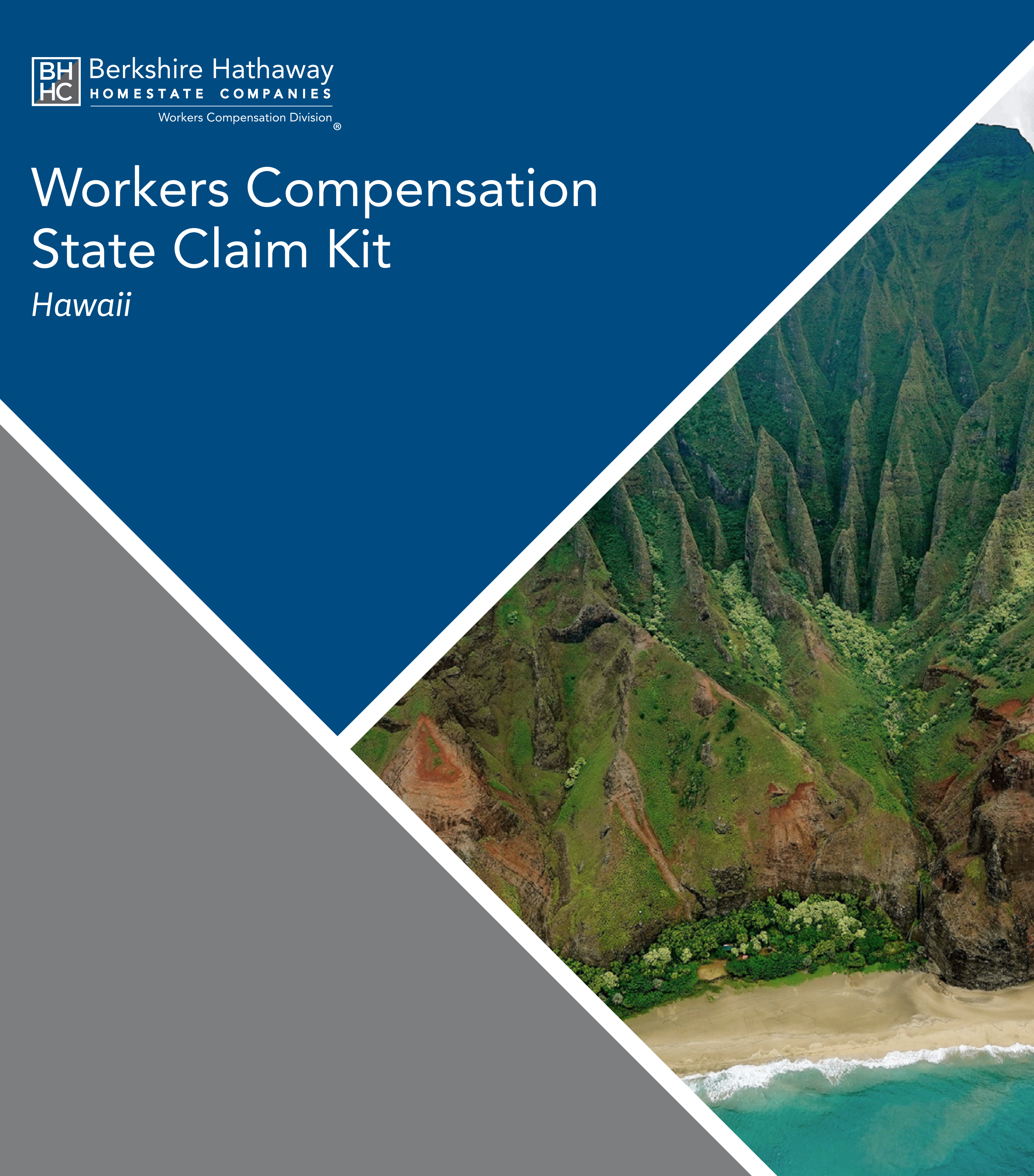


Berkshire Hathaway HomeState Companies
Workers Compensation Division®

Workers Compensation State Claim Kit

Hawaii

Table of Contents

BHHC HI Claims Kit Introductory Letter - 04/2026 1

BHHC Requirements for HI Posting Notices – 04/2026 2

HI Form – Notice to Employees RE: Disability Compensation Law – 01/2024 3

HI Form WC-1 – Employer's Report of Industrial Injury – 07/2022 4

HI Form WC-14 – Employee's Wage Report – 01/2018 8

BHHC Employee's Authorization for Release of Information (English & Spanish) - 04/2026 11

