



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Division TM

Workers Compensation State Claim Kit

Louisiana



Table of Contents

BHHC LA Claims Kit Introductory Letter –05/2025	1
BHC Requirements for LA Posting Notice – 05/2025	2
LA Form – Workers’ Compensation Poster – 05/2003	3
English.....	3
Spanish	4
LA Form – Workers’ Compensation Fraud Poster	5
LA Form IA-1 – First Report of Injury or Illness – 2002	6
LA Form LWC-WC-1025ER – Employer’s Certificate of Compliance – 03/2016.....	9
LA Form LWC-WC-1121 – Physician Choice Form	11
English.....	11
Spanish	12
BHHC Authorization for the Release of Information (English & Spanish) - 08/2023.....	13
BHHC Medical History Request – 8/2023	15
BHHC General Employee Incident Report - 08/2023	16
English.....	16
Spanish	17
BHHC General Supervisor Incident Report - 08/2023	18
English.....	18
Spanish	20
BHHC General Witness Incident Report – 09/2023	22
English.....	22
Spanish	23
BHHC Express Scripts First Fill Form (English & Spanish) – 02/2025	24
BHHC Workers’ Compensation Fraud Posters - 03/2025	26
English.....	26
Spanish	27

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.

Louisiana 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 or 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](http://bhhcpolicyholder.bhhc.com/Client/External/Claims)

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com





Workers Compensation Posting Requirements

Workers Compensation Poster

Post in one or more conspicuous places at all business locations

To complete the form, please enter the following information in the spaces provided:

- Your company name and address
- • The name and contact information of a company representative
- • The name of your designated workers' compensation insurer

For your convenience, our other contact information has been entered on the Poster.

(Louisiana Revised Statutes 23:1302)

Stop Workers' Compensation Fraud Poster

Post in one or more conspicuous places at all business locations near the Workers' Compensation Poster.

Workers' Compensation

Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

- 1 the disease manifests itself.
- 2 the employee is disabled as a result of the disease.
- 3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

- 1 the date of death.
- 2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

Employer

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

Revised May 2003



www.laworks.net

Compensacion del Trabajador

Reportando de lesiones/heridas

Usted debe reportar a su empleador cualquier enfermedad ocupacional o lesión personal que esté relacionada con el trabajo, aún y cuando usted piense que es insignificante o menor.

Enfermedades ocupacionales o muerte

En caso de enfermedad ocupacional, no todos los reclamos son elegibles a menos que el empleado haga el reclamo con su empleador dentro del siguiente año de la fecha que:

1. La enfermedad se manifiesta por si sola.
2. El empleado está desabilitado como resultado de esta enfermedad.
3. El empleado sabe o tiene razones poderosas para creer que la enfermedad está relacionada con su ocupación.

En caso de muerte que aparece como resultado de una muerte ocupacional, no todos los reclamos son válidos solamente que el o los dependientes hagan un reclamo con el empleador del empleado muerto dentro de 1 (uno) año de:

1. La fecha de muerte.
2. La fecha que el reclamante tenga suficientes pruebas para creer que la muerte fué resultado de muerte ocupacional.

Aviso para reclamar o solicitar

En caso de lesiones o muerte causadas por accidente relacionados al trabajo o accidentes, el empleado lesionado o cualquier persona que haga un reclamando y para tener derecho a la compensación ya sea como reclamante o como el representante de la persona que está reclamando para poder tener derecho a la compensación, deberá dar aviso a su empleador dentro de los 30 días siguientes despues de la lesión. Si el aviso no es dado dentro de los siguientes 30 días, ningún pago será hecho por dicha lesión o muerte. En adición, cualquier acción fraudulenta por el empleador, empleado o cualquier otra persona con el propósito de obtener o buscar cualquier beneficio o pagos a través del Programa de Compensación de Trabajadores dicha persona está sujeta a cargos criminales al igual que a responsabilidad civil.

El aviso arriba mencionado deberá ser presentado con el empleador en la dirección que aparece en el lado derecho.

