Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division®

Workers Compensation State Claim Kit

Connecticut

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division®

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division®

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

Dear Policyholder,

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

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

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

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

bhhcpolicyholder.bhhc.com/Client/External/Claims

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division®

Workers' Compensation Posting Requirements

Notice to Employees Poster

- Post in one or more conspicuous places readily accessible to all employees at all business locations
- Text must be bolded and in at least 10-point font-size

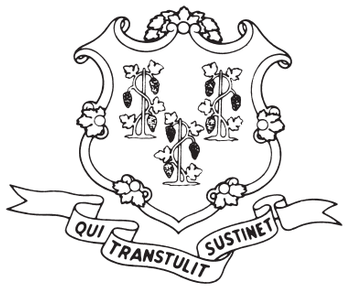
To complete the form, please enter the following information in the spaces provided:

- Your company name
- Your designated insurance company/carrier name
- The address and phone number for the Connecticut Workers' Compensation District Office that is assigned to your area
- Date posted

For your convenience, our other contact information has been entered on the poster and we have attached a copy of a listing of the Commission's District Offices. Please note, the form fields are designed to populate text meeting the statutory font-size requirement.

(Connecticut General Statutes § 31-279(a), § 32-281(f) and Regulations of Connecticut State Agencies § 31-279(B))

NOTICE
TO EMPLOYEES



State of Connecticut Workers' Compensation Commission **Revised 10-01-2021**

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,

_____

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the administrative law judge may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name _____

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

Approved Medical Care Plan ☐ **Yes** ☐ **No**

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.

If your employer has listed a location below, you <u>MUST</u> file your compensation claim there.
When filing your claim, you are also required – by law – to send it by certified mail.

If blank below, ask your employer where to file your claim.

Employer Name _____

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMPLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted: _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).

Connecticut Towns and their Workers' Compensation Districts

Rev. 12-20-2021

Workers' Compensation Commission District Offices and the cities, towns and subdivisions they serve.

First District — Administrative Law Judge, 999 Asylum Avenue, Hartford, CT 06105; (860) 566-4154

The Hartford District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Bloomfield
Blue Hills
Broad Brook
Crystal Lake
Dobsonville
East Granby
East Hartford
East Windsor
East Windsor Hill
Ellington
Enfield
Hartford
Hazardville
Melrose
North Somers
North Thompsonville
Poquonock
Rainbow
Rockville
Sadds Mill
Scantic
Scitico
Silver Lane
Somers
Somersville
South Windsor
Suffield
Talcotville
Thompsonville
Tolland
Vernon
Vernon Center
Warehouse Point
West Suffield
Wilson
Windsor
Windsor Locks
Windsorville

Second District — Administrative Law Judge, 55 Main Street, Norwich, CT 06360; (860) 823-3900

The Norwich District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Abington
Almyville
Amston
Andover
Ashford
Attawaugan
Atwoodville
Ballouville
Baltic
Bolton
Bolton Notch
Bozrah
Bozrah Street
Brooklyn
Burnetts Corner
Canterbury
Center Groton
Central Village
Chaplin
Chesterfield
Chestnut Hill *(Lebanon)*
Clark Falls
Clarks Corner
Columbia
Coventry
Danielson
Dayville
Doaneville
Eagleville
East Brooklyn
Eastford
East Killingly
East Putnam
East Thompson
East Willington
East Woodstock
Ekonk
Elmville
Exeter
Fabyan
Fitchville
Franklin
Gales Ferry
Gilead
Gilman
Glasgo
Goshen Hill
Graniteville
Greenville
Griswold
Grosvenordale
Groton
Groton Heights
Groton Long Point
Gurleyville
Hallville
Hampton
Hanover
Harrisville
Hebron
Hopeville
Hop River
Hydeville
Jewett City
Jordan Village
Kenyonville
Killingly
Killingly Center
Laurel Glen
Lebanon
Ledyard
Ledyard Center
Liberty Hill
Lisbon
Long Society
Lords Point
Mansfield
Mansfield Center
Mansfield Depot
Mansfield Hollow
Mashantucket
Mashapaug
Mechanicsville *(Thompson)*
Merrow
Mohegan
Montville
Moosup
Morningside Park
Mystic
Newent
New London
Noank
North Ashford
North Franklin
North Grosvenordale
North Stonington
North Windham
North Woodstock
Norwich
Norwichtown
Oakdale
Occum
Ocean Beach
Old Mystic
Oneco
Orcuttville
Pachaug
Packerville
Pawcatuck
Phoenixville
Plainfield
Pleasure Beach
Pomfret
Pomfret Center
Pomfret Landing
Poquetanuck
Poquonock Bridge
Preston
Putnam
Putnam Heights
Quaddick
Quaker Hill
Quinebaug
Rogers
Scotland
Sodom
South Chaplin
South Killingly
South Willington
South Windham
South Woodstock
Sprague
Spring Hill *(Mansfield)*
Stafford
Stafford Springs
Staffordville
Sterling
Sterling Hill
Stonington
Storrs
Taftville
Thompson
Uncasville
Union
Versailles
Village Hill *(Lebanon)*
Voluntown
Warrenville
Waterford
Wauregan
Wequetequock
Westford
Westminster
West Mystic
West Stafford
West Thompson
West Willington
West Woodstock
Willimantic
Willington
Wilsonville
Windham
Woodstock
Woodstock Valley
Yantic

