENT OF LABOR NUMBER	FEDERAL ID NUMBER
	☐ WC-2 ☐ WC-5		

DETAIL OF INJURY/ILLNESS (I/I) - SECTION 2

DATE OF INJURY/ILLNESS REPORTED	DATE OF INJURY/ILLNESS	TIME OF I/I	TIME OF DAY	ON EMPLOYER'S PREMISE	DID EMPLOYEE WORK A FULL SHIFT?
			☐ AM ☐ PM	☐ NO ☐ YES	☐ NO ☐ YES

IF NOT ON EMPLOYER'S PREMISES, INDICATE PLACE WHERE INJURY/ILLNESS OCCURRED	CITY	STATE	ZIP CODE

A. HOW DID THIS INJURY/ILLNESS OCCUR? - Please describe fully the events that resulted in injury/illness or occupational disease. Explain what happened. Please continue in Supplemental Section if additional space is needed.

TIME WORK SHIFT BEGAN	TIME OF DAY	TIME WORK SHIFT END	TIME OF DAY	SOURCE OF INJURY/ILLNESS	EVENT
	☐ AM ☐ PM		☐ AM ☐ PM		

TASK	ACTIVITY	INJURY/ILLNESS FACTOR	AOS

B. WHAT WAS THE EMPLOYEE DOING WHEN INJURED? - Please be specific. Identify tools, equipment, or material the employee was using. Please continue in Supplemental Section if additional space is needed.

C. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE - e.g., The machine employee struck against or struck him, the vapor or poison inhaled or swallowed, the chemical that irritated employee's skin. In cases of strains, the object employee was lifting, pulling, etc. Please continue in Supplemental Section if additional space is needed.

CASE NUMBER

DETAIL OF INJURY/ILLNESS (I/I) - SECTION 2 (continued)

D. DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF THE BODY AFFECTED - Please continue in Supplemental Section if additional space is needed.

MULTIPLE BODY PARTS? ☐ NO ☐ YES	NATURE OF INJURY/ILLNESS	PART OF BODY CODE

#	SIDE OF INJURY/ILLNESS				PART OF BODY	DISFIGUREMENT		BURN	
1.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES
2.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES
3.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES
4.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES
5.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES

TIME LOST INFORMATION - SECTION 3

DATE DISABILITY BEGAN	WAS EMPLOYEE FURNISHED MEALS, TIPS, OR LODGINGS? ☐ NO ☐ YES	AVERAGE WEEKLY WAGE	IF EMPLOYEE IS BACK TO WORK, GIVE DATE	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS? ☐ NO ☐ YES

IF EMPLOYEE DECEASED, GIVE DATE	HOURLY WAGE	MONTHLY SALARY	HRS WORKED/WEEK	WEIGHING FACTOR

DECEDENT'S DEPENDENTS - SECTION 4

1.	DEPENDENT 1 – LAST NAME	FIRST NAME	M.I.	SUFFIX	RELATION TO DECEASED	
	DEPENDENT 1 - ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( ) -	
2.	DEPENDENT 2 – LAST NAME	FIRST NAME	M.I.	SUFFIX	RELATION TO DECEASED	
	DEPENDENT 2 - ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( ) -	
3.	DEPENDENT 3 – LAST NAME	FIRST NAME	M.I.	SUFFIX	RELATION TO DECEASED	
	DEPENDENT 3 - ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( ) -	
4.	DEPENDENT 4 – LAST NAME	FIRST NAME	M.I.	SUFFIX	RELATION TO DECEASED	
	DEPENDENT 4 - ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( ) -	

TREATMENT (OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE) - SECTION 5

NAME OF PHYSICIAN	PHONE NUMBER ( ) -	EMAIL ADDRESS

ADDRESS	CITY	STATE	ZIP CODE		NO	YES
				INPATIENT OVERNIGHT	☐	☐
				EMERGENCY ROOM ONLY?	☐	☐

NAME OF MEDICAL FACILITY	ADDRESS	CITY	STATE	ZIP CODE

INSURANCE CARRIER - SECTION 6

NAME OF WC INSURANCE CARRIER	CARRIER ID

IS LIABILITY DENIED? ☐ NO ☐ YES	IF LIABILITY DENIED, WHY?

