Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division®

Workers Compensation State Claim Kit

Maine

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.

Maine state law recommends employers report every industrial injury or occupational disease claim to their workers compensation carrier as soon as possible or within 5 days of employer knowledge of injury.

State law also requires that employers authorize initial medical treatment within 24 hours of knowledge that an occupational injury 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 WCB-90

Workers' Compensation Board Notice to Employees

- Post in one or more conspicuous places at all business locations and work sites
- Print on 11" x 17" paper

(39-A Maine Revised Statutes § 406)

FOR DATES OF INJURY ON AND AFTER JANUARY 1, 2020

WORKERS' COMPENSATION

WORKERS' COMPENSATION BOARD REGIONAL OFFICES

AUGUSTA
442 Civic Center Drive, Suite 225
156 State House Station
Augusta, ME 04333-0156
207-287-2308
1-800-400-6854

LEWISTON
36 Mollison Way
Lewiston, ME 04240-5811
207-753-7700
1-800-400-6857

BANGOR
396 Griffin Road, Suite 105
Bangor, ME 04401
207-941-4550
1-800-400-6856

PORTLAND
56 Northport Drive, Suite 201
Portland, ME 04103
207-822-0840
1-800-400-6858

CARIBOU
43 Hatch Drive, Suite 110
Caribou, ME 04736-2347
207-498-6428
1-800-400-6855

Visit our website at:
www.maine.gov/wcb
Statewide TTY: 711

Notice to Employees:

State law requires your employer to provide workers'compensation insurance for its employees. Workers'compensation insurance provides benefits to employees who are injured at work.

If you are injured at work, NOTIFY YOUR EMPLOYER AT ONCE. You may lose your right to receive benefits unless your employer is notified within 60 days of your injury. Your claim is also subject to a two year statute of limitations. Worker advocates are available at the Workers' Compensation Board to help injured workers.

It is against the law for employers to misclassify employees as independent contractors for the purposes of avoiding workers' compensation insurance, unemployment coverage, or other employer paid taxes and withholdings. For more information on laws pertaining to the hiring of independent contractors, visit the Worker Misclassification Task Force website at www.maine.gov/labor/misclass.

If you have any questions about your rights, please contact one of the regional offices.

A l'intention des Employes:

D'après les lois de l'Etat du Maine, votre employeur est tenu de souscrire à une assurance indemnisant ses employés victimes d'un accident du travail.

Si vous êtes victime d'un accident du travail, PREVENEZ VOTRE EMPLOYEUR IMMEDIATEMENT. Passé un délai de 60 jours, vous risquez de perdre vos droits à l'indemnisation. Au-delà de deux ans, votre déclaration n'est plus recevable. Pour aider les victimes d'un accident du travail, le Workers'Compensation Board met des conseillers juridiques à leur disposition.

La loi interdit aux employeurs de classifier fallacieusement leurs salariés comme étant des contractants privés aux fins d`échapper a l`assurance compensatrice-employé, aux indemnités de chômage, ou aux autres charges et retenues dues par employeur. Pour plus de détails sur la législation relative a l`utilisation des services privés, visitez le site internet de Worker Misclassification Task Force (Unité anti-fraude en matière de classification des salariés) : www.maine.gov/labor/misclass.

Si vous n'êtes pas sûr de vos droits, veuillez contacter l'un des bureaux régionaux.

Aviso a los Trabajadores:

La ley del estado de Maine requiere que su empresario proporcione el seguro de compensaciones para el trabajador a todos los trabajadores. El seguro de compensaciones para el trabajador proporciona beneficios a los trabajadores accidentados en el trabajo.

En caso de sufrir accidente o daño laboral, NOTIFÍQUELO INMEDIATAMENTE A SU EMPRESARIO. Podría perder el derecho a recibir compensación a menos que su empresario sea notificado de este accidente o daño en el plazo de 60 días. Así mismo esta reclamación debe hacer referencia a unaccidente o daño que no haya ocurrido hace más de dos años. Los defensores del trabajador están disponibles para proporcionar ayuda a los trabajadores accidentados en el Consejo de Administración de Compensaciones para el Trabajador (Workers' Compensation Board).

El hecho de no clasificar a los empleados como contratistas independientes, con el propósito de evitar el seguro por compensación al trabajador, cobertura para desempleados, ú otros impuestos pagados y retenidos por el empleador; está en contra de la ley del empleador. Para mayor información acerca de las leyes pertenecientes a la contratación de contratistas independientes, visite el Worker Misclassification Task Force en la página web de www.maine.gov/labor/misclass.