BHHC Medical History Request – 04/2026 13

BHHC General Employee Incident Report - 04/2026. 14

English 14

Spanish 15

BHHC General Supervisor Incident Report - 04/2026 16

English 16

Spanish 18

BHHC General Witness Incident Report – 04/2026 20

English 20

Spanish 21

HI Form WC-101 – Highlights of the Hawaii Workers' Compensation Law Brochure – 03/2025 22

BHHC Express Scripts First Fill Form (English & Spanish) – 02/2025 24

BHHC Workers' Compensation Fraud Posters - 03/2025 26

English 26

Spanish 27

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

Dear Policyholder,

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

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

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

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

bhhcpolicyholder.bhhc.com/Client/External/Claims

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

Workers Compensation Posting Requirements

Requirements for Notice to Employees

RE DISABILITY COMPENSATION LAW POSTER

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

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

Requirements for WC-101 0

HIGHLIGHTS OF THE HAWAII WORKERS' COMPENSATION LAW BROCHURE

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

(Rule 12-10-68(b))

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

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

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

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

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

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

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

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

Disability Compensation Division:

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

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

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

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

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

Revised 09/21/2020

NEW
AMEND

WC-1 rev. 01/2022

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

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

CASE NUMBER
DATE RECEIVED

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

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

IDENTIFICATION - SECTION 1

EMPLOYEE NAME – LAST	FIRST	M.I.	SUFFIX

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

ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)

CITY	STATE	ZIP CODE	EMAIL ADDRESS

PHONE NUMBER	DATE HIRED	YEARS EMPLOYED CODE	OCCUPATION
( ) -			

DEPARTMENT	PAYROLL COMP CLASS CODE	SOC CODE	OCC CODE

REGISTERED EMPLOYER	DBA

ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER POINT OF CONTACT	PHONE NUMBER	EMAIL ADDRESS
	( ) -	

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

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

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

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

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

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

TASK	ACTIVITY	INJURY/ILLNESS FACTOR	AOS

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

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

EQUAL OPPORTUNITY EMPLOYER/PROGRAM
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-9161.

CASE NUMBER

DETAIL OF INJURY/ILLNESS (I/I) - SECTION 2 (continued)		
D. DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF THE BODY AFFECTED - Please continue in Supplemental Section if additional space is needed.		
MULTIPLE BODY PARTS? NO YES	NATURE OF INJURY/ILLNESS	PART OF BODY CODE

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

TIME LOST INFORMATION - SECTION 3				
DATE DISABILITY BEGAN	WAS EMPLOYEE FURNISHED MEALS, TIPS, OR LODGINGS? NO YES	AVERAGE WEEKLY WAGE	IF EMPLOYEE IS BACK TO WORK, GIVE DATE	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS? NO YES
IF EMPLOYEE DECEASED, GIVE DATE	HOURLY WAGE	MONTHLY SALARY	HRS WORKED/WEEK	WEIGHING FACTOR

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

TREATMENT (OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE) - SECTION 5				
NAME OF PHYSICIAN	PHONE NUMBER ( ) -	EMAIL ADDRESS		
ADDRESS	CITY	STATE	ZIP CODE	NO YES INPATIENT OVERNIGHT EMERGENCY ROOM ONLY?
NAME OF MEDICAL FACILITY	ADDRESS	CITY	STATE	ZIP CODE

INSURANCE CARRIER - SECTION 6			
NAME OF WC INSURANCE CARRIER			CARRIER ID
IS LIABILITY DENIED? NO YES	IF LIABILITY DENIED, WHY?		
NAME OF ADJUSTING COMPANY		ADJUSTER NAME	
EMAIL ADDRESS		PHONE NUMBER ( ) -	ADJUSTER ID NUMBER
POLICY NUMBER	POLICY PERIOD FROM: TO:	MEDICAL DEDUCTIBLE	CARRIER CLAIM NUMBER

SIGNATURE - SECTION 7		
SIGNATURE	TITLE	DATE

EQUAL OPPORTUNITY EMPLOYER/PROGRAM
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-9161.

