



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Division TM

Workers Compensation State Claim Kit

New Mexico



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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.

New Mexico state law requires employers to report every industrial injury or occupational disease claim to their workers compensation carrier within 72 hours of employer knowledge or notice. This requirement includes claims where no lost time is anticipated.

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

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com





Workers Compensation Posting Requirements

If You Are Injured At Work Poster

- Post in one or more conspicuous places at all business locations and work sites
 - Keep in the area where notices to employees are posted and applicants for employment are customarily located
 - Attach a collection of Form NOA-1-W – Notice of Accident or Occupational Disease Disablement for employee use
- Must be printed on 11" x 17" paper

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

- The name of your designated insurance company
- Policy period dates (beginning & ending)
- Your company name

(New Mexico Statutes Annotated § 52-1-29)

Form NOA-1-W – Notice of Accident or Occupational Disease Disablement

Post a collection of this form attached or adjacent to the If You Are Injured At Work Poster

(New Mexico Statutes Annotated § 52-1-29 and § 52-3-19 (C))



WORKERS' COMPENSATION ACT

If You Are Injured At Work Si Se Lastima En El Trabajo

- 1) **Notice --** In most cases you must tell your employer about the accident within 15 days, using the Notice of Accident Form.

2) **You have the right** to information and assistance from an information specialist known as an Ombudsman at the Workers' Compensation Administration.

3) **Claims information --** Contact your employer's Claims Representative (see box below).
- 1) **Aviso. --** En la mayoría de los casos usted debe de avisarle a su empleador del accidente dentro de los primeros 15 días usando las formas de Aviso de Accidente.

2) **Usted tiene el derecho** a información y ayuda contactándose con un especialista en información conocido como "Ombudsman" en la Administración para la Compensación a los Trabajadores.

3) **Información acerca de Reclamaciones. --** Contáctese con el representante de reclamaciones de su compañía.

Employer's Insurer / Claims Representative:

Name:

Phone #:

Address:

Note: Employer must fill in insurer / claims representative information.

YOUR RIGHTS

If you are injured in a work-related accident:

Your employer / insurer must pay all reasonable and necessary medical costs.

You may or may not have the right to choose your health care provider. If your employer / insurer has not given you written instructions about who chooses first, call an ombudsman. In an emergency, get emergency medical care first.

If you are off work for more than seven days, your employer / insurer must pay wage benefits to partially offset your lost wages.

If you suffer "permanent impairment," you may have the right to receive partial wage benefits for a longer period of time.

Ombudsmen are located at the following offices:					
Albuquerque:	Farmington:	Hobbs:	Las Cruces:	Las Vegas:	Roswell:
1-866-967-5667	1-800-568-7310	1-800-934-2450	1-800-870-6826	1-800-281-7889	1-866-311-8587
1-505-841-6000	1-505-599-9746	1-575-397-3425	1-575-524-6246	1-505-454-9251	1-575-623-3997
					Santa Fe: 1-505-476-7381

SUS DERECHOS

Si se lastima en el trabajo:

Su empleador / asegurador debe de pagar por los gastos médicos necesarios y razonables.

Es posible que usted tenga, o no tenga, el derecho de escoger el proveedor de servicios para la salud. Si su empleador / asegurador no le ha dado instrucciones por escrito de quien es él que selecciona primero, pregúntele o llame a un ombudsman. En una emergencia, obtenga asistencia médica de emergencia primero.

Si usted está fuera del trabajo por más de siete días, su empleador / asegurador debe de hacerle un pago compensatorio de prestaciones para compensar parcialmente la pérdida de su salario.

Si usted sufre "daño permanente," usted puede tener el derecho a recibir prestaciones parciales de salario por un periodo de tiempo más largo.

