Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division®

Workers Compensation State Claim Kit

Alaska

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.

Alaska 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

Form 07-6120 – Employer's Notice of Insurance Poster

- Post in three or more conspicuous places at all business and work sites examples:
  - Office
  - Mess house, boarding house, or break/lunch room
  - Another prominent location
- The document must be signed by two witnesses

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

- The name of your designated insurer
- Your policy period dates (start and end)
- The name of your company
- Name and title of the individual completing the form
- Please note, as indicated above, the form must be signed by two witnesses

For your convenience, our other contact information and the name and address of our Adjusting Company in Alaska have been entered on the Form 07-6120.

(Alaska Statutes § 23.30.060)

EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by

Insurer

Street and Number
PO Box 881716

City: San Francisco | State: CA | Zip Code: 94188

For the period from _____ Through _____

Adjusting Company
Northern Adjusters

Street and Number
1401 Rudakof Circle

City: Anchorage | State: AK | Zip Code: 99508 | Telephone: 907-868-3999

This insurance pays benefits for job-connected injuries, illnesses or death as provided by the Alaska Workers' Compensation Act

Employer

By

Title

Witness

Witness

Immediately (not later than 15 days from injury or death date) give your employer and the Alaska Workers' Compensation Division written notice of a job-related injury, illness, or death. Get the "Report of Occupational Injury or Illness" form from your employer for this purpose.

If you have questions about your rights or benefits under the Alaska Workers' Compensation Act, contact the insurer at the above address and the Alaska Workers' Compensation Division at the nearest office listed below:

ANCHORAGE
3301 Eagle Street
Suite 304
Anchorage AK 99503
(907) 269-4980

FAIRBANKS
675 7th Ave
Station K
Fairbanks AK 99701-4531
(907) 451-2889

JUNEAU
PO Box 115512
1111 W 8th St Rm 305
Juneau AK 99811-5512
(907) 465-2790

NOTICE TO EMPLOYER: AS 23.30.060 requires that you post this notice in three conspicuous places on the employer's premises.

Alaska Dept of Labor and Workforce Development
Division of Workers' Compensation
PO Box 115512 | Juneau, AK | 99811-5512
workerscomp@alaska.gov

REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Date Received (Division Use Only):

EMPLOYEE:

1. Last Name	First Name	Initial	2. Date of Birth	3. Social Security Number	
4a. Mailing Address			5. Telephone Number	6. E-Mail Address	
4b. City	State	Zip Code	7. Marital Status	8. # of Dependents	9. Gender
10. Location (City/Town/Village/Camp) Where Injury or Occupational Illness Happened			11. Date of Injury or Illness	12. Time of Injury or Illness	13. On Employer's Premises? ◯ YES ◯ NO
14. Part(s) of Body Injured ☐ Left ☐ Right			15. Describe Nature of Injury / Illness (i.e., sprain, laceration, etc)		

16. Describe How Injury or Occupational Illness Happened

17. Initial Treatment

◯ No Medical Treatment
◯ Minor On-site Remedies by Employer Medical Staff
◯ Minor Clinic/Hospital Remedies and Diagnostic Testing
◯ Emergency Evaluation, Diagnostic Testing, and Medical Procedures
◯ Hospitalization Greater than 24 Hours
◯ Future Major Medical/Lost Time Anticipated

18. Witness Name(s) and Phone Number(s)

19. To all health care providers:

You are authorized to provide my employer, its workers' compensation liability insurance company, and its claims adjuster information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above. This information will be used to evaluate my entitlement to receive benefits, including payment of medical benefits, under the Alaska Workers' Compensation Act. This authorization is valid for a one-year period from the date of my signature. I know I have a right to receive a copy of this authorization and agree a photographic copy of this authorization is as valid as the original.

20. Employee Signature: **Date Signed**

21. If Employee Unavailable to Sign, Explain the Circumstances

EMPLOYER:

22. Employer Name	FEIN		23. Insurance Policy Number	Effective Date	Expiration Date
24a. Employer Mailing Address			25. Insurer Name		FEIN
24b. City	State	Zip Code / 24c. Telephone	26. Claim Administrator Name		FEIN
27. Employer E-Mail Address			28a. Claim Administrator Mailing Address		
29. Date Employer First Knew of Injury / Illness	30. If Fatal, Date of Death		28b. City	State	Zip Code
31. Off Work After Injury / Illness? ◯ YES ◯ NO ☐ 4 or More Days?	32. Date Returned to Work		33. Employee Occupation / Job Title		
34. Rate of Pay	35. Earnings Calculated By ◯ Hr. ◯ Day ◯ Output ◯ Wk. ◯ Mo. ◯ Yr.		36. Employee Paid for Day Injured or Ill? ◯ YES ◯ NO		

37. Provide Any Additional Details of How Injury or Illness Happened. If You Doubt Validity of Injury or Illness, State Reason.