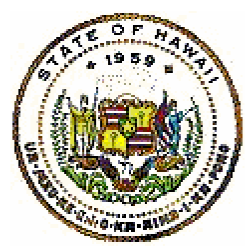
CASE NUMBER

SUPPLEMENTAL - SECTION 8
A. HOW DID THIS INJURY/ILLNESS OCCUR? (continued from Section 2.A)
B. WHAT WAS THE EMPLOYEE DOING WHEN INJURED? (continued from Section 2.B)
C. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (continued from Section 2.C)
D. DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF THE BODY AFFECTED (continued from Section 2.D)

EQUAL OPPORTUNITY EMPLOYER/PROGRAM
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-9161.

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

EQUAL OPPORTUNITY EMPLOYER/PROGRAM
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-9161.



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

Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

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

Instructions

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

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

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

Delivery Information

Delivery by U.S. Mail

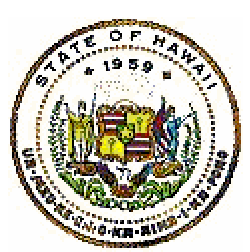
Department of Labor and Industrial Relations, Disability Compensation Division
P.O. Box 3769, Honolulu, Hawaii 96812-3769

Delivery In-Person

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

Delivery via Fax

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



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

Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

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

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

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

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

Employer:			Employee's Occupation:		Hourly Rate:	
Date Employed:			Presently Employed?		If terminated, date:	
Disabled from:			through:		Returned to Work:	
Indicate the days and hours normally worked:						
Sunday:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:
If other than the above, please indicate:						

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

Employer:	Telephone: ( )
Address	
Date:	By:

(To be signed in ink)

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

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

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

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

	Dates (inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period		Amount paid excluding overtime or extra work		Overtime or extra work	
	From	To	Year							
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
	Total									

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

	Dates (inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period		Amount paid excluding overtime or extra work		Overtime or extra work	
	From	To	Year							
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										
37										
38										
39										
40										
41										
42										
43										
44										
45										
46										
47										
48										
49										
50										
51										
52										
	Total									

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

Authorization for the Release of Information / Autorización Para La Liberación De Información

Claim Number/Número de Reclamo

Date of Injury / Fecha de la Lesión

Employee/Empleado

Date of Birth / Fecha de Nacimiento

I hereby authorize the divisions of Berkshire Hathaway Homestate Companies, their representative or bearer, to review, inspect, copy, and/or photograph any and all of the following documents:

Por este medio autorizo las divisiónes de Berkshire Hathaway Homestate Companies, su representante o portador, a revisar, inspeccionar, copiar, y/o fotografiar cualquier y todo de los siguientes documentos:

Any and all medical records, including but not limited to office and hospital records, laboratory results, diagnostic reports and films, psychiatric records, medical correspondences, doctor's and nurse's notes, and medical histories relevant to my workers' compensation claim. I also hereby give permission to Berkshire Hathaway Homestate Company representatives to contact the attending physicians involved in the treatment of all related conditions.

Cualquier y todo expediente médico, incluyendo pero no limitado, a los expedientes de la oficina y hospitales, resultados de laboratorios y filminas, expedientes psiquiátricos, correspondencia médica, notas de los doctores y enfermeros(as), e historiales médicos relevantes a mi reclamo de compensación de trabajadores. También, por este medio le doy permiso a los representantes de Berkshire Hathaway Homestate Company para comunicarse con el médico tratante envuelto en el tratamiento de todas las condiciones relacionadas.

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:

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.

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.

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.

Authorization for the Release of Information / Autorización Para La Liberación De Información

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.

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.

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) Adimitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

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)

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

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

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

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

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

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

What did you do after the incident occurred?

The above form is true and correct.

Signature

Date Completed

Informe de Incidente del Empleado

A ser completado por el trabajador lesionado.

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Hora en que usted empezó a trabajar el día del incidente

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

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

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

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

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

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

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

¿Qué hizo después de ocurrido el incidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario

Supervisor's Report of Employment Incident

Employee Name

Employer Name

Date of Incident

Time of incident

Time the employee began work on day of incident

Did the employee report the incident immediately?

Address of Incident

City, State

Zip

Offsite? (Y/N)

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

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

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

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

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

Supervisor's Report of Employment Incident

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

- Unused/unavailable lifting equipment
- 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

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?

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)?