Un aviso dado no deberá ser invalidado o mantenerse invalidado por cualquier inexactitud en el tiempo, lugar, naturaleza o causa de la lesión al momento de hacer la declaración, o de otra manera, solamente si se demuestra que el empleador fué mal informado para con esto perjudicar. El fallar o faltar de notificar es posible que no perjudique al empleado si el empleador sabe del accidente o si el empleador no es perjudicado por la tardanza o por faltar de hacer la notificación.

Medicos

En caso que usted es lesionado, usted tiene el derecho de elegir al médico para su tratamiento. El empleador puede escoger otro médico y hacer arreglos para otro exámen para el cual usted será requerido para atender.

Reclamo formal

Para poder preservar sus derechos a los beneficios bajo la Ley de Compensación de los Trabajadores del estado de Louisiana, usted debe hacer un reclamo formal con la oficina administrativa del Programa de la Ley de Compensación de los Trabajadores dentro del siguiente año después del accidente si no se han hecho pagos o dentro del año después del último pago de beneficios.

Información

Si usted desea cualquier información relacionada a sus derechos y a los beneficios a los cuales usted tiene derecho descritos por la ley, usted puede llamar o escribir a la Office of Worker's Compensation Administration, PO Box 94040, Baton Rouge, Louisiana 70804-9040 o al teléfono (225) 342-7555.

Nombre y Dirección de la Compañía de Seguros

La notificación deberá ser dada ya sea llevándola personalmente o enviándola por correo certificado regresando o regresar el recibo solicitado a:

Representante del empleador

Empleador

R.S. 23:1302 manifiesta que éste aviso debe estar puesto en un lugar visible y conveniente en el negocio del empleador.

Revisado Mayo 2003



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Warning Signs of Workers' Compensation Fraud

Experience shows that when two or more of the following factors are present in a workers' compensation claim, there is a chance that the claim may be fraudulent. Many perfectly legitimate claims may contain one or any number of these characteristics. If you are unsure, call the Workers' Compensation Fraud Section at **1-800-201-3362** or email WCFraud@ldol.state.la.us.

- **Monday Morning**
The alleged injury occurs late on a Friday afternoon but is not reported until Monday.
- **Employment Change**
A reported accident occurs just before or after a strike, layoff, end of a big project, or at the conclusion of seasonal work, or immediately following disciplinary action and/or termination.
- **New Employee**
Injured employee has been on the job 30 days or less.
- **No Witnesses**
No one sees the accident, and the employee's own description does not logically support the cause of the injury.
- **Details Surrounding Accident Changes**
Details given to the immediate supervisor by the injured worker are different when the details are given to complete the first report of injury.
- **Injury Never Reported**
The injured employee states that he reported the accident to his immediate supervisor. Later it is determined that the injury was never reported.
- **History of Changes**
The claimant has a history of frequently changing physicians, changing addresses and numerous past employment changes.
- **Suspicious Claims History**
The claimant has a record of numerous, suspicious or litigated claims.
- **Claimant Hard to Reach**
Beware the claimant who is hard to reach at home when allegedly disabled.
- **Attorney Representation**
The claimant has hired an attorney before the first report of injury has been completed.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)				CARRIER/ADMINISTRATOR CLAIM NUMBER		OSHA LOG NUMBER		REPORT PURPOSE CODE					
				JURISDICTION		JURISDICTION CLAIM NUMBER							
				INSURED REPORT NUMBER									
INDUSTRY CODE				EMPLOYER FEIN				EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #			
								PHONE #					
CARRIER/CLAIMS ADMINISTRATOR													
CARRIER (NAME, ADDRESS, & PHONE #)				POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)							
				TO									
CARRIER FEIN				POLICY/SELF-INSURED NUMBER				ADMINISTRATOR FEIN					
												CHECK IF APPROPRIATE	
SELF INSURANCE													
				AGENT NAME & CODE NUMBER									
EMPLOYEE/WAGE													
NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE			
ADDRESS (INCL ZIP)				SEX M MALE F FEMALE U UNKNOWN		MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN		OCCUPATION/JOB TITLE					
								EMPLOYMENT STATUS					
PHONE				# OF DEPENDENTS				NCCI CLASS CODE					
RATE PER:		☐	DAY WEEK	☐	MONTH OTHER:	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		☐	YES	☐	NO
OCCURRENCE/TREATMENT													
TIME EMPLOYEE BEGAN WORK		☐	AM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		☐	AM	LAST WORK DATE		DATE EMPLOYER NOTIFIED	
		☐	PM			() CANNOT BE DETERMINED		☐	PM			DATE DISABILITY BEGAN	
CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED					
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO				TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE					
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED							
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED							
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL													
										CAUSE OF INJURY CODE			
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?				☐	YES	☐	NO		
				WERE THEY USED?				☐	YES	☐	NO		
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)				INITIAL TREATMENT					
								0 NO MEDICAL TREATMENT					
								1 MINOR: BY EMPLOYER					
								2 MINOR CLINIC/HOSP					
								3 EMERGENCY CARE					
								4 HOSPITALIZED > 24 HOURS					
				5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED									
OTHER													
WITNESSES (NAME & PHONE #)													
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE						PHONE NUMBER			

