



Berkshire Hathaway  
HOMESTATE COMPANIES

Workers Compensation Division®

# Workers Compensation State Claim Kit

*South Carolina*



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P.O. Box 881236 San Francisco, CA 94188  
(888) 495-8949  
[bhhc.com](http://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.

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

State law also requires that employers authorize initial medical treatment within 24 hours of knowledge that an occupational injury or 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](mailto:newclaim@bhhc.com)



# Workers Compensation Posting Requirements

## Workers' Compensation Compliance Poster

- Post in one or more conspicuous places at all business locations

To complete the form, please enter the name of your designated insurance carrier in the space provide. For your convenience, our other contact information has been entered on the Poster.

(South Carolina Code of Regulations 67-301)



# South Carolina Workers' Compensation

## Workers' Compensation Compliance Poster

### We are operating under and subject to the South Carolina Workers' Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

### Workers' Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

### If you are injured on the job, you should:

1. Notify your employer at once. You cannot receive benefits unless your employer knows you are injured.
2. Tell the doctor your employer sends you to that you are covered by workers' compensation.
3. Notify the Workers' Compensation Provider listed on this poster or the South Carolina Workers' Compensation Commission at 803.737.5700 if you experience undue delays or problems with your claim.

South Carolina  
 Workers' Compensation Commission  
 P.O. Box 1715, 1333 Main Street, Suite 500  
 Columbia, S.C. 29202-1715  
 803-737-5700  
[www.wcc.sc.gov](http://www.wcc.sc.gov)

### Workers' Compensation Provider Name

### Mailing Address

### Claims Telephone Number

**S.C. WORKERS' COMPENSATION COMMISSION – FIRST REPORT OF INJURY OR ILLNESS**

|                                    |               |  |                           |                     |            |
|------------------------------------|---------------|--|---------------------------|---------------------|------------|
| EMPLOYER (NAME & ADDRESS INCL ZIP) |               | CARRIER/ADMINISTRATOR CLAIM NUMBER         | OSHA LOG NUMBER           | REPORT PURPOSE CODE |            |
|                                    |               | JURISDICTION                               | JURISDICTION CLAIM NUMBER |                     |            |
|                                    |               | INSURED REPORT NUMBER                      |                           |                     |            |
|                                    |               | EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) |                           |                     | LOCATION # |
| INDUSTRY CODE                      | EMPLOYER FEIN |  |                           | PHONE #             |            |

**CARRIER/CLAIMS ADMINISTRATOR**

|                                    |   |   |
|------------------------------------|---|---|
| CARRIER (NAME, ADDRESS, & PHONE #) | POLICY PERIOD<br><br><p align="center">TO</p>                   | CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) |
|                                    | CHECK IF APPROPRIATE<br><input type="checkbox"/> SELF INSURANCE |   |
| CARRIER FEIN                       | POLICY/SELF-INSURED NUMBER                                      | ADMINISTRATOR FEIN                              |
| AGENT NAME & CODE NUMBER           |   |   |

**EMPLOYEE/WAGE**

|   |   |  |  |               |
|---|---|--|--|---------------|
| NAME (LAST, FIRST, MIDDLE)  | DATE OF BIRTH   | SOCIAL SECURITY NUMBER   | DATE HIRED   | STATE OF HIRE |
| ADDRESS (INCL ZIP)  | SEX<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Unknown | MARITAL STATUS<br><input type="checkbox"/> Unmarried/Single/Divorced<br><input type="checkbox"/> Married<br><input type="checkbox"/> Separated<br><input type="checkbox"/> Unknown | OCCUPATION/JOB TITLE   |               |
|   |   |  | EMPLOYMENT STATUS  |               |
| PHONE   | # OF DEPENDENTS   |  | NCCI CLASS CODE  |               |
| RATE PER:<br><input type="checkbox"/> DAY <input type="checkbox"/> MONTH<br><input type="checkbox"/> WEEK <input type="checkbox"/> OTHER: | DAYS WORKED/WEEK  | FULL PAY FOR DAY OF INJURY?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  | DID SALARY CONTINUE?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |               |

**OCCURRENCE/TREATMENT**

|   |  |  |                            |   |
|---|--|--|----------------------------|---|
| TIME EMPLOYEE BEGAN WORK<br><input type="checkbox"/> AM <input type="checkbox"/> PM   | DATE OF INJURY/ILLNESS   | TIME OF OCCURRENCE<br>( <input type="checkbox"/> ) CANNOT BE DETERMINED<br><input type="checkbox"/> AM <input type="checkbox"/> PM | LAST WORK DATE             | DATE EMPLOYER NOTIFIED<br>DATE DISABILITY BEGAN |
| CONTACT NAME/PHONE NUMBER   | TYPE OF INJURY/ILLNESS   |  | PART OF BODY AFFECTED      |   |
| DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   | TYPE OF INJURY/ILLNESS CODE  |  | PART OF BODY AFFECTED CODE |   |
| DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED  | ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED |  |                            |   |
| SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED  | WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED                  |  |                            |   |
| HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL |  |  | CAUSE OF INJURY CODE       |   |

