



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Division®

Workers Compensation State Claim Kit

Minnesota



Table of Contents

BHHC MN Claims Kit Introductory Letter – 05/2026	1
BHHC Instructions for MN Workers’ Compensation Poster – 05/2026	2
MN Form Workers’ Compensation Poster – 01/2026	3
English.....	3
Hmong.....	4
Somali.....	5
Spanish	6
MN Form FR01 – First Report of Injury – 03/2016.....	7
MN Form – Employee Information Sheet 06/2009	9
English.....	9
Spanish	10
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
BHHC Express Scripts First Fill Form (English & Spanish) – 02/2025	22
BHHC Workers’ Compensation Fraud Posters - 04/2026	24
English.....	24
Spanish	25



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.

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

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com





Workers Compensation Posting Requirements

Workers Compensation Poster

- Post in one or more conspicuous places at all business locations and work sites
- Must contain the name and address of the insurance carrier.

To complete the form, please enter the name of your designated insurance carrier (insurer) in the space provided. For your convenience, our other contact information has been entered on the poster.

(Minnesota Statutes § 176.139)

Workers' compensation

If you are injured

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not make a timely report of the injury to your employer. The time limit may be as short as 14 days.

Some work-related psychological injuries may qualify you for benefits: if your injury is post-traumatic stress disorder with at least one month of persistent symptoms and diagnosed by a licensed psychologist or psychiatrist; or if the psychological injury is accompanied by a physical injury.

- Provide your employer with as much information as possible about your injury.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO),

you may treat with a doctor of your choice. Your employer must notify you in writing if you are covered by a CMCO.

- Cooperate with all requests for information about your claim.

The law allows the workers' compensation insurer to obtain medical information related to your work injury without your authorization, but they must send you written notification when they request the information.

The insurer cannot obtain other medical records unless you sign a written authorization.

- Get specific, written confirmation from your doctor about any authorization to be off work.

Workers' compensation pays for

- Medical care for your work injury, as long as it is reasonable and necessary.
- Wage-loss benefits for part of your lost income.
- Compensation for permanent damage to or loss of function of a body part.
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer due to your work injury.
- Benefits to your spouse and/or dependents if you die as a result of a work injury.

What the insurer must do

- The insurer must investigate your claim promptly. If you have been disabled for more than three calendar-days, the insurer must begin payment of benefits or send you a denial of liability within 14 days after your employer knew you were off work or had lost wages because of your claimed injury.
- If the insurer accepts your claim for wage-loss benefits and you have been disabled for more than three calendar-days: The insurer will notify you and must start paying wage-loss benefits within the 14 days noted above. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.
- If the insurer denies your claim for wage-loss benefits and you have been disabled for more than three calendar-days: The insurer will send notice to you within 14 days. The notice must clearly explain the facts and reasons why it believes your injury or illness did not result from your work or why the claimed wage-loss benefits are not related to your injury.

If you disagree with the denial, talk with the insurance claim adjuster who is handling your claim. If you are not satisfied and still disagree with the denial, call the Department of Labor and Industry's Workers' Compensation Help Desk at 651-284-5005 or 800-342-5354.

Fraud

Collecting workers' compensation benefits you are not entitled to is theft. Call 888-372-8366 to report workers' compensation fraud.

Insurer name and contact information



651-284-5032 • 800-342-5354 • dli.workcomp@state.mn.us • dli.mn.gov

Posting required by law in a location where employees can easily see this notice.