If You Need HELP Call:

Ask for an Ombudsman

Si Usted Necesita Ayuda Llame Al:

Pregunte por un Ombudsman

1 - 8 6 6 - W O R K O M P (1-866-967-5667)

Visit our website at: <https://workerscomp.nm.gov>

For FREE copies of this poster and Notice of Accident Forms call: 1-866-967-5667

USE A NOTICE OF ACCIDENT FORM TO REPORT YOUR ACCIDENT TO YOUR SUPERVISOR

EMPLOYER: You are required by law to display this poster where your employees can read it. Post the Notice of Accident forms with it. The poster without the Notice of Accident forms does not comply with law. You have other rights and duties under the law.

NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT NOTIFICACIÓN DE ACCIDENTE O ENFERMEDAD DE OFICIO

In accordance with New Mexico law, Section 52-1-29, Section 52-3-19 and Section 52-1-49, NMSA 1978; NMAC 11.4.4.11
Conforme a la Ley de la Compensación de los Trabajadores, Sección 52-1-29, Sección 52-3-19 y Sección 52-1-49, NMSA 1978; NMAC 11.4.4.11

I, _____, was involved in an on-the-job accident or was disabled
Yo, (name of employee/nombre del empleado) me lastimé en un accidente en el trabajo o fui incapacitado
by an occupational disease at approximately _____, on _____, 20_____.
por enfermedad de oficio aproximadamente (time/a la(s) hora(s)) el (date/fecha) del 20_____.
Employee's social security number: _____ Where did the accident occur? _____
Número de seguro social del empleado: ¿Dónde ocurrió el accidente? _____
What happened? _____
¿Qué ocurrió? _____

To be completed by Employer:

Completado por el empleador:

If Yes, Employer has right to change health care provider after 60 days.

En caso afirmativo, el empleador tiene derecho a cambiar de proveedor de atención médica después de 60 días.

WORKER'S INITIALS _____

Worker will choose health care provider. Yes ___ No ___

Trabajador elegirá proveedor de atención médica.

If No, Worker has the right to change health care provider after 60 days.

En caso que no elige, el trabajador tiene derecho a cambiar de proveedor de atención médica después de 60 días.

INICIALES DEL TRABAJADOR

Signed: _____

Firma: (employee/empleado)

Date/Fecha: _____

Signed/Notice Received: _____

Firma/Notificación recibida: (employer or representative/empleador o representante)

Date/Fecha: _____

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

PREVIOUS NOA FORMS ARE STILL VALID FOR USE

Form NOA-1

Employer/employee: Each keep one copy.

Empleador/empleado: Retener una copia.

---SEE BACK OF THIS FORM---

---VER AL REVERSO DE ESTA FORMA---

Worker --

For emergency medical care, go to any emergency medical facility.

Workers and Employers with questions about workers' compensation may contact an Ombudsman at any New Mexico Workers' Compensation Administration office for information and assistance. The offices are open Monday through Friday, 8 a.m. to 5 p.m., except holidays.

Trabajador

Para emergencias médicas vaya a cualquier clínica / hospital.

Trabajadores y empleadores con preguntas acerca de la compensación de los trabajadores pueden comunicarse con un asesor ("ombudsman") a cualquier oficina de la Administración de la Compensación de los Trabajadores para información y asistencia. Las oficinas están abiertas desde las ocho de la mañana hasta las cinco de la tarde de lunes a viernes, con la excepción de días festivos.

Statewide Helpline -- Línea de Asistencia

1-866-WORKOMP / 1-866-967-5667

toll free -- llamada sin costo de larga distancia

New Mexico Workers' Compensation Administration

PO Box 27198, Albuquerque, NM 87125

Albuquerque: (505) 841-6000 - 1 (800) 255-7965

Farmington: (505) 599-9746 - 1 (800) 568-7310

Hobbs: (575) 397-3425 - 1 (800) 934-2450

Las Cruces: (575) 524-6246 - 1 (800) 870-6826

Las Vegas: (505) 454-9251 - 1 (800) 281-7889

Roswell: (575) 623-3997 - 1(866) 311-8587

Santa Fe: (505) 476-7381



New Mexico Workers' Compensation Administration Bulletin

Special Edition

Employers are required to post the workers' compensation poster with the Notice of Accident Forms at their workplaces.