|  |                              |  |  |   |
|--|------------------------------|--|--|---|
| DATE RETURN(ED) TO WORK  | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO | WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)                        |                              | HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)  |  | INITIAL TREATMENT                               |
|  |                              |  |  | 0 <input type="checkbox"/> No Medical Treatment |
|  |                              |  |  | 1 <input type="checkbox"/> MINOR: BY EMPLOYER   |
|  |                              |  |  | 2 <input type="checkbox"/> MINOR CLINIC/HOSP    |
|  |                              |  |  | 3 <input type="checkbox"/> EMERGENCY CARE       |
| 4 <input type="checkbox"/> HOSPITALIZED > 24 HOURS                     |                              |  |  |   |
| 5 <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED |                              |  |  |   |

**OTHER**

|                             |               |                         |              |
|-----------------------------|---------------|-------------------------|--------------|
| WITNESSES (NAME & PHONE #)  |               |                         |              |
| DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER |



**South Carolina Workers' Compensation Commission**

1333 Main Street, Suite 500

P.O. BOX 1715

Columbia, SC 29202-1715

803-737-5722

**EMPLOYER'S INSTRUCTIONS**

**DO NOT ENTER DATA IN SHADED FIELDS**

**DATES:**

Enter all dates in MM/DD/YYYY format.

**INDUSTRY CODE:**

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

**CARRIER:**

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

**CLAIMS ADMINISTRATOR:**

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

**AGENT NAME & CODE NUMBER:**

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

**OCCUPATION/JOB TITLE:**

This is the primary occupation of the claimant at the time of the accident or exposure.

**EMPLOYMENT STATUS:**

Indicate the employee's work status. The valid choices are:

Full-Time On Strike Unknown Volunteer

Part-Time Disabled Apprenticeship Full-Time Seasonal

Not Employed Retired Apprenticeship Part-Time Piece Worker

**DATE DISABILITY BEGAN:**

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

**CONTACT NAME/PHONE NUMBER:**

Enter the name of the individual at the employer's premises to be contacted for additional information.

**TYPE OF INJURY/ILLNESS:**

Briefly describe the nature of the injury or illness, (e.g. Lacerations to the forearm).

**PART OF BODY AFFECTED:**

Indicate the part of body affected by the injury/illness, (e.g. Right forearm, lower back).

**DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:**

(e.g. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.



**South Carolina Workers' Compensation Commission**

1333 Main Street, Suite 500  
P.O. BOX 1715  
Columbia, SC 29202-1715  
803-737-5722

**EMPLOYER'S INSTRUCTIONS – cont'd**

**ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:**

(e.g. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

**SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:**

(e.g. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

**WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:**

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g. walking along a hallway).

**HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:**

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

**DATE RETURN(ED) TO WORK:**

Enter the date following to most recent disability period on which the employee returned to work.



Claimant's Name: \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: ( ) - \_\_\_\_\_ Work Phone: ( ) - \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_  
 Preparer's Name: \_\_\_\_\_ Preparer's Phone #: ( ) - \_\_\_\_\_

Date of Injury: \_\_\_\_\_  
 month day year

**A. Total Wages Paid**

- Check Applicable Method:
  - Report of earnings of injured employee based on four completed quarters.
  - Report of earnings of injured employee who did not complete four quarters based on actual time worked.
  - Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire date: \_\_\_\_\_
  - Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just (attach documentation to show how average weekly wage and compensation rate were calculated).
- List total wages paid as reported to the Department of Employment and Workforce on the Employer Quarterly Contribution and Age Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

| Quarter | Ending Date | Total Wages Paid |
|---------|-------------|------------------|
| 1st     | _____       | \$ _____         |
| 2nd     | _____       | \$ _____         |
| 3rd     | _____       | \$ _____         |
| 4th     | _____       | \$ _____         |

Total Paid 2. \$ \_\_\_\_\_

- List total value of other allowances of any character made in lieu of wages during four quarters above. 3. \$ \_\_\_\_\_
- Add lines 2 and 3. **TOTAL WAGES PAID:** 4. \$ \_\_\_\_\_
- List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. \_\_\_\_\_

**B. Average Weekly Wage**

- To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5). **AVERAGE WEEKLY WAGE:** 6. \$ \_\_\_\_\_

**C. Compensation Rate**

- The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by sixty-six and two thirds percent. Estimate compensation rate by multiplying average weekly wage (line 6) by sixty-six and two thirds percent. See part 8 below to determine the actual compensation rate. 7. \$ \_\_\_\_\_
- The compensation rate is as follows (choose one):
  - When average weekly wage (line 6) is less than \$75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
  - When the estimated compensation rate (line 7) is less than \$75.00 and average weekly wage (line 6) is more than \$75.00, the compensation rate is \$75.00. Enter \$75.00 on line 8.
  - When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
  - Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8. \_\_\_\_\_
  - The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.

**WEEKLY COMPENSATION RATE:** 8. \$ \_\_\_\_\_

Employer's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED, THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803)737-5723.

# 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](http://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

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Visit [www.MyMatrixx.com](http://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.