January 2026

Nyiaj Pab Txhawb Rau Cov Neeg Ua Hauj Lwm

Yog tias koj raug mob

- Qhia txhua yam kev raug mob rau koj tus neeg saib xyuas kom sai li sai tau, txawm yog qhov raug mob yuav yog me los si loj. Koj yuav tsis tau txais cov nyiaj pab txhawb yog tias koj tsis qhia txog koj qhov kev raug mob rau koj lub chaw ua hauj lwm raws sij hawm. Lub sij hawm teem tseg yuav luv li 14 hnuab xwb.
- Qee qhov kev raug mob ntawm lub paj hlwb uas muaj feem xyuam nrog kev ua hauj lwm yuav tsim nyog tau txais kev pab: yog tias koj qhov kev raug mob yog kev ntxhov siab tom qab ntsib xwm txheej txaus ntshai uas muaj cov tsos mob tshwm sim ntev li ib hlis los sis ntau dua thiab tau txais kev kuaj los ntawm ib tus kws kho mob hlwb (psychologist los sis psychiatrist) uas muaj ntaub ntawv tso cai; los sis yog tias kev raug mob ntawm lub paj hlwb ntawv muaj kev raug mob ntawm lub cev nrog rau.
- Muab cov ntaub ntawv qhia txog koj qhov kev raug mob rau koj tus tswv hauj lwm kom ntau li ntau tau.
- Mus nrhiav kev kho mob uas tsim nyog kom sai li sai tau. Yog tias koj tsis tau nyob hauv kev tiv thaiv ntawm ib lub koom haum saib xyuas kev kho mob uas tau txais kev tso cai (CMCO), koj tuaj yeem mus kho mob nrog ib tus kws kho mob uas koj xaiv. Koj tus tswv hauj lwm yuav tsum sau ntawv ceeb toom rau koj yog tias koj nyob hauv kev tiv thaiv ntawm ib lub koom haum CMCO.
- ib qho kev koom tes nrog txhua qhov kev thov kom muab ntaub ntawv ntsig txog koj daim ntawv foob thov nyiaj pab. .

Txoj cai tso cai rau lub tuam txhab pov hwm tau txais cov ntaub ntawv kho mob ntsig txog koj qhov kev raug mob hauv kev ua hauj lwm yam tsis tas koj tso cai, tab sis lawv yuav tsum tau xa cov ntaub ntawv ceeb toom rau koj thaum lawv thov cov ntaub ntawv ntawv.

Lub tuam txhab pov hwm tsis tuaj yeem tau txais lwm cov ntaub ntawv kho mob ntxiv, tshwj tsis yog koj kos npe tso cai ua ntawv rau lawv.

Yuav tsum tau txais daim ntawv lees paub kom meej los ntawm koj tus kws kho mob txog txhua qhov kev tso cai kom tsum tsis txhob ua hauj lwm.

Cov nyiaj pab txhawb rau cov neeg ua hauj lwm yog los them rau

- Kev saib xyuas kab mob rau koj qhov kev raug mob hauv kev ua hauj lwm, ntev npaum li nws tsim nyog thiab xav tau.
- Cov nyiaj pab them rov qab rau qhov nyiaj hli uas poob lawm rau ib feem ntawm koj cov nyiaj tau los.
- Nyiaj thim rov qab rau kev puas tsuaj mus tas li los sis kev tsis tau hauj lwm ntawm ib feem ntawm lub cev.
- Cov kev pab cuam rov qab los kawm hauj lwm yog tias koj tsis tuaj yeem rov qab mus ua koj txoj hauj lwm qub los sis rov mus nrog koj tus tswv hauj lwm qub ua ntej koj raug mob vim yog koj qhov kev raug mob hauv kev ua hauj lwm.
- Cov nyiaj pab rau koj tus khub niam txiv thiab/los sis cov neeg uas koj yug yog tias koj tuag vim yog raug mob hauv kev ua hauj lwm.