En caso de tener cualquier pregunta sobre sus derechos, favor de dirigirse a una de las oficinas regionales de compensaciones para el trabajador.

ENGLISH
Interpreters Available
When calling for assistance, please say the name of your language in English and an interpreter will be called for you. Please stay on the line.

SPANISH
Tenemos intérpretes a su disposición
Si necesita que le atiendan en español por favor diga "Spanish" y le conectaremos con un intérprete. Por favor manténgase en la línea.

PORTUGUESE
Temos intérpretes à sua disposição
Se precisar de atendimento em Português, por favor diga "Portuguese" e um intérprete será prontamente chamado. Por favor, aguarde na linha.

ITALIAN
Abbiamo intèrpreti disponibili
Se avete bisogno di assistenza in Italiano, Vi preghiamo di dire "Italian" e un intèrprete sará messo a Vostra disposizione. Vi preghiamo di rimanere in linea.

FRENCH
Des interprètes sont à votre disposition
Lorsque vous appelez pour demander de l'aide, prononcez le mot "French" et nous mettrons un interprète à votre disposition. Prière de rester en ligne.

POLISH
Tłumacze dostępni na życzenie.
Aby uzyskać pomoc tłumacze, proszę powiedzieć po angielsku "Polish" i czekać na linii.

RUSSIAN
"К вашим услугам имеются переводчики"
"Когда Вы обращаетесь за помощью по телефону, пожалуйста скажите, что Вы говорите по-русски (произнесите "РАШН"), и мы обеспечим Вас переводчиком. После этого, пожалуйста, оставайтесь на линии."

CHINESE
提供口譯服務
打電話請求幫助時，請用英語說"挾音呢斯"(CHINESE)— 我們將爲您提供口譯人員。請不要挂斷電話。

JAPANESE
通訳サービスをご利用いただけます
通訳を必要とされる場合は「ジャパニーズ」とおっしゃり、通訳がでるまでそのままでお待ちください。

KOREAN
한국어 통역을 이용하실 수 있습니다.
도움이 필요하여 전화를 거실 때 영어로 코리언(KOREAN)이라고 말씀하시면 통 역자를 연결해 드릴 것입니다. 전화를 끊지 마시고 기다리십시오.

VIETNAMESE
"Có Thông Dịch Viên"
"Khi gọi điện thoại để được giúp đỡ, xin quý vị hãy nói "VIETNAMESE" để chúng tôi cho thông dịch viên giúp quý vị. Xin quý vị chờ trên đường dây.

ARABIC
مترجمون شفهيون متيسّرون لخدمتكم
عند إتّصالكم للمساعدة أو لطلب خدمة معيّنة نرجو منكم أن تذكروا (أ-رَ-بِ-ك)ونحن سنقدّم لكم مترجما شفهيا . ابقوا على الخط من فضلكم.

PERSIAN
افراد مترجم در دسترس مي باشند.
را كه بدان صحبت مي كنيد به انگليسي ذكر كنيد تا راجع به امري به ما تلفن مي كنيد، لطفاً نام زباني هنگاميكه براي درخواست كمک يا قطع نكنيد. شما تماس گرفته شود. لطفاً روي خط منتظر بمانيد.
با يک مترجم براي

SOMALI
Turjunaanno waa la helayaa
Marka aad caawinaad inoogu soo yeeraneysid, fadhlan luqaddaada af Ingiriisi inoogu sheeg turjubaan ayaa lguugu yeeri doonaaye. Taleefoonkana ha dhigin.

To the employer: This notice must be posted in a conspicuous place upon your premises accessible to employees. 39-A MRSA §406. The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services or activities.
This poster is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone: (888) 801-9087 or TTY: 711.