Third District — Administrative Law Judge, 700 State Street, New Haven, CT 06511; (203) 789-7512

The New Haven District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Allingtown
Augerville
Bethany
Branford
Burr Hill
Clinton
Clintonville
Durham
East Haven
East River
Fair Haven
Foxon
Guilford
Hamden
Indian Neck
Killingworth
Madison
Momauguin
Montowese
Morningside
Mount Carmel
New Haven
North Branford
Northford
North Guilford
North Haven
North Madison
Orange
Pine Orchard *(Branford)*
Pond Meadow *(Killingworth)*
Quinnipiac
Rivercliff
Rockland
Sachem Head
Short Beach
Spring Glen
Stony Creek
West Haven
Westville
Whitneyville
Woodbridge

Fourth District — Administrative Law Judge, 350 Fairfield Avenue, Bridgeport, CT 06604; (203) 382-5600

The Bridgeport District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Ansonia
Berkshire
Botsford
Bridgeport
Derby
Devon
Dodgingtown
Easton
East Village
Fairfield
Greenfield Hill
Greens Farms
Hattertown
Hawleyville
Huntington
Huntingtontown
Long Hill District
Lordship
Milford
Monroe
Newtown
Nichols
Riverside *(Newtown)*
Sandy Hook
Saugatuck
Shelton
Southport
Stepney
Stevenson
Stratford
Trumbull
Upper Stepney
Westport
Woodmont

Fifth District — Administrative Law Judge, 55 West Main Street, Waterbury, CT 06702; (203) 596-4207

The Waterbury District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Amesville
Bantam
Beacon Falls
Bethlehem
Burrville
Campville
(Litchfield)
Canaan
Canaan Valley
Cornwall
Cornwall Bridge
Cornwall Center
Cornwall Hollow
Drakeville
East Canaan
East Litchfield
East Morris
East Plymouth
Ellsworth
Falls Village
Flanders
Goshen
Greystone
Harwinton
Hotchkissville
Huntsville
Kent
Kent Furnace
Lakeside
Lakeville
Lime Rock
Litchfield
Lower City
Macedonia
Middlebury
Millville
Milton
Minortown
Morris
Naugatuck
Newfield
(Torrington)
Norfolk
North Canaan
Northfield
North Kent
North Woodbury
Oakville
Oxford
Pequabuck
Plymouth
Pomperaug
Prospect
Quaker Farms
Salisbury
Seymour
Sharon
South Britain
Southbury
South Canaan
Southford
South Kent
Straitsville
Taconic
Terryville
Thomaston
Torringford
Torrington
Twin Lakes
Union City
Warren
Waterbury
Watertown
West Cornwall
West Goshen
West Torrington
White Oak
Woodbury
Wrightville

Sixth District — Administrative Law Judge, 24 Washington Street, New Britain, CT 06051; (860) 827-7180

The New Britain District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Avon
Bakersville
Barkhamsted
Berlin
Bristol
Burlington
Canton
Canton Center
Colebrook
Collinsville
East Berlin
East Hartland
Edgewood
Elmwood
Farmington
Forestville
Granby
Hartland
Kensington
Marion
Mechanicsville
(Granby)
Milldale
Nepaug
New Britain
New Hartford
Newington
North Canton
North Colebrook
North Granby
Pine Meadow
Plainville
Plantsville
Pleasant Valley
Riverton
Robertsville
Simsbury
Southington
Tariffville
Unionville
Weatogue
West Avon
West Granby
West Hartford
West Hartland
West Simsbury
Wethersfield
Whigville
Winchester
Winchester Center
Winsted
Wolcott