Yam ua lub tuam txhab pov hwm them nyiaj yuav tsum tau ua

- Lub tuam txhab pov hwm yuav tsum tshawb fawb koj daim ntawv thov nyiaj pab kom nrawm nroos. Yog tias koj tsis tuaj yeem ua hauj lwm tau ntau tshaj li peb hnuab, lub tuam txhab pov hwm yuav tsum pib them nyiaj pab los sis xa ntawv tsis lees paub txog kev lav phib xaub rau koj tsis pub dhau 14 hnuab tom qab koj tus tswv hauj lwm paub tias koj tsum ua hauj lwm los sis poob nyiaj hli vim yog koj qhov kev raug mob uas tau foob ntawv.
- Yog tias lub tuam txhab pov hwm lees txais koj daim ntawv thov nyiaj pab rau qhov nyiaj hli uas poob lawm thiab koj tsis tuaj yeem ua hauj lwm tau ntau tshaj li peb hnuab: Lub tuam txhab pov hwm yuav ceeb toom rau koj thiab yuav tsum pib them nyiaj pab rau lub sij hawm 14 hnuab uas tau hais saum toj no. Lub tuam txhab pov hwm yuav tsum them nyiaj pab kom raws sij hawm. Cov nyiaj pab rau qhov nyiaj hli uas poob yuav raug them raws li lub sij hawm koj tau txais nyiaj hli ua hauj lwm dhau los.
- Yog tias lub tuam txhab pov hwm tsis kam txais koj daim ntawv thov nyiaj pab rau qhov nyiaj hli uas poob lawm thiab koj tsis tuaj yeem ua hauj lwm tau ntau tshaj li peb hnuab: Lub tuam txhab pov hwm yuav xa tsab ntawv ceeb toom rau koj tsis pub dhau 14 hnuab. Tsab ntawv ceeb toom ntawv yuav tsum piav qhia meej txog qhov tseeb thiab cov laj thawj uas lawv ntseeg tias koj qhov kev raug mob los sis kev mob nkeeg tsis tau tshwm sim los ntawm koj txoj hauj lwm, los sis vim li cas cov nyiaj pab uas koj thov ho tsis muaj feem xyuam nrog koj qhov kev raug mob.

Yog tias koj tsis pom zoo nrog qhov kev tsis kam txais ntawv, cia tham nrog tus neeg hloov kho daim ntawv thov pov hwm uas yog tus saib xyuas koj daim ntawv foob. Yog tias koj tseem tsis txaus siab thiab tseem tsis pom zoo nrog qhov kev tsis kam txais ntawv, hu rau Lub Chaw Pab Cuam Neeg Ua Hauj Lwm (Workers' Compensation Help Desk) ntawm Lub Tuam Txhab Hauj Lwm thiab Kev Lag Luam (Department of Labor and Industry) ntawm tus xov tooj 651-284-5005 los sis 800-342-5354.

Kev dag ntxias

Kev txais cov nyiaj pab neeg ua hauj lwm uas koj tsis tsim nyog tau txais yog kev nyiaj. Hu rau 888-372-8366 txhawm rau qhia txog kev dag ntxias ntsig txog nyiaj pab neeg ua hauj lwm.

Lub npe ntawm lub tuam txhab pov hwm thiab cov ntaub ntawv tiv tauj



651-284-5032 • 800-342-5354 • dli.workcomp@state.mn.us • dli.mn.gov

Txoj cai tswj kom yuav tsum tau muab tsab ntawv ceeb toom no tso tseg rau ntawm qhov chaw uas cov neeg ua hauj lwm tuaj yeem pom tau yooj yim.

Ib Hli Ntuj Xyoo 2026

Magdhawga Shaqaalaha

Haddii aad dhaawacanto

- U sheeg wixii dhaawac ah kormeerahaaga sida ugu dhakhsaha badan, adiga oo aan u eegayn inaad dhaawaca mid yar u aragto iyo in kale. Waxaa laga yaabaa inaad lumiso xuquuqda magdhawga shaqaalaha haddii aanad warbixinta dhaawaca waqtigeeda ku siin loo shaqeeyahaaga. Xadka waqtiga waxay noqon kartaa sida ugu gaaban 14 maalmood.

Dhaawacyada maanka ee la xiriira shaqada ayaa laga yaabaa inaad ugu qalanto dheefaha: haddii dhaawacyadaadu ay tahay xanuun walaac ah ka dib dhaawac oo leh ugu yaraan hal bil oo astaamo joogto ah oo uu xaqiijiyay dhakhtarka cilmi-nafsiga oo shati leh ama dhakhtarka maanka; ama haddii dhaawaca maanka uu la socdo dhaawac jireed.

- Sii loo shaqeeyahaaga macluumaadka ugu badan ee suurtoogalka ah ee ku saabsan dhaawacaaga.
- U hel daaweyn kasta oo loo baahan yahay sida ugu dhakhsaha badan. Haddii aanad haysan caymiska hay'ad daryeel oo la xaqiijiyay (certified

managed care organization, CMCO), waxaad daaweyn ka heli kartaa dhakhtar aad dooratay. Loo shaqeeyahaaga waa inuu qoraal ahaan kugu ogeysiiyaa haddii caymis lagugu siiyay CMCO.

- La shaqee dhammaan codsiyada macluumaadka ku saabsan sheegashadaada.