The Workers' Compensation Administration asks all insurers and self-insurance administrators to educate employers so that they comply correctly with the posting requirement.

Employers should be advised to:

- Display the poster properly at all work sites;
- Post **Notice of Accident (NOA)** forms with the poster;
- Educate their employees on the use of the NOA forms.
- The poster has a blank space in which the employer is required to write the name of the employer's insurance carrier or self-insurance program, along with a contact telephone number.
- The contacts must be located in New Mexico as required by law.
- Employers are required to hang or post a supply of NOA forms attached to the poster. The forms can be hung at the bottom where indicated.

Complying with the law:

- If the poster is displayed without the forms attached or adjacent, that does not comply with the law.
- Employers must give workers access to the two-part carbonless Notice of Accident form or a printed copy that can be downloaded from the WCA website.
- When a worker uses the form to report an accident, the employer is required to accept the form as the worker's official notice, to sign and date the form and give the worker a copy.

Where to get posters and forms:

The WCA poster and NOA are available on the WCA web site:
www.workerscomp.state.nm.us

Go to any WCA office in person; for large quantities, please telephone ahead.

To request and receive printed copies of the poster and/or Notice of Accident forms by mail, contact the Publications Office at:

**Call: (505) 841-6000 or,
1-800-255-7965,
or email request to:
wca.hotline@state.nm.us**

These materials are free of charge. For large quantities, you will be asked to pay mailing costs.

WCA HELPLINE - HOTLINE:
(toll free in New Mexico)

1-866-WORKOMP

1-866-967-5667

www.workerscomp.state.nm.us

What is the poster for and why are employers required to post it?

The purpose of the workers' compensation poster is:

- to inform workers that their employer has workers' compensation insurance (or self-insurance) coverage, and that they have certain rights if they are injured;
- to provide a way for workers to notify their employers in writing if they have an accident, with a copy that the worker may keep for his or her own records.

By law, employers must allow their employees to report accidents in writing using the NOA forms. It is not legal for employers to require employees to report by another method, unless the employer has received approval from the Director of the WCA.

The intention of the law is for workers to have free access to the forms. If the worker has to ask the supervisor for a form to fill out, that is contrary to the purpose of the law.

When does a worker NOT have to use an NOA form?

- If the employer (or someone in authority, such as a supervisor) had "actual notice" of the accident. Usually this means the employer or supervisor was present and witnessed the accident.
- If the worker is prevented from giving notice by circumstances beyond the worker's control. In such case, the worker must give notice within 60 days.

What is the consequence if an employer does not post the poster?

The right of the injured worker to notify the employer and make a claim is extended from 15 days to 60 days.

This is considered to be a disadvantage for the employer, especially if there is any question about whether the claim was valid. It is very hard to investigate an accident 60 days after it happened.

Frequently asked questions:

May employers print their own posters?

If privately printed posters are exact copies of the WCA poster, and are provided to employers by insurers free of charge, that is acceptable.

How long will the current poster last?

The current poster is valid until it is rescinded by order of the Director, a change in the rules, or a change in the law. The previous poster was in use for 11 years.

What if employers want to put the poster into a frame so that there will be a neat display?

That is OK as long as NOA forms are placed near the poster and are accessible to workers.

What about the poster that employers can buy from commercial companies?

- It is not necessary for employers to buy commercial posters.
- Commercially purchased posters are acceptable by law if they are identical to the WCA poster.
- Commercial vendors normally do not provide NOA forms to employers along with the mandatory posters. If the employer does not post NOA forms, it does not comply with the law.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION OFFICES

Albuquerque Headquarters:

2410 Centre Ave. SE Albuquerque, NM 87106
Phone: (505) 841-6000 toll-free: 1-800-255-7965

Regional Field Offices:

Farmington:

3535 East 30th Street, Ste. 212 Farmington, NM 87402
Phone: (505) 599-9746 toll-free: 1-800-568-7310

Las Cruces:

1120 Commerce Dr, Suite B-1 Las Cruces, NM 88011
Phone: (575) 524-6246 toll-free: 1-800-870-6826

Las Vegas:

32 NM 65 Las Vegas, NM 87701
Phone: (505) 454-9251 toll-free: 1-800-281-7889

Lovington:

100 West Central, Suite A Lovington, NM 88260
Phone: (575) 396-3437 toll-free: 1-800-934-2450

Roswell:

Penn Plaza Building, 400N. Pennsylvania Ave., Ste. 425
Roswell, NM 88201 (575) 623-3997 toll-free: 1-866-311-8587

Santa Fe:

810 West San Mateo, Ste., A-2 Santa Fe, NM 87505
(505) 476-7381

**The Importance of Notice of Accident
in New Mexico workers' compensation
By Judge Gregory Griego**

The workers' compensation law, section 52 -1-29 (A) NMSA, requires an injured worker to give written notice of an accident. The notice of the accident must be provided within 15 days of when worker knew or should have known of the accident occurrence. A notice of an accident must be provided to the employer, an employer's agent, or another person acting within supervisory capacity. Mosher v. Bituminous Ins. Co., 96 NM 674, 634 P.2d 696 (Ct. App. 1981).

Actual notice of an accident by a supervisor can substitute for the written notice required by the statute. Section 52-1-29 (A) NMSA. Actual notice can take many forms, including direct observation of an accident, or the consequences of an accident.

Notice to a health care provider normally will not constitute notice of an accident complying with the statute. Sanchez v. Azotea Contractors, 84 NM 764, 508 P.2d 34 (Ct. App. 1973).

Verbal notice to a supervisor may constitute actual notice, but only if it puts the employer on notice regarding the time, place and circumstances of a work accident. Bell v. Kenneth P. Thompson Co., 76 NM 420, 415 P.2d 546 (S. Ct. 1966). Verbal notice of an accident can be given to a supervisor by someone other than the worker. For example, a co-worker can inform a supervisor of the occurrence of a work accident.

Mere knowledge of an injury, without relation to a work accident is insufficient notice within the requirements of the statute. Herndon v. Albuq. Publ. Sch., 92 NM 635, 593 P.2d 470 (Ct. App. 1978). For example, the statement, "My neck hurts," would not constitute notice of an accident. The statement, "My neck hurts since I lifted an engine block yesterday," would be sufficient as notice to an employer.

Actual notice of an accident is subject to the same time limitations and requirements as written notice. See Rohrer v. Eidal International, 79 NM 711, 449 P.2d 81 (Ct. App. 1968).

The failure to give timely notice of an accident constitutes an absolute defense to a claim for worker's compensation benefits. Geeslin v. Goodno, Inc., 75 NM 174, 402 P.2d 156 (S. Ct. 1965). The defense is considered to be an affirmative defense, which must be raised by the employer. Mosher v. Bituminous Ins. Co., 96 NM 674, 634 P.2d 696 (Ct. App. 1981). The practical effect of this is that notice is assumed to have been given unless there is a specific denial of notice on the part of the employer. Employer bears the burden of proof establishing a lack of notice.

Employer is required under Section 52-1-29 (B) NMSA to keep posted in a prominent location a poster promulgated by the Workers Compensation Administration regarding the law of workers' compensation. The poster is required by statute to have posted along with it forms of notice which have been approved by the Director of the Workers' Compensation Administration. Section 52-1-29 (C) NMSA.

If an employer fails to comply with the statutory requirement regarding the posting of the WCA poster, the time for providing notice by a worker of an accident can extend up to 60 days from the accident. Section 52-1-29 (B) NMSA. Trial decisions have held that the posting of the notice poster, without the notice forms, was inadequate and the time for notice was extended to 60 days. A trial decision has held that the placement of the poster and notice forms in a locked cabinet without ready access was inadequate.