WCB-90 (1/1/2020, revised 12/4/2023)

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)

2a. ☐ LOST TIME - ONE OR MORE DAYS 2b. WAS EMPLOYEE PAID FOR IJ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO

3. ☐ LOST EARNINGS BUT NO LOST TIME 4. ☐ MEDICAL/HEALTH CARE 5. ☐ FATALITY DATE OF DEATH: ____/____/____ MM DD YYYY

6a. ☐ OCCUPATIONAL DISEASE 6b. DATE OF LAST EXPOSURE: ____/____/____ MM DD YYYY 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ MM DD YYYY

7a. ☐ CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: ____/____/____ MM DD YYYY 7c. DATE CORRECTION SENT TO WCB: ____/____/____ MM DD YYYY

EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):		10. EMPLOYER NAME:	
11. STREET/P.O BOX MAILING ADDRESS:	12. CITY:	13. STATE:	14. ZIP:	15. TELEPHONE NUMBER: ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:	18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:		

(check one) ☐ INSURER ☐ THIRD PARTY ADMINISTRATOR (TPA) ☐ SELF-ADMINISTERED EMPLOYER

19. INSURANCE / TPA COMPANY NAME:	20. POLICY NUMBER:		21. INSURER FILE NUMBER:	
22. STREET/P.O. BOX MAILING ADDRESS:	23. CITY:	24. STATE:	25. ZIP:	26. TELEPHONE NUMBER: ( )

EMPLOYEE

27. LAST NAME:	28. FIRST NAME:	29. MI:	30. TELEPHONE NUMBER: ( )	31. SOCIAL SECURITY NUMBER:	32. GENDER: ☐ MALE ☐ FEMALE
33. STREET/P.O. BOX MAILING ADDRESS:	34. CITY:		35. STATE:	36. ZIP:	37. DATE OF BIRTH: ____/____/____ MM DD YYYY
38. OCCUPATION/JOB TITLE:	39. DATE OF HIRE: ____/____/____ MM DD YYYY	40. WEEKLY WAGE AT TIME OF INJURY: $		41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS:	

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ____/____/____ MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	43. DATE OF INCAPACITY: ____/____/____ MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): 46. TIME OF INJURY (e.g. 1:10 p.m.):	45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ MM DD YYYY 47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO IF YES, GIVE DATE: ____/____/____ MM DD YYYY

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	49. BODY PART(s) AFFECTED (e.g. lower right forearm):	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): WAS ACTIVITY PART OF NORMAL JOB DUTIES? ☐ YES ☐ NO	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO:	55. HEALTH CARE PROVICER NAME:	56. MAILING ADDRESS:	57. TELEPHONE NUMBER: ( )

PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OR PRINT):	59. TELEPHONE NUMBER: ( )	60. DATE SENT TO WCB: ____/____/____ MM DD YYYY

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY Maine Relay 711.

WCB-1 (eff. 1/1/13)

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

WAGE STATEMENT

1. REVISION DATE: _____/_____/_____ MM DD YYYY

2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. STREET/P.O. BOX MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. HOME PHONE NUMBER: ( )
12. DATE OF INJURY: _____/_____/_____ MM DD YYYY	13. SPECIFIC INJURY OR ILLNESS:		14. BODY PART(S) AFFECTED:	

EMPLOYER/INSURER

15. INSURER FILE NUMBER:	16. EMPLOYER NAME:	17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:
18. INSURER NAME:	19.INSURER MAILING ADDRESS AND PHONE NUMBER:	

20. DOES EMPLOYEE WORK CONCURRENTLY? ☐ YES ☐ NO IF YES, A WAGE STATEMENT MUST BE SUBMITTED FOR EACH EMPLOYER

NAME(S) OF EMPLOYERS: _____; _____ ; _____

21. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS' COMPENSATION? ☐ YES ☐ NO

IF YES: THE AVERAGE WEEKLY WAGE MUST BE RECALCULATED IF/WHEN FRINGE BENEFITS CEASE (SEE RULE 1.5(2))

22. METHOD OF CALCULATION:
☐ 102(4)(A) – SALARIED
☐ 102(4)(B) – VARYING WAGES
☐ 102(4)(C) – SEASONAL WORKER
☐ 102(4)(D) – OTHER*

* NOTE: IF WAGES WERE CALCULATED USING SECTION 102(4)(D), YOU MUST SUBMIT COMPARABLE WAGES WITH THIS FILING AND PROVIDE A DETAILED EXPLANATION OF THE CALCULATION IN THE COMMENTS BOX.