Sharciga ayaa u oggolaanaya caymiyaha magdhawga shaqaalaha inuu helo macluumaad caafimaad oo la xiriira dhaawaca shaqada iyaga oo aan haysan oggolaanshahaaga, laakiin waa inay kuu soo diraan ogeysiis qoraal ah marka ay codsadaan macluumaadka.

caymiyuhu ma heli karo diiwaanada kale ee caafimaadka illaa aad saxiixdo oggolaansho qoraal ah.

- Dhakhtarkaaga ka hel caddeyn qoraal ah oo cad oo oo ku saabsan oggolaansho kasta oo aad shaqada kaga maqnaanayso.

Magdhawga Shaqaalaha Waxay Bixisaa

- Daryeelka caafimaadka ee dhaawaca shaqada, illaa iyo inta ay macquul tahay oo ay lagama maarmaan tahay.
- Dheefaha luminta mushaharka ee qayb ka mid ah dakhligaaga lumay.
- Magdhawga dhaawaca joogtada ah ama luminta xubin jirka ka mid ah.

- Adeegyada baxnaaninta xirfadaha haddii aanad ku soo laaban karin shaqadaada dhaawaca ka hor ama loo shaqeeyahaaga dhaawaca ka hor sababo la xiriira dhaawaca shaqada.

- Dheefaha lamaanahaaga iyo/ama kuwa kugu tiirsan haddii aad u dhimato dhaawaca shaqada.

Waxa ay tahay in caymiyuhu sameeyo

- Caymiyuhu waa inuu si degdeg ah u baaro sheegashadaada. Haddii aad naafo tahay in ka badan saddex maalmood oo kalendar ah, caymiyuhu waa inuu bilaabaa bixinta dheefaha ama uu kuugu soo diraa diidmada mas'uuliyadda 14 maalmood gudahood ka dib marka loo shaqeeyahaagu ogaado inaad shaqada ka maqnayd ama aad lumisay mushaharka dhaawaca aad sheegtay darteed.

- Haddii caymiyuhu aqbaloo sheegashadaada dheefaha luminta mushaharka oo aad naafo ahayd in ka badan saddex maalmood oo kalendar: Caymiyuhu wuu ku soo ogeysiin doonaa oo waa inuu bilaabaa bixinta dheefaha luminta mushaharka 14-ka maalmood gudahood ee kor lagu xusay. Caymiyuhu waa inuu dheefaha ku bixiyaa waqtigooda. Dheefaha luminta mushaharka waxaa lagu bixiyaa si lamid ah muddada mushaharka shaqada caadiga ah.

- Haddii caymisku diido sheegashadaada dheefaha luminta mushaharka oo aad naafo ahayd in ka badan saddex maalmood oo kalendar: Caymiyuhu wuxuu kuu soo diri doonaa ogeysiis 14 maalmood gudahood. Ogeysiisku waa inuu si cad u sharaxaa xaqiiqooyinka iyo sababaha ay u aaminsan yihiin in dhaawacaaga ama xannuunkaagu aanay ka soo bixin shaqadaada ama sababta dheefaha luminta mushaharka ee la sheeganayo aanay la xiriirin dhaawacaaga.

Haddii aanad ku raacsaneyn diidmada, la hadal hawlweadeenka sheegashada caymiska ee maareynaya sheegashadaada. Haddii aanad ku qanacsanayn oo aanad weli ku raacsanayn diidmada, ka wac Miiska Caawinta Department of Labor and Industry's Workers' Compensation lambarka 651-284-5005 ama 800-342-5354.

Khiyaano

Qaadashada dheefaha magdhawga shaqaalaha ee aanad xaq u lahayn waa xatooyo. Wac 888-372-8366 si aad uga warbixiso khiyaanada magdhawga shaqaalaha.

Magaca Caymiyaha iyo macluumaadka xiriirka



Compensación para trabajadores

Si usted sufre una lesión

- Informe cualquier lesión a su supervisor lo antes posible, sin importar qué tan leve parezca. Usted puede perder el derecho a recibir beneficios de compensación para trabajadores si no informa la lesión a su empleador dentro del plazo establecido. El plazo establecido puede ser tan breve como 14 días.