BHHC®

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

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

Address all inquiries to:

Department of Labor & Industrial Relations
Disability Compensation Division

Oahu:	830 Punchbowl Street, Room 209 P.O. Box 3769 Honolulu, Hawaii 96812-3769 Phone: (808) 586-9188
Hawaii:	State Office Building 75 Aupuni Street, Room 108 Hilo, Hawaii 96720 Phone: (808) 974-6464
West Hawaii:	P.O. Box 49 Kealakekua, Hawaii 96750 Phone: (808) 322-4808
Maui:	State Office Building, #2 2264 Aupuni Street Wailuku, Hawaii 96793 Phone: (808) 243-5322
Kauai:	State Office Building 3060 Eiwa Street, Room 202 Lihue, Hawaii 96766-1887 Phone: (808) 274-3351

For more information, please visit our website at:
http://labor hawaii.gov/dcd

Equal Opportunity Employer/Program

Auxiliary aids and services are available upon request to individuals with disabilities.

TDD/TTY Dial 711 then ask for (808) 586-9188.

Rev 03/2025

HIGHLIGHTS OF THE HAWAII PREPAID HEALTH CARE LAW

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

The information herein is intended to provide employers and employees with general understanding of the Prepaid Health Care Act. For comprehensive details, please refer to the law (Chapter 393, HRS).

PREPAID HEALTH CARE ACT

Originally enacted in 1974, the Hawaii Prepaid Health Care Act was the first in the nation to set minimum standards of health care coverage for workers. Preempted in October of 1981 by the Federal Employee Retirement Income Security Act of 1974 (ERISA), the Prepaid Health Care Act was reinstated effective March 1, 1983.

The Prepaid Health Care Act requires Hawaii employers to provide health care coverage for eligible employees to insure protection against the high cost of medical and hospital care for nonwork-related illness or injury.

EXCLUDED EMPLOYMENT

Services excluded from health care coverage include, but are not limited to: 1) individuals who work less than twenty hours per week; 2) Federal, State, and County workers; 3) agricultural seasonal workers; 4) insurance or real estate salespersons paid solely by commission; 5) individuals working for son, daughter, or spouse; and 6) children under age 21 working for father or mother. (For a complete listing, refer to Section 393-5 of the law.)

SECURING COVERAGE

Employers may obtain health coverage by: 1) purchasing an approved health care plan from a health care contractor or a Hawaii licensed insurance carrier; 2) adopting an approved self-insured health care plan; or 3) negotiating a collective bargaining agreement.

Employees may form associations for the purpose of providing health care coverage as long as such health care protection is obtained from an authorized health care contractor.

ELIGIBILITY FOR ENROLLMENT

Employees who work twenty hours or more per week and earn a monthly wage of at least 86.67 times the Hawaii minimum hourly wage are deemed eligible after four consecutive weeks of employment. Health care coverage must then be provided to such eligible employees at the earliest enrollment date of the employer's health care contractor.

EXEMPTIONS FROM COVERAGE

Exempt Employees

The following categories of employees can claim an exemption from coverage:

1) those covered by a Federally established health insurance or prepaid health care plan, such as Medicare, Medicaid or medical care benefits provided for military dependents and military retirees and their dependents;
2) those covered as dependents under a qualified health care plan;
3) those who are recipients of public assistance or covered by a State-legislated health care plan governing medical assistance; and
4) those who are followers of religious groups who depend upon prayer or other spiritual means for healing.

"Employee Notification to Employer" (Form HC-5)

To claim an exemption or individual waiver, an employee must complete and submit Form HC-5 to the employer. The employer is prohibited from coercing or attempting to coerce the employee to waive coverage. The employer retains the original Form HC-5 and gives a copy to the employee. The employer sends a copy to the Department of Labor and Industrial Relations only when the employee selects waiver #4 or upon request by the Director. The exemption/waiver notification is binding for one year and must be renewed every December 31.

CONCURRENT EMPLOYMENT

An employee who works concurrently for two or more employers is required to designate the principal and secondary employer and file notification (Form HC-5) with the employers for subsequent filing with the Department of Labor and Industrial Relations. The principal employer shall be the employer who pays the employee the most wages; only in cases where the employer who does not pay the most wages employs the employee for at least 35 hours per week does the employee determine which of the employers shall be the principal employer. The designated principal employer is required to provide coverage pursuant to the law.

An employee's determination of principal employer is binding for one year or until change of employment occurs. Whenever an employee elects to make a change with respect to the status of each, notification (Form HC-5) must be filed. (For complete details, refer to Section 393-6 of the law.)