Seventh District — Administrative Law Judge, 111 High Ridge Road, Stamford, CT 06905; (203) 325-3881

The Stamford District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Banksville
Belltown
Bethel
Boardmans Bridge
Branchville
Bridgewater
Brookfield
Brookfield Center
Byram
Cannondale
Church Hill
Cos Cob
Cranbury
Danbury
Darien
East Norwalk
Gaylordsville
Georgetown
Germantown
Glenbrook
Glenville
Greenwich
High Ridge
Long Ridge
(Stamford)
Lower Merryall
Lyons Plains
Marble Dale
Merryall
Mianus
Mill Plain
New Canaan
New Fairfield
New Milford
New Preston
Noroton
Noroton Heights
North Stamford
Northville
North Wilton
Norwalk
Old Greenwich
Park Lane
Redding
Redding Ridge
Ridgebury
(Ridgefield)
Ridgefield
Riverside
(Greenwich)
Romford
Round Hill
(Greenwich)
Rowayton
Roxbury
Roxbury Falls
Roxbury Station
Sherman
Silvermine
(Norwalk)
South Norwalk
South Wilton
Springdale
Stamford
Titicus
Topstone
Turn Of River
Upper Merryall
Washington
Washington Depot
West Norwalk
Weston
West Redding
Wilton
Winnipauk
Woodville

Eighth District — Administrative Law Judge, 649 South Main Street, Middletown, CT 06457; (860) 344-7453

The Middletown District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Addison
Baileyville
Bashan
Black Hall
Black Point
Buckingham
Buckland
Centerbrook
Cheshire
Chester
Cobalt
Colchester
Cornfield Point
Crescent Beach
Cromwell
Deep River
East Glastonbury
East Haddam
East Hampton
East Lyme
Essex
Fenwick
Flanders Village
Gildersleeve
Glastonbury
Grove Beach
(Westbrook)
Haddam
Haddam Neck
Hadlyme
Hamburg
Higganum
Highland
Highland Park
Hopewell
Ivoryton
Knollwood Beach
Laysville
Leesville
Little Haddam
Lyme
Manchester
Manchester Green
Marlborough
Meriden
Middlefield
Middlefield Center
Middle Haddam
Middletown
Millington
Mixville
Moodus
Niantic
North Lyme
North Plains
North Westchester
Old Lyme
Old Saybrook
Pond Meadow
(Westbrook)
Ponset
Portland
Rockfall
Rocky Hill
Salem
Salem Four Corners
Saybrook Manor
Saybrook Point
Shailerville
Sound View
South Glastonbury
South Lyme
South Meriden
Tylerville
Wallingford
Westbrook
Westfield
Winthrop
Yalesville

State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Date filed in Chairman's Office

(for WCC use only)

Employer *(Name, Address & Zip)* | Phone #

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

SIC Code | FEIN

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ☐ Check, if Self-Insured | Policy Period *(MM/DD/YY)* FROM: TO:

Employee: Last Name First Name Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender ☐ Male ☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ _____ . _____ per ☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ☐ a.m. ☐ p.m.

Time of Occurrence ☐ cannot be determined ☐ a.m. ☐ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Contact Name

Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ☐ Yes ☐ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

If provided, were they used? ☐ Yes ☐ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

☐ No Medical Treatment ☐ Emergency Care

☐ Minor — by Employer ☐ Hospitalized More Than 24 Hours

☐ Minor — by Clinic / Hospital ☐ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division®

Employee Incident Report

This for should be filled out by the injured employee.

Name

Employer Name

Date of Incident

Time of incident

Time you began work on day of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)
Yes or No

How did the injury occur? What job duties were you performing? Please describe in your own words.

What part(s) of your body was injured (indicating right and/or left)?

Have you sought any medical treatment for these injuries? If so, specify where and when.

Have you ever injured this part of your body before (yes or no)? If so, please describe how and when the previous injury(s) occurred.

What witnesses were present when the incident occurred? Please provide names if applicable.

Who did you report the injury to? When was the injury reported? Please provide name(s) and job title(s).

What did you do after the incident occurred?

The above form is true and correct.

Signature

Date Completed

RESET FORM

PRINT THIS FORM

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division®

Informe de Incidente del Empleado

A ser completado por el trabajador lesionado.