Algunas lesiones psicológicas relacionadas con el trabajo pueden calificarlo para recibir beneficios: si su lesión es un trastorno de estrés postraumático con al menos un mes de síntomas persistentes y diagnosticado por un psicólogo o psiquiatra con licencia; o si la lesión psicológica está acompañada de una lesión física.
- Proporcione a su empleador toda la información posible sobre su lesión.
- Obtenga cualquier tratamiento médico necesario lo antes posible. Si usted no está cubierto por una organización certificada de atención médica administrada (CMCO, por sus siglas en inglés), puede recibir atención de un médico de su elección. Su empleador debe notificarle por escrito si usted está cubierto por una CMCO.
- Coopere con todas las solicitudes de información relacionadas con su reclamo.

La ley permite que la aseguradora de compensación para trabajadores obtenga información médica relacionada con su lesión laboral sin su autorización, pero debe enviarle una notificación por escrito cuando solicite dicha información.

La aseguradora no puede obtener otros registros médicos a menos que usted firme una autorización por escrito.
- Obtenga una confirmación específica y por escrito de su médico sobre cualquier autorización para ausentarse del trabajo.

La compensación para trabajadores cubre

- Atención médica por su lesión laboral, siempre que sea razonable y necesaria.
- Beneficios por pérdida de salario que cubren parte de sus ingresos perdidos.
- Compensación por daño permanente o pérdida de función de alguna parte del cuerpo.
- Servicios de rehabilitación vocacional si no puede regresar a su puesto ni continuar trabajando con su empleador previo a la lesión debido a la lesión laboral.
- Beneficios para su cónyuge o dependientes si usted fallece como resultado de una lesión laboral.

Lo que la aseguradora debe hacer

- La aseguradora debe investigar su reclamo de manera oportuna. Si usted ha estado incapacitado por más de tres días calendario, la aseguradora debe comenzar a pagar los beneficios o enviarle una denegación de responsabilidad dentro de los 14 días posteriores a que su empleador supo que usted estaba fuera del trabajo o había perdido salario debido a la lesión reportada.
- Si la aseguradora acepta su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días calendario, la aseguradora le notificará y deberá comenzar a pagar los beneficios por pérdida de salario dentro del plazo de 14 días mencionado. La aseguradora debe realizar los pagos en tiempo y forma. Los beneficios por pérdida de salario se pagan con la misma frecuencia que sus cheques de pago.
- Si la aseguradora niega su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días calendario: la aseguradora le enviará un aviso en un plazo de 14 días. El aviso debe explicar claramente los hechos y las razones por las cuales considera que su lesión o enfermedad no se originó en el trabajo o por qué los beneficios solicitados por pérdida de salario no están relacionados con su lesión.

Si usted no está de acuerdo con la denegación, hable con el gestor de reclamos que maneja su caso. Si no queda satisfecho y continúa en desacuerdo, llame al Workers' Compensation Help Desk del Department of Labor and Industry al 651 284 5005 o 800 342 5354.

Fraude

Recibir beneficios de compensación para trabajadores sin tener derecho a ellos constituye un delito. Llame al 888 372 8366 para denunciar fraude en compensación para trabajadores.

Nombre e información de contacto de la aseguradora

mn DEPARTMENT OF
LABOR AND INDUSTRY

651-284-5032 • 800-342-5354 • dli.workcomp@state.mn.us • dli.mn.gov
Aviso que la ley exige colocar en un sitio de fácil visibilidad para los empleados.