NAME OF ADJUSTING COMPANY	ADJUSTER NAME

EMAIL ADDRESS	PHONE NUMBER ( ) -	ADJUSTER ID NUMBER

POLICY NUMBER	POLICY PERIOD FROM: TO:	MEDICAL DEDUCTIBLE	CARRIER CLAIM NUMBER

SIGNATURE - SECTION 7

SIGNATURE	TITLE	DATE

CASE NUMBER

SUPPLEMENTAL - SECTION 8

A. HOW DID THIS INJURY/ILLNESS OCCUR? (continued from Section 2.A)

B. WHAT WAS THE EMPLOYEE DOING WHEN INJURED? (continued from Section 2.B)

C. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (continued from Section 2.C)

D. DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF THE BODY AFFECTED (continued from Section 2.D)

ENGLISH	This document contains important information. If you need language assistance at no cost to you, please contact us by telephone or in person immediately.
ILOKANO	Daytoy nga dokumento ket addaan ti importante nga impormasyon. No masapul mo ti mangipatarus nga libre, pangngaasim ta awagan na kami ti telepono wenno umay na kami kitaen nga daras.
TAGALOG	Ang dokumentong ito ay naglalaman ng importanteng impormasyon. Kung nangangailangan kayo ng libreng tulong para maintindihan ito, mangyaring makipag-ugnay sa amin sa pamamagitan ng telepono o makipagkita kagaad sa amin.
CHINESE SIMPLIFIED	此文件有重要信息。如果您需要免费的语言协助服务，请您立刻给我们打电话或来我们办公室请求帮助。
CHINESE TRADITIONAL	此文件有重要信息。如果您需要免費的語言協助服務，請您立刻給我們打電話或來我們辦公室請求幫助。
SPANISH	Este documento contiene información importante. Si necesita los servicios de un intérprete sin costo alguno para usted, por favor llame de inmediato por teléfono o contacte con alguna persona de nuestra oficina.
JAPANESE	この書類には重要な情報が含まれています。無償で日本語の支援を受けたい場合は、早急に電話あるいは直接窓口にて申込を行ってください。
CHUUKESE	Mei auchea met masowan ei taropwe. Ika pwe ke mochen aninis ren noumw chon chiaku esap kamo, kose mochen kokori kich won tengwa ika fen pusin chuto rech.
MARSHALLESE	Ilo pepa in ewor melele ko aorok. Ne kwoj aikuj jiban na ukok ilo ejjelok wonen, jouj im kokkeitaak kem ilo talboon ak ilo wobij e ien eo emakaaj tata.
KOREAN	이 문서는 중요한 정보가 포함되어 있습니다. 무료로 언어 도움이 필요하시면, 바로 전화 하시거나 오셔서 상담하십시오.
VIETNAMESE	Tài liệu này bao gồm các thông tin quan trọng. Nếu bạn cần hỗ trợ ngôn ngữ miễn phí, xin vui lòng đến gặp trực tiếp chúng tôi hoặc liên lạc qua điện thoại ngay lập tức.

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM WC-14
EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS

Instructions

Please completely fill out the WC-14 EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS FORM.

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail
Department of Labor and Industrial Relations, Disability Compensation Division
P.O. Box 3769, Honolulu, Hawaii 96812-3769

Delivery In-Person
Department of Labor and Industrial Relations, Disability Compensation Division
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

Delivery via Fax
Department of Labor and Industrial Relations, Disability Compensation Division
(808) 586-9219

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

FORM WC-14 EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS

EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS PRIOR TO DATE OF INJURY

Employee:	SS No.:	Case No.: - -	Date of Injury:

The above employee reported employment with your firm Under the Hawaii Workers' Compensation Law; an employee's benefits are calculated based on wages earned. Please assist us in determining benefits by completing this form

Employer:	Employee's Occupation: WORKERS' COMPENSATION	Hourly Rate:
Date Employed:	Presently Employed?	If terminated, date:
Disabled from:	through:	Returned to Work:

Indicate the days and hours normally worked:

Sunday: ☐	Monday: ☐	Tuesday: ☐	Wednesday: ☐	Thursday: ☐	Friday: ☐	Saturday: ☐

If other than the above, please indicate:

Please call Records and Claims Branch at 586-9161 if you have Questions

Employer:	Telephone: ( )
Address	
Date:	By:

(To be signed in ink)

Auxiliary aids and services are available upon request. Please call: (808) 586-9161; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.

Employee:	SS No.:	Case No.: - -	Date of Injury:

	Dates (inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period		Amount paid excluding overtime or extra work		Overtime or extra work	
	From	To	Year							
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2										
3										
4										
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21										
22										
23										
24										
25										
26										
	Total									

This statement of Employee's earnings is taken from our Payroll Records.