38. Signature of Authorized Employer or Representative	**39. Title**	**40. Date Signed**

WARNING TO EMPLOYEES AND EMPLOYERS: AS 23.30.250 imposes civil penalties for fraud as well as certain false or misleading statements and acts. Criminal penalties for theft by deception (including fines and incarceration) apply to knowingly made false statements, claims, or misclassification of employees.

Alaska Division of Workers' Compensation Offices
workerscomp@alaska.gov

3301 Eagle Street, #304
Anchorage, AK 99503-4149
(907) 269-4980

1111 West 8th Street, #305
PO Box 115512
Juneau, AK 99811-5512
(907) 465-2790

675 Seventh Avenue, Station K
Fairbanks, AK 99701-4531
(907) 451-2889

Instructions for
REPORT OF OCCUPATIONAL INJURY OR ILLNESS

TO THE EMPLOYEE

You must report your injury or illness to your employer **within fifteen (15) days** of the date it occurred or began. Failure to report within this timeframe may impact your eligibility for benefits.

This form is provided for convenience, but use of this specific form is not required by the Division of Workers' Compensation. Many insurers or claims administrators have their own forms or reporting processes, so your employer may provide you with different paperwork. Your employer is required to report your injury to the Division through its insurance carrier via electronic data interchange (EDI). When your employer files the report of injury, the Division will send you notice that a case has been established. If you choose to use this form to notify your employer, keep a copy for your records and submit it to your employer as soon as possible.

After obtaining medical treatment, ask your health care provider to submit a Physician's Report (8 AAC 45.086) to your employer.

You will not be paid compensation for lost wages for the first three (3) days off work unless your disability lasts more than 28 days. The first installment of compensation becomes due on the 14th day after the employer has knowledge of the injury, illness or disease. After the first payment, you should get a check every two (2) weeks while you are disabled. If you have not received payment within 21 days after the date you were injured or became ill, contact the insurer or adjuster first. If you have any questions or problems, contact the Division of Workers' Compensation office nearest you. If you are off work for three (3) or more days, you will need to provide additional information to your employer's claims adjuster regarding your wages, marital status, and number of dependents.

If you believe your injury or illness may prevent you from returning to your prior job, you may be eligible for reemployment benefits. If you are off work for 25 days or more, contact the Division's Anchorage office to learn more. You can also refer to the *Workers' Compensation & You* brochure available at: https://labor.alaska.gov/wc/

TO THE EMPLOYER

The injury must be reported to the Division through your insurer or claims administrator via electronic data interchange (EDI) within **ten (10) days** of your knowledge of the injury or illness, in accordance with AS 23.30.070. Failure to report the injury through EDI within the required timeline may result in a **penalty of 20% on the compensation owed** to the injured worker. You may use this form to collect information from your employee or assist in compiling the required data for your insurer. Keep a copy of any completed forms for your records.

> *Injury* means accidental injury or death arising out of and in the course of employment, and an occupational disease or infection that arises naturally out of the employment or which naturally or unavoidably results from an accidental injury.
>
> *Injury* does not include mental injury caused by stress unless it is established that (A) the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment, and (B) the work stress was the predominant cause of the mental injury. A mental injury is not considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or similar action taken in good faith by the employer.

OSHA REQUIREMENTS

Report industrial deaths and accidents to the Division of Labor Standards and Safety.

Alaska Statute 18.60.058 requires employers to report to Division of Labor Standards and Safety any employment accident which is fatal to one or more employees or which results in the overnight hospitalization of one or more employees. The report, which must be made immediately, but no later than 8 hours after receipt by the employer of information that the accident has occurred, must relate the circumstances of the accident, the number of fatalities, and the extent of the injuries.

Monday-Friday Alaska OSH (800) 770-4940 · 24-hour OSHA Hotline (800) 321-6742

RELEASE OF MEDICAL INFORMATION

RE: _____ v. _____

Alaska Workers' Compensation Claim No.: _____

TO: Any doctor, chiropractor, hospital, clinic, health insurer, physical therapist, government agency, insurer, employer or other person, entity, firm, or organization having custody of medical records or medical information pertaining to me, the undersigned person

I, the undersigned person, give my consent and authorize you to release the following medical records and information in your possession to _____, the defendants, or representative of the defendants, in the above Workers' Compensation Claim filed by me. I also consent and authorize, but do not necessarily request, you to discuss the following medical records and information pertaining to me with the defendant or the defendant's representative.