Enero de 2026

First Report of Injury

See Instructions on Reverse Side



FRO 1

Print in ink or type
 Enter dates in MM/DD/YYYY format

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #		2. OSHA case #		3. Time employee began work on date of injury <input type="checkbox"/> am <input type="checkbox"/> pm	
4. DATE OF CLAIMED INJURY		5. Time of injury <input type="checkbox"/> am <input type="checkbox"/> pm		6. Date of death # of dependents (if death is related to injury)	
7. EMPLOYEE Name (last, suffix, first, middle)				8. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
				9. Marital status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried	
10. Home address			11. Home phone #		12. Date of birth
City State Zip Code			14. Occupation		13. Date hired
			15. Regular department		16. Apprentice <input type="checkbox"/> Yes <input type="checkbox"/> No
17. Average weekly wage		18. Rate per hour	19. Hours per day	20. Days per week	
				Normal work schedule Sun - Sat <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S	
21. Employment status (check all that apply) <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer					
22. Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was. Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."					
23. What was the injury or illness (include the part(s) of body)? Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.			24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.		
25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No Name and address of the place of the occurrence		26. Date of first day of any lost time		27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI	
		28. Date employer notified of injury		29. Date employer notified of lost time	
		30. Return to work date		31. RTW same employer <input type="checkbox"/> Yes <input type="checkbox"/> No	
				32. RTW with restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No	
33. Treating physician (name)		34. Extent of medical treatment (check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Minor on-site by employer's medical staff <input type="checkbox"/> Minor clinic/hospital			
35. Certified Managed Care Organization (if any)		<input type="checkbox"/> Emergency room <input type="checkbox"/> Hospitalization more than 24 hours <input type="checkbox"/> Future major medical anticipated			
36. EMPLOYER Legal name			37. EMPLOYER DBA name (if different)		
38. Mailing address			39. Employer FEIN		40. Unemployment ID #
City State Zip Code			41. Employer's contact name and phone #		
42. Physical address (if different)			43. Witness (name and phone) - if more than 1 attach a separate sheet		
City State Zip Code			44. NAICS code		45. Date form completed
46. INSURER name			51. CLAIMS ADMIN COMPANY (CA) name (check one) <input type="checkbox"/> Insurer <input type="checkbox"/> TPA		
47. Insured legal name and FEIN			52. CA address		
48. Policy # (including effective dates) or self-insured certificate #			City State Zip Code		
49. Insurer FEIN		50. Date insurer received notice		53. CA FEIN	
				54. CA claim #	
55. To be completed by the CA:		Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?
					Death result of injury?

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov.

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence, at P.O. Box 64221, St. Paul, MN 55164-0221.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see <https://www.irs.gov/Businesses/Small-Businesses-&Self-Employed/Lost-or-Misplaced-Your-EIN>.
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR (For first reports of injury filed on or after Jan. 1, 2014)

Pursuant to Minnesota Statutes, section 176.231, and Minnesota Rules, part 5220.2530, insurers and self-insured employers must file with the Department's Workers' Compensation Division an electronic first report of injury, according to the requirements set out in sections 2 to 4 of the Minnesota implementation guide, in all cases where a first report of injury is required to be filed under Minnesota Statutes, chapter 176. The Minnesota implementation guide can be found on the Department's website at www.dli.mn.gov/WC/Edi.asp.

A first report of injury submitted by the insurer or self-insured employer in any other manner or format is not considered filed with the division, except for a written first report of injury on a paper form filed by a self-insured employer within seven days of death or serious injury.

If the claim does not involve lost time beyond the waiting period or potential permanent partial disability (PPD), or has not been requested to be filed by the Department, a first report of injury does **not** need to be filed.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Minnesota workers' compensation system employee information sheet

What does workers' compensation pay for?

- Medical care for the work injury, as long as it is reasonable and necessary.
- Wage-loss benefits for part of your lost income (there is a three-calendar-day waiting period before these benefits start).
- Benefits for permanent damage or loss of function of a body part.
- Benefits to your spouse and/or dependents if you die of a work injury.
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer.

How are workers' compensation benefits paid?

Your workers' compensation benefits are paid by an insurance company or your employer, if your employer is self-insured. State law sets the benefit levels. Note: Pursuant to statute, the insurer can obtain medical information specific to your work injury without your authorization.

If the insurer *accepts* your claim for wage-loss benefits and you have been disabled for more than three calendar days:

- The insurer will send you a copy of the Notice of Insurer's Primary Liability Determination form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

If the insurer *denies* your claim for wage-loss benefits:

- The insurer will send you a copy of the Notice of Insurer's Primary Liability Determination form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.

Insurer name:

Phone:

- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below.

If you have other questions or need more help, call the Minnesota Department of Labor and Industry's Workers' Compensation Hotline. Your call will be answered by experienced workers' compensation specialists, who will provide instant, accurate information and assistance.

Twin Cities and southern Minnesota: 651-284-5005 or 800-342-5354
Duluth and northern Minnesota: 218-733-7810 or 800-342-5354

Additional information is available at www.dli.mn.gov/workers/workers-compensation-workers.