23. LIST GROSS EARNINGS FOR EACH WEEK:

WK 1	WEEK ENDING	GROSS EARNINGS	WK 19	WEEK ENDING	GROSS EARNINGS	WK 37	WEEK ENDING	GROSS EARNINGS
2			20			38		
3			21			39		
4			22			40		
5			23			41		
6			24			42		
7			25			43		
8			26			44		
9			27			45		
10			28			46		
11			29			47		
12			30			48		
13			31			49		
14			32			50		
15			33			51		
16			34			**WK OF INJURY**		
17			35			**24. TOTAL EARNINGS $**		
18			36			**25. GROSS AVERAGE WEEKLY WAGE $**		

26. COMMENTS:

27. PREPARER'S FULL NAME (REQUIRED): E-MAIL ADDRESS (REQUIRED):	28. TELEPHONE NUMBER (REQUIRED): ( ) TOLL-FREE NUMBER: ( )	29. DATE SENT TO WCB: _____/_____/_____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. REVISION DATE: _____/_____/_____ MM DD YYYY	**FRINGE BENEFITS WORKSHEET**	2. WCB FILE NUMBER (if known):

EMPLOYEE				
3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. STREET/P.O. BOX MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. HOME PHONE NUMBER:
12. DATE OF INJURY: _____/_____/_____ MM DD YYYY	13. SPECIFIC INJURY OR ILLNESS:		14. BODY PARTS (S) AFFECTED:	

EMPLOYER/INSURER		
15. INSURER FILE NUMBER:	16. EMPLOYER NAME:	17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:
18. INSURER NAME:	19.INSURER MAILING ADDRESS AND PHONE NUMBER:	

PROVIDE THE COST OF THE FRINGE BENEFIT PAID BY THE EMPLOYER AS OF THE EMPLOYEE'S DATE OF INJURY IF THE EMPLOYEE WAS RECEIVING THE BENEFIT ON HIS/HER DATE OF INJURY (SEE RULE CHAPTER 1(5)(1)).

NOTE: THE AMOUNTS REPORTED ARE SUBJECT TO VERIFICATION BY THE EMPLOYEE AND HIS/HER REPRESENTATIVE AND DOCUMENTATION MUST BE PROVIDED UPON REQUEST.

20. **Fringe Benefit**	**Provided**	**Continues while Employee is out of work**	**Date Benefits End**	**Weekly Cost of Benefits to Employer**
Health Benefits (incl. insurance)	Yes ☐ No ☐	Yes ☐ No ☐		$
Dental Insurance	Yes ☐ No ☐	Yes ☐ No ☐		$
Disability Insurance (incl. short and long term)	Yes ☐ No ☐	Yes ☐ No ☐		$
401K	Yes ☐ No ☐	Yes ☐ No ☐		$
Life Insurance	Yes ☐ No ☐	Yes ☐ No ☐		$
Education/Training	Yes ☐ No ☐	Yes ☐ No ☐		$
Pension	Yes ☐ No ☐	Yes ☐ No ☐		$
Other (please list):	Yes ☐ No ☐	Yes ☐ No ☐		$
Other (please list):	Yes ☐ No ☐	Yes ☐ No ☐		$

21. TYPE OR PRINT PREPARER NAME (REQUIRED): E-MAIL ADDRESS (REQUIRED):	22. TELEPHONE NUMBER (REQUIRED):	23. DATE MAILED: _____/_____/_____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.

State of Maine Workers' Compensation Board
General Release of Medical/Health Care Information

Name: SSN (last 4 digits): XX-XX-

Date of Birth: Date of Injury/Illness:

Notice to employer/insurer/employee representative: You may only use forms authorized by the State of Maine Workers' Compensation Board for the release of protected medical/health care information to an employer or its insurer. The Board's forms may NOT be altered. Non-compliance may result in penalties.

Notice to employee: The employer/insurer contends your medical records are needed to determine whether your claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable. This means all written records relating to the diagnosis, treatment and care, including but not limited to diagnostic imaging/tests, related to the following body part(s) and/or condition(s):

_____

You have 14 days from receipt of this certificate to complete and return it to the employer/insurer. If you do not understand this form, talk with your legal representative. If you do not have a legal representative, a Workers' Compensation Board Claims Resolution Specialist can help you.

Notice to Health Care Practitions and Facilities: You are required to provide the records to the recipient indicated below within 30 days of receiving this signed authorization. You may also request that the employee sign a medical release acceptable to you pursuant to W.C.B. Rules, Ch. 5 § 1.11(2)(B)

_____

Employee Authorization to Disclose Protected Health Information ("PHI")/Health Care Information

I hereby authorize my health care providers to release the records, regardless of the date of injury, they have related to the diagnosis, treatment and care, including but not limited to diagnostic and imaging tests, of the body part(s) and/or condition(s) listed above subject to the following exclusions:

☐ None
☐ Exclusions: _____

This authorization does NOT authorize the release of information regarding testing, treatment or counseling related to: Psychological matters; substance use disorder; HIV/Aids and sexually transmitted diseases.