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg.

Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of \$500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized self-insured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to \$10,000, imprisonment with or without hard labor for not more than 1 year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than \$500, or imprisoned with or without hard labor for not more than one year, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined up to \$10,000, imprisoned with or without hard labor for up to 10 years, or both depending on the amount of benefits unlawfully obtained or defeated. In addition to these criminal penalties, you may be assessed a civil penalty of up to \$5,000.

EMPLOYER CERTIFICATION

I certify that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT)

Signature Date

Company Name

Company Address

(_____) _____

Phone Number

Insurance Policy Number

Employee Name

Employee Social Security Number

EMPLOYEE CERTIFICATE OF COMPLIANCE

You must submit this form to your employer's workers' compensation insurer or to your employer within 14 days of its receipt. Your workers' compensation benefits may be suspended if you do not timely submit this Certification. You would be entitled to all suspended benefits after this Certification is provided to your insurer, if you are otherwise eligible for benefits.

It is unlawful for you to work and received workers' compensation indemnity benefits, except for supplemental earnings benefits. Supplemental earnings benefits are paid when an employee is able to work, but is unable to earn 90% or more of his pre-injury wages as a result of a job related accident. As an injured worker, you must notify your employer or insurer of the earning of any wages, changes in employment or medical status, receipt of unemployment insurance benefits, receipt of social security benefits and receipt of retirement benefits. If you receive benefits for more than 30 days, you will be required to certify your earnings to your insurer quarterly.

It is unlawful for you to receive workers' compensation indemnity disability benefits and unemployment benefits at the same time, except for permanent partial disability benefits. Permanent partial disability benefits are paid solely for amputation or for anatomical loss of use of a body part or function. If you violate this provision, you may be fined up to \$10,000, imprisoned up to 90 days, or both.

It is unlawful for you to willingly make, or to assist or counsel someone to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined, imprisoned, or both, as follows:

<u>Unlawful Benefits Paid or Claimed</u>	<u>Fine</u>	<u>Imprisonment</u>
\$10,000 or more	up to \$10,000	up to 10 years, with or without hard labor
\$2,500 or more but less than \$10,000	up to \$5,000	up to 5 years, with or without hard labor
less than \$2,500	up to \$500	up to 6 months

In addition to these criminal penalties, you may be assessed a civil penalty of up to \$5,000 and may forfeit your right to receive workers' compensation benefits.

Warning: Per L.A.R.S.23:1208 of the Louisiana Workers' Compensation Statute, it shall be unlawful for a person, for the purpose of obtaining or defeating any benefit payment under the provisions of this Chapter, either for himself or for any other person, to willfully make a false statement or representation. Penalties for violations include imprisonment, fines, and/or the forfeiture of benefits.

EMPLOYEE CERTIFICATION

I certify that I understand the contents of this entire document, and understand I am held responsible for this information. I certify my compliance with the above stated requirements regarding receipt of workers' compensation benefits.

_____ Print Name	_____ Signature	_____ Social Security Number	_____ Date
_____ Address	_____ City	_____ State/Zip	_____ Phone Number

Note: Only one copy is required per case from the employee.

**NOTICE
TO INJURED WORKERS**

YOU HAVE THE RIGHT TO CHOOSE YOUR OWN DOCTOR!