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Hora en que usted empezó a trabajar el día del incidente

Dirección del Incidente

Ciudad, Estado

Código Postal

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

¿Cómo ocurrió la lesión? ¿Qué deberes del trabajo estaba desempeñando? Por favor, describa en sus propias palabras.

¿Qué parte(s) de su cuerpo resultó(aron) lesionada(s) (indicando derecha y/o izquierda)?

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

¿Se ha lesionado anteriormente alguna vez esta parte de su cuerpo (sí o no)? Si es así, por favor, describa cómo y dónde ocurrió(eron) la(s) lesión(es) anterior(es).

¿Qué testigos estuvieron presentes cuando ocurrió el incidente? Por favor, proporcione nombres si es aplicable.

¿A quién informó la lesión? ¿Cuándo fue informada la lesión? Por favor, proporcione nombre(s) y puesto(s).

¿Qué hizo después de ocurrido el incidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario

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Supervisor's Report of Employment Incident

Employee Name

Employer Name

Date of Incident

Time of incident

Time the employee began work on day of incident

Did the employee report the incident immediately? Yes or No

Address of Incident

City, State

Zip

Offsite? (Y/N) Yes or No

How did the injury occur? What job duties was the employee performing?

What part(s) of the employee's body were reported as injured?

Has the employee sought any medical treatment for these injuries? If so, specify where and when.

What witnesses were present when the incident occurred (including self)?

Do you have any reason to question the legitimacy of the incident? If so, please explain:

Supervisor's Report of Employment Incident

Indicate working conditions present that led to incident (please check all that apply)

- ☐ Unused/unavailable lifting equipment
- ☐ Unused/unavailable sharps container
- ☐ Electrical exposure
- ☐ Lack of training
- ☐ Poor housekeeping
- ☐ Interaction with patient or resident
- ☐ Chemical exposure
- ☐ Other:
- ☐ Unused/unavailable PPE (gloves, hardhat, goggles, etc.)
- ☐ Unguarded or improperly guarded equipment
- ☐ Obstructed view
- ☐ Wet/slippery floor
- ☐ Interaction with co-worker
- ☐ Interaction with customer
- ☐ Motor vehicle incident

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

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division®

Informe de Incidente del Supevisor

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente? Si/No

Dirección del Incidente

Ciudad, Estado

Código Postal

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

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

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

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

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

Informe de Incidente del Supevisor

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

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

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

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

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division®

Witness' Report/Statement of Employee Incident

Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)
Yes or No

Date of Incident

Time of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)
Yes or No

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

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

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

What did the employee do after the incident occurred?

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

The above form is true and correct.

Witness' Signature

Date Completed

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Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division®

Informe de Incidente del Testigo

Nombre del Empleado

Nombre del Testigo

Teléfono del Testigo

Dirección del Testigo

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/No)

Fecha Del Incidente

Hora del incidente

Dirección del incidente

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/ No) Si/No

¿Presenció el incidente? Si es así, ¿cómo ocurrió?¿Qué deberes laborales estaba realizando el empleado?

¿Qué parte(s) del cuerpo del empleado resultaron lesionadas? Describa el tipo de lesión (tensión, moretón, etc.)

¿Qué dijo el empleado lesionado en el momento de la lesión? ¿El empleado lesionado se quejó de dolor en el momento de la lesión? Si se quejaron de dolor, especifique la(s) parte(s) del cuerpo(s).

¿Qué hizo el empleado después de que ocurrió el incidente?

¿Había otros testigos presentes en el momento del incidente? Si es así, por favor escríbalos aquí.

La forma anterior es verdadera y correcta.

Firma del Testigo

Fecha

RESET FORM

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STATE OF CONNECTICUT
WORKERS' COMPENSATION COMMISSION

AUTHORIZATION TO OBTAIN AND/OR DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____
(Please Print Name) (Required)

I, the undersigned, authorize _____
(Hospital or Provider)

To disclose, in writing, protected health information (PHI) to:

_____
(Person or Entity to whom information is to be disclosed)

And its attorneys and representatives. The PHI to be disclosed is relevant medical records and reports relating to my medical treatment/consultations/examinations and/or diagnostic procedures performed at the above-referenced medical facility. I understand that I have the right to copy or inspect the PHI to be disclosed as permitted under Federal HIPAA law and state law.