Worker is expected to give notice of an accident when the worker knows or should have known of a work related injury and seriousness of the accident and its resulting injuries. In one case, the worker felt a minor neck pain at the time of the accident. The worker later related serious arm pain to the work accident. The time for giving notice began to run when the worker was aware of the relation between work and injury. Garnsey v. Concrete, Inc., 1996-NMCA-081, 122 NM 195. It is not uncommon for a worker to first become aware of the relation between a work incident and an injury when they are informed of that by a health care provider. Even where there is a clear relation between an accident and injury, the time for notice does not begin to run until a reasonable worker would appreciate the seriousness of the injury. Gomez v. B. E. Harvey Gin Co., 110 NM 100 (S. Ct. 1990).



Workers' Compensation

Fraud is a CRIME

**To report fraud call
(505) 841-6832 or
1-800-255-7965**



NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS

2410 CENTRE AVE. SE ♦ PO BOX 27198
ALBUQUERQUE, NM 87125-7198

OFFICIAL USE ONLY

PLEASE PRINT IN BLACK INK OR TYPE.

G E N E R A L	EMPLOYER (NAME & ADDRESS INCL ZIP)				CARRIER / ADMINISTRATOR CLAIM #		OSHA LOG NUMBER		REPORT PURPOSE CODE				
					JURISDICTION		JURISDICTION CLAIM NUMBER						
					INSURED REPORT NUMBER								
	PHONE NUMBER		EMPLOYER FEIN		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #				
								INDUSTRY CODE					
C A R R I E R	C L A I M S A D M I N	CARRIER (NAME, ADDRESS & PHONE NO)				POLICY PERIOD TO		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)					
						CHECK IF APPROPRIATE ☐ SELF INSURANCE							
		CARRIER FEIN		POLICY / SELF-INSURED NUMBER				ADMINISTRATOR FEIN					
		AGENT NAME & CODE NUMBER											
E M P L O Y E E	NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE		
	ADDRESS (INCL ZIP)				GENDER ☐ MALE ☐ FEMALE ☐ UNKNOWN		MARITAL STATUS ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN		OCCUPATION/JOB TITLE OR (SOC) CODE				
	PHONE NUMBER				# OF DEPENDENTS				EMPLOYMENT STATUS				
									NCCI CLASS CODE				
W A G E	RATE		PER:		☐ DAY ☐ WEEK	☐ MONTH ☐ OTHER:	# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		☐ YES ☐ NO	☐ YES ☐ NO	
									DID SALARY CONTINUE?		☐ YES ☐ NO	☐ YES ☐ NO	
O C C U R R E N C E	TIME EMPLOYEE BEGAN WORK		☐ AM ☐ PM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE ☐ AM ☐ PM		LAST WORK DATE		DATE EMPLOYER NOTIFIED		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 RETURNED TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?				☐ YES ☐ NO ☐ YES ☐ NO				
T R E A T M E N T	PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)						HOSPITAL (NAME & ADDRESS)				INITIAL TREATMENT ☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC/HOSPITAL ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HRS ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED		
O T H E R	WITNESSES (NAME & PHONE #)												
	DATE ADMINISTRATOR NOTIFIED				DATE PREPARED		PREPARER'S NAME & TITLE						

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

Phone: (505) 841-6000

In-State Toll Free: 1-800-255-7965

FARMINGTON: 505-599-9746/1-800-568-7310

LAS CRUCES: 505-524-6246/1-800-870-6826

LAS VEGAS: 505-454-9251/1-800-281-7889

LOVINGTON: 505-396-3437/1-800-934-2450

Roswell: 505-623-3781

Santa Fe: 505-476-7381

FILING INSTRUCTIONS

PURPOSE: To report all alleged work-related injuries or illnesses resulting in more than 7 days of lost work or in death of the worker. This form is not an admission or denial by the employer as to whether the worker's alleged injury or illness is compensable, **and must be completed by the employer or the employer's representative.**

WHEN TO FILE: This form must be filed within 10 days of knowledge of any alleged work-related injury or illness that results in more than 7 days of lost work. **It must be filed even if the employer disputes the worker's claim of work-related injury or illness.**

WHERE TO FILE: Mail the original form to the New Mexico Workers' Compensation Administration (Attention: Statistics) at the address on the front of this form. **Copies must also be provided to the worker and the employer's workers' compensation insurer.**

PENALTIES: Each instance of failure to file this form when required is punishable by a fine of up to \$1,000.00.