WHEN YOU ARE INJURED AT WORK OR BECOME SICK BECAUSE OF SOMETHING THAT HAPPENED AT WORK, THE LAW GIVES YOU THE RIGHT TO CHOOSE YOUR OWN DOCTOR IN ANY FIELD OR SPECIALTY OF MEDICINE FOR MEDICAL TREATMENT.

THE LAW ALSO ALLOWS YOUR EMPLOYER TO HAVE YOU SEE HIS/HER DOCTOR, BUT YOU DO NOT HAVE TO AGREE TO CONTINUE TREATMENT WITH YOUR EMPLOYER'S DOCTOR UNLESS THAT IS WHAT YOU WANT.

IF YOU WANT YOUR EMPLOYER'S DOCTOR TO CONTINUE TREATING YOU AFTER YOUR FIRST VISIT WITH HIM/HER, AND AFTER RECEIVING THIS FORM, YOU MAY CHOOSE YOUR EMPLOYER'S DOCTOR AS YOUR TREATING DOCTOR.

ONCE YOU CHOOSE EITHER YOUR EMPLOYER'S DOCTOR OR YOUR OWN DOCTOR AS YOUR TREATING DOCTOR, YOU MAY NOT BE PERMITTED TO CHOOSE ANOTHER DOCTOR IN THAT SAME FIELD OR SPECIALTY OF MEDICINE TO TREAT YOU FOR YOUR INJURY OR ILLNESS LATER ON. HOWEVER, YOU ARE NOT REQUIRED TO GET YOUR EMPLOYER'S APPROVAL TO CHANGE TO A DOCTOR IN ANOTHER FIELD OR SPECIALTY OF MEDICINE (La. R.S. 23:1121(B)(1)).

IF YOUR EMPLOYER DENIES YOUR RIGHT TO CHOOSE YOUR DOCTOR, YOU HAVE A RIGHT TO A SPEEDY HEARING BEFORE A WORKERS' COMPENSATION JUDGE TO RESOLVE THE DENIAL OF YOUR RIGHT (La. R.S. 23 1121 (B)(1) and 1124 (B)).

I HEREBY CHOOSE MY OWN DOCTOR TO TREAT ME FOR MY INJURY OR ILLNESS:
DR. _____.

OR

BY SIGNING THIS FORM, I STATE THAT I KNOW ABOUT MY RIGHT TO CHOOSE MY OWN TREATING DOCTOR, AND BEING SO ADVISED, I HEREBY ACCEPT AND CHOOSE TO CONTINUE TREATING WITH MY EMPLOYER'S DOCTOR:
DR. _____.

DATE

SIGNATURE OF EMPLOYEE

DATE

SIGNATURE OF EMPLOYER REPRESENTATIVE

(Note: If the employee is illiterate or has a language barrier, an authorized representative of the employer/insurer shall attest by their signature that this form and right of physician choice has been reasonably explained to that employee prior to his/her signature on this form. Failure to do so can jeopardize the employer's/insurer's right to subsequently refuse consent to the employee's request for treatment by a different physician within the same field or specialty.)

**AVISO
PARA TRABAJADORES LESIONADOS**

¡USTED TIENE DERECHO A ELEGIR A SU PROPIO DOCTOR!

CUANDO USTED SE LESIONA EN EL TRABAJO O ENFERMA POR ALGO QUE OCURRIÓ EN EL TRABAJO, LA LEY LE DA DERECHO A ELEGIR A SU PROPIO DOCTOR EN CUALQUIER CAMPO O ESPECIALIDAD DE LA MEDICINA PARA RECIBIR TRATAMIENTO MÉDICO.

LA LEY TAMBIÉN LE PERMITE A SU PATRÓN HACER QUE UN DOCTOR LO ATIENDA, PERO USTED NO TIENE QUE ACEPTAR CONTINUAR EL TRATAMIENTO CON ESTE DOCTOR A MENOS QUE ASÍ LO DESEE.

SI DESEA SEGUIR RECIBIENDO TRATAMIENTO DEL DOCTOR DE SU PATRÓN DESPUÉS DE LA PRIMERA VISITA, Y DESPUÉS DE RECIBIR EL PRESENTE FORMULARIO, USTED PUEDE ELEGIR A ESTE DOCTOR COMO EL MÉDICO TRATANTE.