Your employer is required by law to give you this information. This form may be copied or reproduced electronically. This document can be provided in audio, Braille or large print by the Department of Labor and Industry. (Updated August 2018, formatting and website address only.)

Información sobre el Sistema de Compensación a trabajadores por accidentes en Minnesota

¿Por cuales cosas paga el seguro de compensación a trabajadores?

- Atención medica por su accidente/lesión de trabajo, siempre y cuando sea razonable y necesaria.
- Beneficios parciales por pérdida de ingresos. (Hay un período de espera de tres días civiles antes de que comiencen estos beneficios.)
- Compensación por daños permanentes o por la pérdida del funcionamiento de una parte del cuerpo.
- Beneficios a su cónyuge y/o sus dependientes si usted fallece como resultado de una lesión en el trabajo.
- Servicios de rehabilitación vocacional si, a causa de una lesión en el trabajo, usted no puede regresar al trabajo que tenía o a la empresa para la que trabajaba antes de sufrir dicha lesión.

¿Como se pagan los beneficios de compensación a trabajadores accidentados?

Sus beneficios de compensación a trabajadores son pagados por un asegurador o por su empleador si el está asegurado si- mismo. La ley estatal de Minnesota define los niveles de pago de beneficios. Tome nota: de acuerdo a estatutos, el asegurador de compensación podrá obtener información médica relacionada específicamente con su lesión de trabajo sin su autorización, siempre y cuando le envíe un aviso por escrito de dicha solicitud al momento de hacerla.

Si la aseguranza acepta su reclamación de beneficios por pérdida de ingresos y usted ha estado incapacitado por más de tres días civiles:

- El asegurador le enviará una copia del formulario de Aviso de Determinación de Responsabilidad Principal del Asegurador (Notice of Insurer's Primary Liability Determination) indicando que aceptó su reclamación.
- El asegurador deberá comenzar a pagarle los beneficios por pérdida de ingresos. El asegurador deberá pagar los beneficios de manera puntual. Los beneficios por pérdida de ingresos se pagan a los mismos intervalos de tiempo que sus cheques de nómina.

Si el asegurador rechaza su reclamación de beneficios por pérdida de ingresos:

- El asegurador le enviará una copia del formulario de Aviso de Determinación de Responsabilidad Principal del Asegurador (Notice of Insurer's Primary Liability Determination) indicando que está rechazando la reponsabilidad principal por su reclamación. El formulario debe explicar claramente los hechos y los motivos por los cuales el asegurador cree que su lesión o enfermedad no es resultado de su trabajo.
- Si usted no está de acuerdo con el rechazo, debe hablar con el tasador de reclamaciones de seguro que esté encargado de su reclamación. La compañía de seguros de su empleador podrá responder a la mayoría de sus preguntas acerca de su reclamación.

Nombre de Aseguranza:

Número de teléfono:

- Si no está satisfecho con la respuesta que reciba del empleador y aún no está de acuerdo con el rechazo, debe comunicarse con el Departamento del Trabajo y la Industria llamando a uno de los números que se indican a continuación para hablar acerca de sus opciones.

Si tiene preguntas o necesita más ayuda, llame al Departamento del Trabajo y la Industrial de Minnesota:

Ciudades gemelas el area Sur de Minnesota: 651-284-5005 or 800-342-5354

Duluth y el area norte de Minnesota: 218-733-7810 or 800-342-5354

Especialistas en compensación a trabajadores con experiencia responderán a su reclamación y le proveerán información y asistencia instantáneas y precisas.

Hay información adicional acerca de la compensación a trabajadores por accidentes en el trabajo disponible en el sitio de Internet del Departamento en www.dli.mn.gov/workers/workers-compensation-workers.

Su empleador está requerido por ley a proveerle esta información. Este formulario puede ser copiado o reproducido electrónicamente. Este documento puede ser provisto en audio, Braille o letra grande por el Departamento de Trabajo e Industria. (Updated August 2018, formatting and website address only.)

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

Claim Number/Número de Reclamo

Date of Injury / Fecha de la Lesión

Employee/Empleado

Date of Birth / Fecha de Nacimiento

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

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

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

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

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) Admitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

Employee Incident Report

This form should be filled out by the injured employee.