I authorize the following PHI to be obtained/disclosed from my medical records:
Dates of Service or Date range _____
Body part(s) _____

PROTECTED RECORDS

REQUIRED: Please initial the lines below to indicate you authorize the release of the protected information specified, even if the categories do not necessarily apply to the patient's medical records.

(Initial _____) Alcohol, Drug or Substance Abuse Treatment Records
(Initial _____) HIV Testing & Related Information
(Initial _____) Reproductive Healthcare Services
(Initial _____) Mental or Behavioral Health Treatment Records
(Initial _____) Genetic Testing

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION. In order to revoke this authorization, I may, at any time, send written notification to the above-named hospital/provider. I understand that my revocation of this authorization is ineffective to the extent that the above-named hospital/provider has relied on this authorization to disclose PHI relating to me.

I UNDERSTAND THAT PHI DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE PERSON OR ENTITY I HAVE IDENTIFIED ABOVE AND MAY NO LONGER BE PROTECTED FROM DISCLOSURE TO OTHERS BY FEDERAL OR STATE LAW. I understand that the above-named hospital/provider may not condition my treatment on whether I provide authorization for the requested use or disclosure.

IF THE PHI THAT IS DISCLOSED UNDER THIS AUTHORIZATION IS CONFIDENTIAL HIV/AIDS RELATED INFORMATION, PSYCHIATRIC OR OTHER PROTECTED MENTAL HEALTH INFORMATION, ALCOHOL OR DRUG ABUSE RELATED INFORMATION, OR REPRODUCTIVE HEALTH INFORMATION, THE RECIPIENT MAY BE PROHIBITED FROM REDISCLOSING THAT INFORMATION UNDER FEDERAL OR CONNECTICUT LAW.

I understand that if this disclosure contains information relating to HIV, behavioral health, alcohol, drug and/or substance abuse treatment, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by law. Federal regulations (Title 42 CFR Part 2) and Connecticut General Statutes (Ch. 368x) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of psychiatric or substance abuse information is NOT sufficient for this purpose.

I UNDERSTAND THAT I HAVE THE RIGHT TO DETERMINE A DATE OR EVENT WHEN THIS AUTHORIZATION EXPIRES.
Unless otherwise revoked, this authorization will expire on the following date/event: _____. If I fail to specify an expiration date/event, this authorization will expire six (6) months from the date signed.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this form relates to a Workers' Compensation matter. However, I understand that as a practical matter, my authorization may facilitate the processing and administration of my claim for Workers' Compensation benefits.

My signature below indicates that I have read and understand this authorization and its terms.

Signature of Patient/Parent/Legal Representative Date Relationship to Patient

Revised: October 1, 2025

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division®

Medical History Request

Employee Name _____ **Date of Injury** _____

Employer Name _____ **Completion Date** _____

Please complete this form by providing your medical history for the past 5 years. This will help ensure that we are able to provide all of your medical records to your current treating physician for you to receive the proper care for your work injury.

Thank you for your cooperation.

Past Injuries, Disabilities, or Other Medical Conditions

Hospitalizations

Hospital Name & Address	Phone	Date(s) Adimitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

RESET FORM PRINT THIS FORM

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 7-13-2009

1A

Filing Status and Exemption

This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER October 1, 1991, and must be completed in its entirety.

WCC File #

Date filed in District

(for WCC use only)

EMPLOYEE

Name _____ Date of Birth *(required)* _____

Address _____

City/Town _____ State _____ Zip Code _____

DATE OF INJURY:

_____

FILING STATUS AND EXEMPTIONS — In order to determine your weekly benefit rate, as per Sec. 31-310 C.G.S.,we need the following information:

1. Select your Federal tax filing status based upon your **ACTUAL filing status as of the date of injury**, listed at right: *(Must match your tax return, as if you were filing with the IRS on the date of your injury.)*

   ❑ Single ❑ Head of Household ❑ Married filing jointly ❑ Married filing separately

2. Number of exemptions *(including yourself)* as of the date of injury listed at right = _____

3. FICA withheld for the above-named employee? ..... ❑ YES ..... ❑ NO — ***If NO, insurer must manually calculate weekly benefit rate.***

4. Check all appropriate boxes:

   ❑ Employee 65 years of age or older ❑ Employee legally blind ❑ Spouse 65 years of age or older ❑ Spouse legally blind

5. List name *(yourself first)*, date of birth, and relationship to you for all exemptions included in question #2, above:

Name	*Date of Birth*	*Relationship*
		SELF

CONCURRENT EMPLOYMENT — To be certain you receive all the benefits to which you are entitled, provide the following information *if you were working for more than one employer on the date of injury indicated above*:

Name of Employer	*Address*	*Date of Hire*

NOTE: Wage information for each concurrent employer must be supplied by the claimant.