INSTRUCTIONS FOR COMPLETION

FILLING IN THE SHADED AREAS IS OPTIONAL. The employer may wish, however, to use some of these areas (such as "Witnesses") for the employer's records. Expanded instructions are found in the publication ***Guide to Completing the Employer's First Report of Injury or Illness***, available from the Administration's Albuquerque office (call either number bold-faced above and ask for Statistics).

Please print in black ink or type, and ensure that all entries are legible before submission. An illegible or incomplete E1 may be returned.

NAIC CODE: Represents the nature of the employer's business at the location where the worker was employed at the time of injury or illness exposure; derived from the federal government publication *North American Industry Classification System Manual*. Include this code if known.

EMPLOYER'S LOCATION ADDRESS: Facility where the worker was employed at the time of injury, if different from mailing address.

CARRIER: Name, mailing address and telephone number of the licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer. A WCA-approved self-insured employer should enter its business name.

CLAIMS ADMINISTRATOR: Name, mailing address and telephone number of the insurance carrier, agency, third party administrator or self-insured responsible for adjusting the claim.

EMPLOYER, CARRIER OR ADMINISTRATOR FEIN: Federal Identification Number, assigned by the Internal Revenue Service.

DID SALARY CONTINUE? Shows if the employer is continuing to pay the worker's regular wages *without charge to employee benefits*.

DATE OF INJURY/ILLNESS: In the case of an occupational illness (arising from the worker's activity or exposure over an extended period), enter the date of diagnosis or the date first reported to the employer as possibly work-related.

DATE EMPLOYER NOTIFIED: The date the worker first notified (verbally or in writing) the employer or the employer's representative of the alleged work-related injury or illness.

DATE DISABILITY BEGAN: The first full day on which the worker lost time from work due to the injury or illness.

TYPE OF INJURY OR ILLNESS: Briefly describe the nature of the injury (such as lacerations to the forearm) or illness (such as carpal tunnel syndrome). Be as specific as possible.

PART OF BODY AFFECTED: The specific part of body affected by the injury or illness (for example, right forearm, lower back).

DEPARTMENT OR LOCATION: If the accident or illness exposure did not occur on the employer's premises, enter specific address or location (for example, Client's office at 123 Main St., Yourtown, NM 87xxx). For occurrences in New Mexico, give ZIP or COUNTY.

ALL EQUIPMENT, MATERIAL OR CHEMICALS: List all equipment, materials and/or chemicals the worker was using, applying, handling or operating when the injury or illness exposure occurred. Be specific (for example, decorator's scaffolding, electric sander, paintbrush and paint). Enter "NA" if not applicable. NOTE: The items listed do not have to be directly involved in the worker's injury or illness.

SPECIFIC ACTIVITY: Describe the specific activity the worker was engaged in when the accident or illness exposure occurred (for example, sanding ceiling woodwork in preparation for painting).

WORK PROCESS: Describe the work process the worker was engaged in when the accident or exposure occurred, such as building maintenance. Enter "NA" for not applicable if not engaged in a work process (for example, if the worker was walking along a hallway).

HOW INJURY OR ILLNESS OCCURRED: Describe how the injury or illness/abnormal health condition occurred. Be very specific. Include the sequence of events and name any objects or substances that directly injured the worker or made the worker ill. (For example: worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

WORKER'S/EMPLOYER'S RIGHTS AND RESPONSIBILITIES

If you, the worker, believe that benefits are due you under the Workers' Compensation Act, and your employer or the employer's insurance carrier has failed or refused to make those benefits available to you, you have a right to file a complaint with the New Mexico Workers' Compensation Administration. Workers and employers with questions about rights or responsibilities under the Act may contact an ombudsman at any Workers' Compensation Administration regional office for information and assistance. To do so, call any of the above-listed telephone numbers (8 a.m. to 5 p.m. M-F).

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 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)

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

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 accident

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 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!



\$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.