This authorization is to release written records only. It does not authorize oral communications with anyone other than me or my representative, if I have one.

This release authorizes the release of records dating from _____ until thirty (30) months after the date I sign this form. This release authorizes the above health care practitioners and/or facilities to release records pursuant to a later request after this release is signed through the termination date of this release.

Acknowledgements:

- **Voluntary:** I understand I have the right not to sign or complete this form. If I exercise that right, the insurer may deny my claim and file a Notice of Controversy ("NOC"). Please note: If a NOC is filed, a Troubleshooter from the Board will contact you and try to resolve the disagreement. More information is available here: www.maine.gov/wcb/employees.html.

- **Redisclosure:** I understand the information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers' Compensation Act (Title 39-A) is compensable.
- **Revocable:** I understand I may revoke this authorization at any time in writing, subject to the rights of any individual who acted in reliance on the authorization prior to receiving notice of revocation, but doing so may result in a loss of, or reduction in, entitlement to workers' compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. The WCB form 220-R is effective only after it is received and does not apply to information that was already disclosed.
- Upon my request, I am entitled to a copy of this authorization and to inspect or copy information disclosed hereunder.
- A copy of this Authorization shall have the same force and effect as the original. Subsequent disclosures may be made under this Authorization.

I authorize release of my medical records to: _____
(Name of recipient/recipient's employer)

Address of recipient/recipient's employer:

_____

Format Requested (select one): **Electronically (if available)**: _____ **Fax to**: _____

Mail to: _____

Employee or Authorized Representative Signature:_____ **Date**:_____

For purposes of this release, "authorized representative" has the same definition as set forth in 22 M.R.S.A. § 1711-C(1)(A).

WCB-220 (effective 09/04/2023, revised 10/23/2023)

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

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)

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

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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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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

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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!

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.

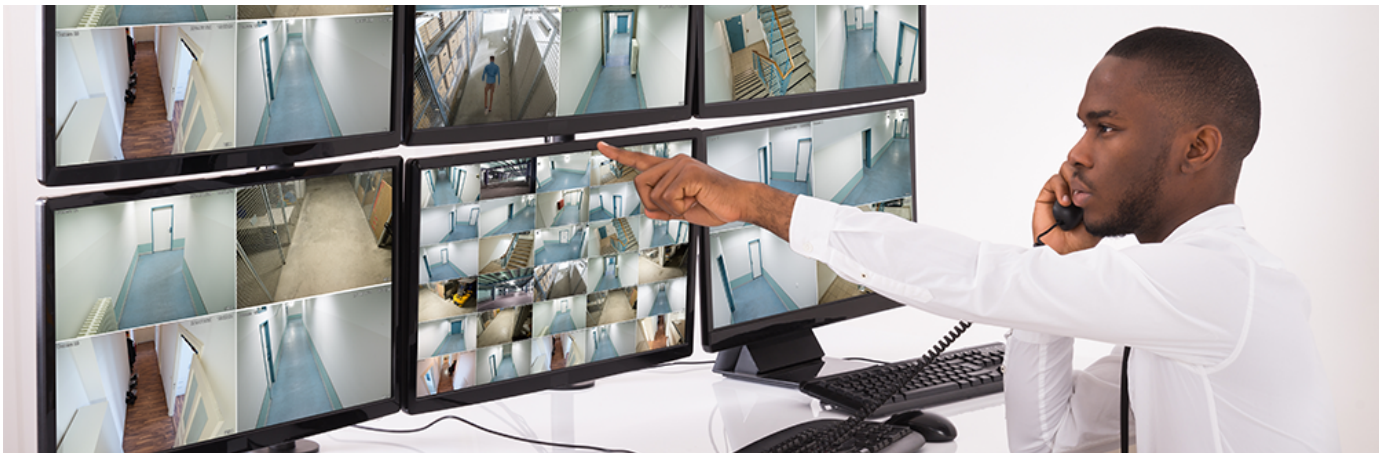
Please do your part to help! Putting criminals out of operation benefits all of us, including keeping your employer's premium rates reasonable.

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.

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.