Name

Employer Name

Date of Incident

Time of incident

Time you began work on day of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)

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

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

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

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

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

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

What did you do after the incident occurred?

The above form is true and correct.

Signature

Date Completed

Informe de Incidente del Empleado

A ser completado por el trabajador lesionado.

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Hora en que usted empezó a trabajar el día del incidente

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

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

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

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

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

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

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

¿Qué hizo después de ocurrido el incidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario

Supervisor's Report of Employment 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 Supervisor

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente?

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

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

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

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

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



Informe de Incidente del Supervisor

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

To the Injured Worker:

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

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

Atencion Trabajador Lesionado:

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

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

ID#: _____

Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: G3YA

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

Employee Information

Full Name

Street Address or PO Box

City

State

ZIP

Date of Birth

Employer Name



To the Pharmacist:

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

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

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

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

AHF PHARMACY
AHOLD CORPORATION
ALBERTSONS
ALIGNRX LLC
AMERITA INC
AURORA PHARMACY INC
BIG Y FOODS INC
BI-LO HOLDINGS LLC
BROOKS/MAXI DRUG
BROOKSHIRE BROTHERS LTD
BROOKSHIRE GROCERY CO
CARDINAL HEALTH
CHEN NEIGHBORHOOD MEDICAL CENT
COBORN'S INC.
COSTCO WHOLESALE, INC
CVS CORP
DEDICATED US HOLDINGS LLC
DISCOUNT DRUG MART
ECKERD
EPIC PHARMACY NETWORK
ESSENTIA HEALTH
EXPRESS RX
FAIRVIEW PHARMACY SVCS
FAMILY FARE, LLC

FOOD LION PHARMACY
FRUTH PHARMACY
GENOA HEALTHCARE LLC
GIANT EAGLE PHARMACY
GUARDIAN PHARMACY LLC
HAC INC
HANNAFORD BROS. CO.
HARPS FOOD STORES INC
HARTIG DRUG
HEALTH MART ATLAS LLC
H-E-B LP
HENRY FORD HEALTH SYSTEM
HOMETOWN PHARMACY INC
HY-VEE FOOD STORES INC
INGLES MARKETS
INSTYMEDS CORP
KPH HEALTHCARE SERVICES
KS PHARM LLC
K-VA-T FOOD STORES INC
LEWIS DRUGS INC
LONGS DRUG STORE
MARC GLASSMAN INC
MEDICAP PHARMACY, INC.
MEDICINE SHOPPE
MEIJER PHARMACY
MERCY PHARMACY SERVICES

NCS HEALTHCARE
NEIGHBORCARE PHARMACY
OSBORN DRUGS INC
PATIENT FIRST
PHARMEDQUEST PHARMACY
PHARMERICA, INC
PMR US HOLDINGS
PRESBYTERIAN MEDICAL
PRESCRIBEIT RX
PRICE CHOPPER PHARMACY
PUBLIX SUPER MARKETS, INC
RALEY'S
RECEPT PHARMACY LP
RITE AID CORPORATION
SAFEWAY, INC.
SAM'S CLUB
SUPERVALU PHARMACIES, INC.
TARGET
THRIFTY WHITE STORES
TOPS MARKETS LLC
UNITED SUPERMARKETS INC
WALGREENS
WAL-MART
WEGMANS FOOD MARKETS,
WEIS MARKETS INC

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



\$1000 REWARD

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

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

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

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

1 (800) 300-JAIL

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



\$1000 RECOMPENSA

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

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

Ayúdenos de su parte. El poner a estos delincuentes fuera de operaciones nos beneficia a todos, incluso esto ayuda a mantener los réditos bajos de la 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 demanda fraudulenta. BerkshireHathaway dividirá la recompensa por partes iguales entre aquellas personas que aportaron informaciones para obtener la convicción. Berkshire Hathaway se reserva el derecho de determinar qué información presentará a la agencia judicial correspondiente. El proceso de crímenes es la responsabilidad exclusiva de las autoridades, que pueden decidir si el proceso debe entablarse or no. Cualquier disputa que pudiera surgir en la interpretación de esta oferta será resuelta por la propia Compañía de Seguros Berkshire Hathaway. Este programa está sujeto a cambios a cancelación sin aviso previo.