The employer is prohibited from coercing, interfering, or influencing an employee in making a determination of principal employer.

PREMIUM PAYMENTS

The employer may elect to pay the entire premium amount or share the cost with the employee. The employer must pay at least one-half the premium cost; however, the employee's contribution cannot exceed 1.5% of the employee's monthly wages. In the event the employee's allowable share constitutes less than one-half of the premium, the employer is liable for the entire remaining portion. The employer is permitted to withhold the employee's contribution from the employee's wages.

An employee cannot agree to pay a greater share from wages, except for the purpose of paying for the added cost of providing prepaid health care benefits for the employee's dependents under the same plan.

CONTINUATION OF COVERAGE PROVISION

In the event an employee is disabled and unable to work, the employer is obligated to enable the employee to continue health care coverage by continuing the employer's share of the premium costs for three months following the month during which the employee became disabled, or for the period for which the employer has undertaken payment of employee's regular wages, whichever is longer. The employee must maintain the employee's portion of the premium payments.

HEALTH CARE CONTRACTOR

Type

A prepaid health care contractor may fall in one of three groups: 1) any medical group or organization which provides health care benefits under a prepaid health care plan; 2) any nonprofit organization which defrays or reimburses in whole or in part the expenses of health care under a prepaid health care plan; or 3) any insurer who defrays or reimburses in whole or in part the expenses of health care under a prepaid health care plan.

Selection

The employer selects the health care contractor and the plan type.

HEALTH CARE PLANS

Type

There are two types of health care plans: 1) a plan by which a prepaid health care contractor would furnish health care, and 2) a plan by which the health care contractor would defray or reimburse, in whole or in part, the expenses of health care.

Benefits

To meet standards as prescribed by law, prepaid health care plans must include at least the following benefits: 1) hospital (including inpatient care for at least 120 days of confinement in each calendar year), 2) surgical, 3) medical, 4) diagnostic, and 5) maternity. (For further details, refer to Section 393-7 of the law.)

Plan Approval

All health care plans must be approved as meeting prescribed minimum standards by the State Department of Labor and Industrial Relations. Such determination is made by the director under the advisement of a seven-member prepaid health care advisory council consisting of representatives from the medical and public health professions, from consumer interest, and from people experienced in prepaid health care protection.

PENALTIES

An employer who fails to comply with the coverage provisions of the law shall be subject to a penalty of not less than $25, or $1 for each employee for every day during which such failure continues, whichever sum is greater. If such default extends for 30 days, the employer's business may be closed for as long as the default continues.

An employer, employee, or health care contractor, who willfully fails to comply with any other provision or any rule or regulation, may be fined not more than $200 for each violation.

Furthermore, any person who, after twenty-one days written notice and the opportunity to be heard by the director, is found to have violated any provision of Chapter 393 or rule adopted thereunder for which no penalty is otherwise provided, shall be fined not more than $250 for each offense.

APPEAL

When health care benefits are denied a worker, the employer or the prepaid health care contractor must promptly mail a notice of denial to the worker who then has twenty days in which to request a review by the Department of Labor and Industrial Relations. If the parties are not satisfied by the department's findings, the case will be referred to the Prepaid Health Care Appeals Referee. The decision of the referee shall be final and binding, unless the aggrieved party appeals the decision.

SPECIAL FUND

The Prepaid Health Care Premium Supplementation Fund is established by general fund appropriation and used to defray the cost of providing health care benefits for employers with less than eight workers entitled to and covered under the Prepaid Health Care Act. To qualify for premium supplementation, the employer must meet the criteria outlined in Section 393-45 of the law.

The Fund may also reimburse health care expenses to workers of bankrupt employers and non-complaint employers. Benefits paid from the Fund shall be recovered from those defaulting employers.

ADMINISTERING AGENCY

The Disability Compensation Division of the Department of Labor and Industrial Relations administers the Hawaii Prepaid Health Care Law. For further information, please contact the offices listed on the back of this brochure.

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!

© 2024 MyMatrixx Healthcare Services, Inc. |
An Evernorth Company. All Rights Reserved.

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 MEDI-
CAL 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!

© 2024 MyMatrixx Healthcare Services, Inc. |
An Evernorth Company. All Rights Reserved.
.

$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.

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

$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.

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