Medical records and information relating to the treatment of my injury or illness at work, and the following parts of my body, diagnoses or conditions, organ systems, chief complaints and/or symptoms:

_____

_____.

This authorization releases medical information from _____ (two years before the date of my earliest work injury or illness related to my claim) to the present.

You should interpret the terms “medical information” and “medical records” broadly to include records, reports, notes, chart notes, letters, photographs, test reports or results (including, as applicable, physical test results, pathology test results, laboratory test results, x-rays, MRI & CAT scans, EMGs, EKGs, sonograms, etc.), bills, and referral letters in your possession, whether generated by you or received from a third party.

This release of information is intended to include records maintained in my maiden or other names as follows: _____.

Please consider a photostatic copy of this authorization to release records to be as effective and valid as the original signed by me.

This release, and all authority to disclose information pertaining to me, shall expire on: _____ (one year from the date of the signature below), unless earlier revoked by me in writing.

Signature: _____ Dated this _____ day of _____ , _____

Printed Name: _____

Under AS 23.30.107, an employee must provide written release of medical and rehabilitation information relating to the injury. Parties should informally resolve disputes over what is relevant. Only if informal resolution is impossible, an employee may petition for a prehearing and a protective order within 14 days after receipt of the request to sign the release. AS 23.30.108.

TO HEALTH CARE PROVIDERS: 45 C.F.R. 164.512(l) exempts workers' compensation disclosures from HIPAA.

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Medical History Request

Employee Name _____ **Date of Injury** _____

Employer Name _____ **Completion Date** _____

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

Thank you for your cooperation.

Past Injuries, Disabilities, or Other Medical Conditions

Hospitalizations

Hospital Name & Address	Phone	Date(s) Adimitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

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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

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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
- ☐ 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
- ☐ Other:

What changes could be made to eliminate or reduce the hazard(s) identified above?

The above form is true and correct.

Prepared by

Signature

Date

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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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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

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MyMatrixx
By EVERNORTH

Temporary Prescription Card

To the Injured Worker:

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

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

Atencion Trabajador Lesionado:

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

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

ID#: _____
Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: G3YA

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

Employee Information

_____
Full Name

_____
Street Address or PO Box

_____
City State ZIP

_____
Date of Birth

_____
Employer Name

To the Pharmacist:

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

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

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

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

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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!

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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.

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BHHC has an AM Best Credit Rating of A++ as of March 30, 2026.
For the latest Best Credit Rating, access ambest.com.

M.F.ENG.21.2.5.1

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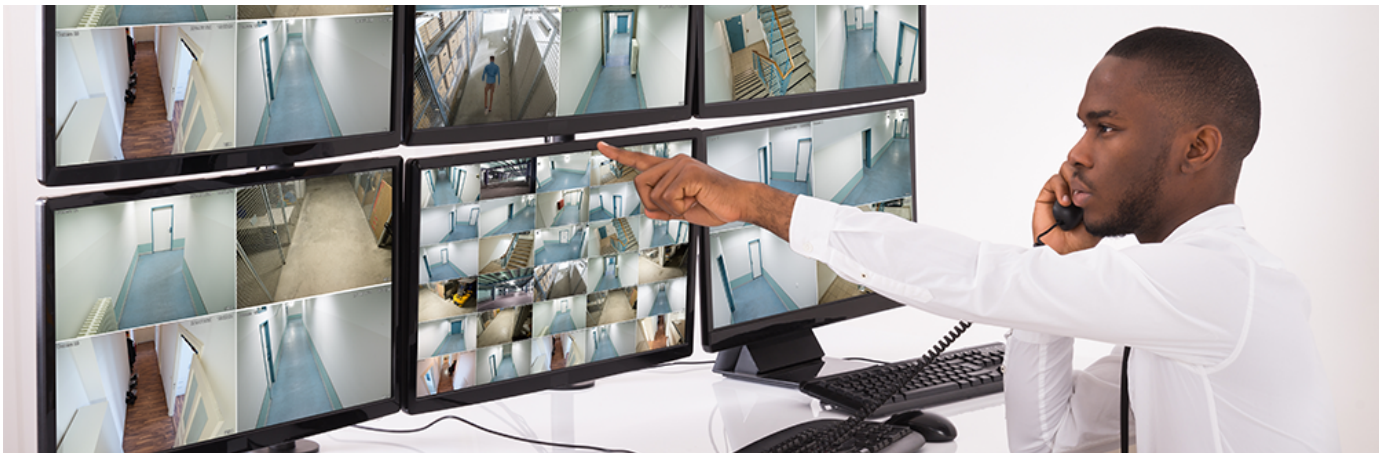
HOMESTATE COMPANIES
Workers Compensation Division®



$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

BHHC has an AM Best Credit Rating of A++ as of March 30, 2026.
For the latest Best Credit Rating, access ambest.com.

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