DESPUÉS DE ELEGIR AL DOCTOR DE SU PATRÓN, O A SU PROPIO DOCTOR, COMO EL MÉDICO TRATANTE, PUEDE NO PERMITÍRSELE ELEGIR MÁS ADELANTE A OTRO DOCTOR EN EL MISMO CAMPO O ESPECIALIDAD DE LA MEDICINA PARA RECIBIR TRATAMIENTO DE LA LESIÓN O ENFERMEDAD. SIN EMBARGO, NO ES NECESARIO QUE OBTENGA LA APROBACIÓN DE SU PATRÓN PARA CAMBIAR A UN DOCTOR EN OTRO CAMPO O ESPECIALIDAD DE LA MEDICINA (La. R.S. 23:1121(B)(1)).

SI SU PATRÓN LE NIEGA EL DERECHO A ELEGIR AL DOCTOR, USTED TIENE DERECHO A UNA AUDIENCIA RÁPIDA ANTE EL JUEZ DEL SEGURO CONTRA ACCIDENTES DE TRABAJO PARA RESOLVER LA DENEGACIÓN DE SU DERECHO (La. R.S. 23 1121 (B)(1) y 1124 (B)).

POR ESTE ACTO ELIJO A MI PROPIO DOCTOR PARA RECIBIR EL TRATAMIENTO DE LA LESIÓN O ENFERMEDAD:

DR. _____.

O

CON MI FIRMA A CONTINUACIÓN, DECLARO QUE CONOZCO MI DERECHO A ELEGIR A MI PROPIO DOCTOR TRATANTE, Y HABIENDO SIDO INFORMADO DE ELLO, POR ESTE ACTO ACEPTO Y ELIJO CONTINUAR EL TRATAMIENTO CON EL DOCTOR DE MI PATRÓN:

DR. _____.

FECHA

FIRMA DEL EMPLEADO

FECHA

FIRMA DEL REPRESENTANTE PATRONAL

(Nota: Si el empleado es analfabeta o tiene una barrera del idioma, un representante autorizado del patrón o de la aseguradora dará fe con su firma que le han explicado de forma razonable este formulario y la elección del médico antes de firmarlo. De no ser así, se puede poner en riesgo el derecho del patrón o la aseguradora a rehusar posteriormente el consentimiento de la solicitud del empleado para recibir tratamiento de un médico distinto dentro del mismo campo o especialidad).

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 divisiones 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 filmas, 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





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) Admitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

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)

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

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)

¿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

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?

Address of Incident

City, State

Zip

Offsite? (Y/N)

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

Obstructed view

Interaction with patient or resident

Unused/unavailable PPE (gloves, hardhat, goggles, etc.)

Lack of training

Interaction with customer

Unused/unavailable sharps container

Wet/slippery floor

Chemical exposure

Unguarded or improperly guarded equipment

Poor housekeeping

Motor vehicle incident

Interaction with co-worker

Other:

Electrical exposure

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

Informe de Incidente del Supervisor



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?

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

¿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 Supervisor

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

Equipo para levantar no usado/no disponible

Vista obstruida

Interacción con paciente o residente

PPE (guantes, casco, gafas, etc.) no usado/no disponible

Falta de capacitación

Interacción con cliente

Contenedor de objetos punzantes no usado/no disponible

Herramientas o equipo defectuosos

Exposición a producto químico

Equipo no resguardado o incorrectamente resguardado

Piso mojado/resbaloso

Incidente de vehículo motorizado

Mala limpieza

Other:

Exposición eléctrica

Interacción con compañero de trabajo

¿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:

Witness' Report/Statement of Employee Incident



Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)

Date of Incident

Time of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)

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

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)

¿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



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!

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 PHARMACY 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!



\$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.



\$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 operaciones nos beneficia a todos, incluso esto ayuda a mantener los réditos bajos de la aseguranza 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 demanda fraudulenta. BerkshireHathaway dividirá la recompensa por partes iguales entre aquellas personas 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 responsabilidad exclusiva de las autoridades, que pueden decidir si el proceso debe entablarse or no. Cualquier disputa que pudiera surgir en la interpretación de esta oferta será resuelta por la propia Compañía de Seguros Berkshire Hathaway. Este programa está sujeto a cambios a cancelación sin aviso previo.