	Dates (inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period		Amount paid excluding overtime or extra work		Overtime or extra work	
	From	To	Year							
27										
28										
29										
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49										
50										
51										
52										
	Total									

This statement of Employee's earnings is taken from our Payroll Records.

Address all inquiries to:

Department of Labor and Industrial Relations
Disability Compensation Division

Oahu: P.O. Box 3769
830 Punchbowl Street, Room 210
Honolulu, Hawaii 96812-3769
Phone: (808) 586-9161

Hawaii: State Office Building
75 Aupuni Street, Room 108
Hilo, Hawaii 96720
Phone: (808) 974-6464

West Hawaii: P.O. Box 49
Kealakekua, Hawaii 96750
Phone: (808) 322-4808

Maui: State Office Building, #2
2264 Aupuni Street
Wailuku, Hawaii 96793
Phone: (808) 243-5322

Kauai: State Office Building
3060 Eiwa Street, Room 202
Lihue, Hawaii 96766
Phone: (808) 274-3351

Auxiliary aids and services are available upon request. Please call the above listed telephone numbers, (808) 586-8847 (TTY), or 1-888-569-6859 (TTY neighbor islands). A request for a reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation be subjected to discrimination, excluded from participation in, or denied the benefits of the department's services, programs, activities, or employment.

HIGHLIGHTS OF THE HAWAII WORKERS' COMPENSATION LAW

STATE OF HAWAII
Department of Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION

Form WC-101 (Rev. 5/03)

HIGHLIGHTS OF THE HAWAII WORKERS' COMPENSATION LAW

INTRODUCTION

Your safety and well being on the job are important to the employer. However, accidents and illnesses can arise from work and when they do, you are covered under the workers' compensation law. This brochure has been prepared to help explain your benefits and responsibilities under the workers' compensation law.

PURPOSE

The purpose of the workers' compensation law is to provide an employee who suffers an industrial injury or illness with medical care, wage loss replacement, and permanent disability benefits. It also provides death benefits for dependents.

WHO CAN RECEIVE WORKERS' COMPENSATION BENEFITS?

Most full-time and part-time employees who suffer from any injury or disease, which results from work or working conditions, are covered. Under the law, certain kinds of employees are not covered.

WHAT SHOULD I DO IF I AM INJURED?

1. Immediately report the injury to your immediate supervisor or employer. You can do this orally or in writing.

2. Obtain appropriate treatment for the injury.

DO I HAVE TO FILE ANY PAPERS TO MAKE A CLAIM?

If your employer fails to file an "Employer's Report of Industrial Injury/Illness" (WC-1) with their workers' compensation insurance carrier, you should contact your nearest Disability Compensation Division office and file an "Employee's Claim for Workers' Compensation Benefits" (WC-5).

WHAT DO I TELL MY PHYSICIAN IF I AM INJURED?

If you are injured as a result of your work, you should tell the person treating you that this is an industrial injury. Ask the physician to send the medical reports and bills to your employer's insurance carrier. The physician should call the employer for the name of the insurance carrier.

FROM WHOM CAN I OBTAIN TREATMENT?

You may obtain treatment from a physician of your choice. However, you may be under the care of only one attending physician. Your attending physician may refer you to other specialist(s) with the approval of the employer's insurance carrier.

You may change your attending physician once, but you must notify the insurance carrier before making the change. Any other changes in physician require approval from the insurance carrier before the change.

IF I AM INJURED, WHAT MEDICAL BENEFITS WILL WORKERS' COMPENSATION PAY FOR?

If your claim is accepted, workers' compensation should pay for the following:

1. Treatments for the injury.
2. Hospital charges.
3. Prescription drugs ordered by your doctor.
4. X-rays as prescribed.
5. Physical therapy as ordered by your doctor.
6. Reasonable transportation expense incidental to treatment. (Keep track of your expenses and mileage.)

WHAT TYPES OF DISABILITY BENEFITS AM I ELIGIBLE FOR?

You are eligible for the following types of disability benefits:

1. TEMPORARY TOTAL DISABILITY (TTD)

If you are unable to work because of an industrial injury, you may receive temporary wage replacement benefits after a three-day waiting period. You may receive 2/3 of your weekly wages up to a specified maximum. (For example, the maximum for 2004 is $596.) TTD is paid for periods a physician certifies you are unable to work.

If your workers' compensation claim is disputed and you are not paid benefits, you may file a temporary disability insurance (TDI) claim with your employer's TDI carrier. If eligible, you will be paid benefits at rates allowed by the TDI law. The TDI carrier may recover the amount they paid from your workers' compensation benefits.