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

I hereby attest that the above information is correct to the best of my knowledge.

Employee's Signature _____ Date _____

MyMatrixx
By EVERNORTH

Temporary Prescription Card

To the Injured Worker:

On your first visit, please give this form to any pharmacy listed on the back side to speed processing of your approved work-related injury prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the MyMatrixx Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador).

¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

ID#: _____
Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: G3YA

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

Employee Information

_____
Full Name

_____
Street Address or PO Box

_____
City State ZIP

_____
Date of Birth

_____
Employer Name

To the Pharmacist:

MyMatrixx administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary.

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

1. Enter RxBin 003858
2. Enter PCN WC
3. Enter Rx Group Number G3YA
4. Enter 9-digit member ID (Patient SSN)
5. Enter Date of Injury

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

MyMatrixx
By EVERNORTH

Participating Pharmacy List

AHF PHARMACY
AHOLD CORPORATION
ALBERTSONS
ALIGNRX LLC
AMERITA INC
AURORA PHARMACY INC
BIG Y FOODS INC
BI-LO HOLDINGS LLC
BROOKS/MAXI DRUG
BROOKSHIRE BROTHERS LTD
BROOKSHIRE GROCERY CO
CARDINAL HEALTH
CHEN NEIGHBORHOOD MEDICAL CENT
COBORN'S INC.
COSTCO WHOLESALE, INC
CVS CORP
DEDICATED US HOLDINGS LLC
DISCOUNT DRUG MART
ECKERD
EPIC PHARMACY NETWORK
ESSENTIA HEALTH
EXPRESS RX
FAIRVIEW PHARMACY SVCS
FAMILY FARE, LLC
FOOD LION PHARMACY
FRUTH PHARMACY
GENOA HEALTHCARE LLC
GIANT EAGLE PHARMACY
GUARDIAN PHARMACY LLC
HAC INC
HANNAFORD BROS. CO.
HARPS FOOD STORES INC
HARTIG DRUG
HEALTH MART ATLAS LLC
H-E-B LP
HENRY FORD HEALTH SYSTEM
HOMETOWN PHARMCY INC
HY-VEE FOOD STORES INC
INGLES MARKETS
INSTYMEDS CORP
KPH HEALTHCARE SERVICES
KS PHARM LLC
K-VA-T FOOD STORES INC
LEWIS DRUGS INC
LONGS DRUG STORE
MARC GLASSMAN INC
MEDICAP PHARMACY, INC.
MEDICINE SHOPPE
MEIJER PHARMACY
MERCY PHARMACY SERVICES
NCS HEALTHCARE
NEIGHBORCARE PHARMACY
OSBORN DRUGS INC
PATIENT FIRST
PHARMEDQUEST PHARMACY
PHARMERICA, INC
PMR US HOLDINGS
PRESBYTERIAN MEDICAL
PRESCRIBEIT RX
PRICE CHOPPER PHARMACY
PUBLIX SUPER MARKETS, INC
RALEY'S
RECEPT PHARMACY LP
RITE AID CORPORATION
SAFEWAY, INC.
SAM'S CLUB
SUPERVALU PHARMACIES, INC.
TARGET
THRIFTY WHITE STORES
TOPS MARKETS LLC
UNITED SUPERMARKETS INC
WALGREENS
WAL-MART
WEGMANS FOOD MARKETS,
WEIS MARKETS INC

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division®

$1000 REWARD

For information leading to the arrest and conviction of any co-worker, health care professional, or the attorney representing a fraudulent workers compensation claim to Berkshire Hathaway Homestate Companies (BHHC)*.

In most states, it is a felony to make or cause to be made a knowingly false or fraudulent material statement in order to obtain workers compensation benefits. BHHC believes that any party engaging in such fraud should be prosecuted to the fullest extent of the law, including jail sentences.

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

Call our toll-free fraud hotline immediately if you have information on a fraudulent claim.