If you have two or more jobs you may be eligible for concurrent benefits. You must notify the nearest Disability Compensation Division office.

2. PERMANENT PARTIAL DISABILITY (PPD)

After you reach the point of stability or maximum medical recovery, you may be sent to a physician to be evaluated on the extent of your permanent impairment. The evaluation will be used to determine the amount of your PPD award.

3. PERMANENT TOTAL DISABILITY (PTD)

If you are unable to do any kind of work, you may be eligible for PTD benefits. Whether you are eligible for PTD benefits is determined at a hearing held by the Department of Labor and Industrial Relations.

4. DISFIGUREMENT

If an injury results in a permanent disfigurement, you may be entitled to additional compensation. Disfigurement includes scars, deformity, and discoloration. Laceration scars and surgical scars are reviewed six months from date of occurrence, however, burn scars are evaluated after one year.

5. DEATH BENEFITS

Where an industrial injury results in death, the surviving spouse and dependent minor children (including full-time students up to 21 years of age) are entitled to weekly benefits as provided in the workers' compensation law. Funeral expenses up to 10 times the maximum weekly benefit rate and burial expenses up to 5 times the maximum weekly benefit rate are also allowed.

6. VOCATIONAL REHABILITATION

When an industrial injury has or may have caused permanent disability and prevents you from returning to your usual job, you may self-refer for vocational rehabilitation services to assist you in returning to suitable work.

WHAT IS THE PROCESS?

If there are any issues which cannot be resolved by agreement, you may request for a hearing. A hearing will be held, and a decision will be rendered. If you or the employer/insurance carrier disagrees with the decision, the decision may be appealed by filing a notice of appeal with the department within 20 calendar days from the date stamped on the decision.

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

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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

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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

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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

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Informe de Incidente del Supevisor

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente? Si/No

Dirección del Incidente

Ciudad, Estado

Código Postal

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

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

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

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

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

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

Informe de Incidente del Supevisor

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

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

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

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración:

RESTABLECER FORMULARIO

IMPRIMIR FORMULARIO

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division

Witness' Report/Statement of Employee Incident

Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)
Yes or No

Date of Incident

Time of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)
Yes or No

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

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

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

What did the employee do after the incident occurred?

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

The above form is true and correct.

Witness' Signature

Date Completed

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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.

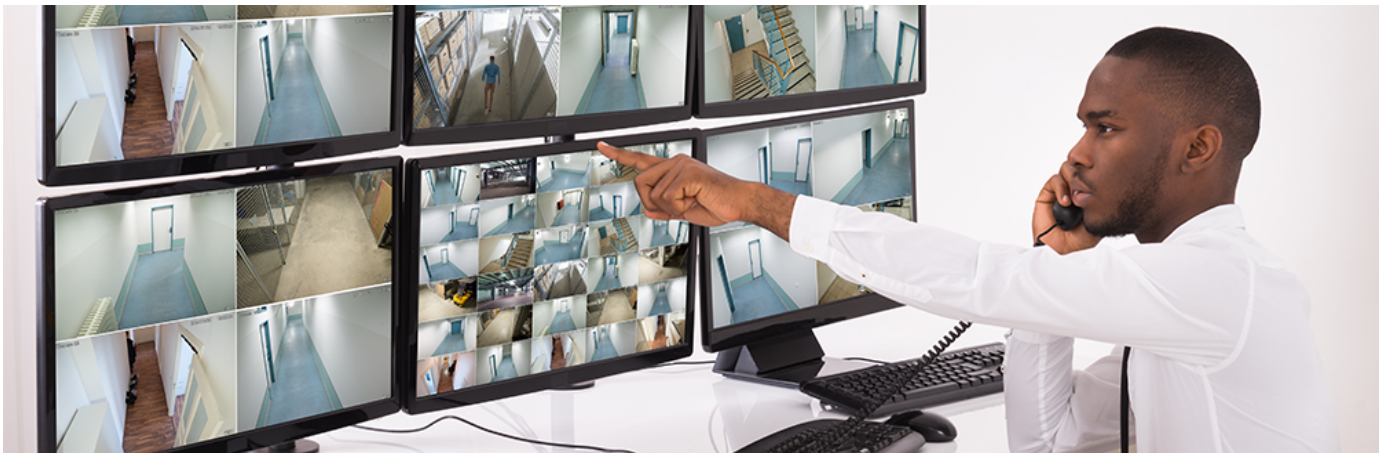
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

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.