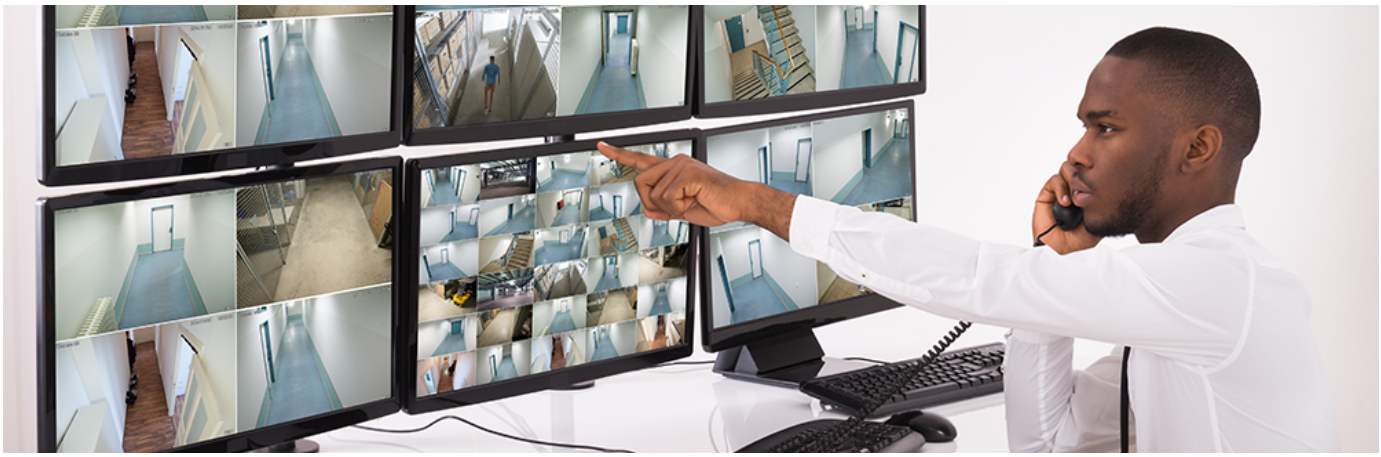
1 (800) 300-JAIL

*Maximum reward of $1,000 per conviction. In the event that more than one individual submits information regarding the same fraudulent claim, BHHC will equally divide the reward among those providing information used in obtaining the conviction. BHHC reserves the right to determine what information, if any, will be provided to the appropriate law enforcement agency. Criminal prosecutions are the sole responsibility of the authorities and may or may not be pursued at their discretion. Any issues regarding the interpretation of this policy shall be resolved by BHHC at their sole discretion. Program subject to change or termination without prior notice.

AM BEST A++ Superior
BHHC has an AM Best Credit Rating of A++ as of March 13,2025.
For the latest Best Credit Rating, access ambest.com.

F.ENG.21.2.4.2

Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division®



$1000 RECOMPENSA

Información que lleva al arresto y a la condena de cualquier compañero de trabajo, profesional de cuidado medico, o abogado que represente un reclamo fraudulento en contra de Berkshire Hathaway Homestate Companies*.

En la mayoría de los estados es un delito grave hacer que haga una declaración de material fraudulento para obtener beneficios de Compensación al Trabajador. Berkshire Hathaway Homestate Companies cree que cualquier persona que se involucre en tal fraude debe ser procesado con todo el rigor de la ley, incluyendo SER SENTENCIADO A LA CARCEL.

Ayúdenos de su parte. El poner a estos delincuentes fuera de op eraciones nos beneficia a todos, incluso esto ayuda a mantener los réditos bajos de la as eguranza de su empleador.

Si usted tiene información sobre un reclamo fraudulento por favor llame de inmediato a nuestra LINEA GRATUITA DE FRAUDE.

1 (800) 300-JAIL

*La recompensa máxima es de $1,000 por convicción. En caso de que más de una persona presente informaciones sobre la misma demando fraudulenta. BerkshireHathaway dividirá la recompensa por partes iguales entre aquellas persones que aportaron informaciones para obtener la convicción. Berkshire Hathaway se reserva el derecho de determinar qué informacion presentará a la agencia judicial correspondiente. El proceso de crímenes es la responsibilidad exclusiva de las autoridades, que pueden decidir si el proceso debe entablarse or no. Cualquier disputa que pudiera surgir en la interpretación de esta ofreta será resuelta por la propia Compañia de Seguros Berkshire Hathaway. Este programa está sujeto a cambios a cancelación sin aviso previo.

AM BEST A++ Superior
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For the latest Best Credit Rating, access ambest.com.

F.SP.21.2.4.5