Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division®

Workers Compensation State Claim Kit

West Virginia

Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division®

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Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division®

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

Dear Policyholder,

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

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

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

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES

Report a Claim

Online

bhhcpolicyholder.bhhc.com/Client/External/Claims

Phone

(800) 661-6029

Fax

(800) 661-6984

E-mail

newclaim@bhhc.com

AM BEST A++ Superior

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

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Workers Compensation Posting Requirements

Workers' Compensation Notice Poster

Post in one or more conspicuous places readily accessible to all employees at all business locations.

To complete the form, please enter the name of your designated insurer.

For your convenience, our other contact information has been entered on the Poster.

(West Virginia Code § 23-2c-15(c))

AM BEST A++ Superior

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For the latest Best Credit Rating, access ambest.com.

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NOTICE REGARDING

Workers Compensation Insurance

All workers employed by the undersigned are hereby notified that the employer has complied with the law as to securing the payment of compensation to employees and their dependants, in accordance with the provisions of the worker's compensation law.

An employee receiving an injury by accident must immediately notify his/her supervisor, superintendent, or the company representative indicated below.

YOUR EMPLOYER HAS WORKER'S COMPENSATION COVERAGE THROUGH:

INSURER NAME

P.O. Box 881716, San Francisco, CA 94188
INSURER ADDRESS

(800) 661-6029
INSURER PHONE NUMBER

(415) 675-5469
INSURER FAX NUMBER

NOTICES OF ACCIDENT/INJURY AND QUESTIONS PERTAINING TO WORKERS' COMPENSATION CLAIMS SHOULD BE BROUGHT TO:

Nicole Albrecht
NAME OF INSURER REPRESENTATIVE

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

Form OIC-WC-2

West Virginia Workers' Compensation
Employers' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I — Employer Information

Insurer: | **Third-Party Administrator:**

Employer's Name: | Nature of Business: | FEIN:

Address:

City: | State: | Zip: | Telephone: ( ) -

Section II — Employee Information

Name: (Last): (First): (M.I.): | **Occupation/Job Title:**

Address: | **Telephone:** ( ) -

City: | State: | Zip: | **Social Security No.:** - -

Date of Birth: _____/_____/_____ | **6. Sex:** ☐ M ☐ F | **Marital Status:**

Injured Employee is (check all that apply): ☐ Full-Time ☐ Part-Time ☐ Volunteer ☐ Owner/Partner ☐ Officer ☐ Retired – Date Retired: _____/_____/_____ | **Employee's Occupation/Job Title:**

Section III — Information Regarding Injury or Disease

Date of Injury or Last Exposure: _____/_____/_____ **Time:** ☐ a.m. ☐ p.m. | **Witnesses to Injury:**

Date Employer Notified of Injury or Disease: _____/_____/_____ | **Supervisor to whom Injury or Disease Reported:**

If Injury was Fatal, Indicate Date of Death: _____/_____/_____

Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address or location where injury occurred:

What was the Employee Doing when Injury Occurred (loading truck, walking down stairs, etc.)**:**

How did the Injury or Disease Occur (be specific; include time that employee began work on the date of injury, any equipment, tools, substances or objects connected to the injury; attach additional sheet if necessary)**:**

Nature of Injury or Disease (cut, bruise, strain, etc.):

Body Part(s) Injured:

Are You Aware of, or Do You Suspect, a Prior Injury to this Body Part? ☐ Yes ☐ No

Do You Have Reason to Question this Injury? ☐ Yes ☐ No (If "yes," attach a specific explanation to this form).

Location of Initial Treatment: **Emergency Room?** ☐ Yes ☐ No **Hospitalized?** ☐ Yes ☐ No

Section IV — Wage and Lost Time Information

Date Hired: _____/_____/_____ | **Last Day Worked After Occupational Injury or Disease:** _____/_____/_____

Number of Work Days Lost: | **Date of Return to Work:** _____/_____/_____ | **Hours Worked per Week:**

Is Light Duty Available? ☐ Yes ☐ No | **Wage on Date of Injury: $** per ☐ hour ☐ day ☐ week ☐ month

Are Wages Being Paid to Injured Employee During Disability? ☐ Yes ☐ No | **If Employee has Returned to Work, is it Alternative or Modified Work?** ☐ Yes ☐ No If "yes," indicate current wage: **$** per ☐ hour ☐ day ☐ week ☐ month

Daily rate of pay on the date of injury: $ **and best quarter wages of preceding four quarters** $

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically West Virginia Code §61-3-24e, provides for severe penalties if I knowingly certify a false report or statement and/or withhold a material fact regarding any information requested. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly with fraudulent intent aiding or abetting anyone in securing or attempting to secure benefits to which he or she is not entitled.

Print Name: _____ **Title:** _____

Signature: _____ **Date:** _____/_____/_____

Form OIC-WC-1

West Virginia Workers' Compensation
Employees' and Physicians' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I — Employee's Claim Information

Insurer: **Third-Party Administrator:**

1. Name: (Last): (First): (M.I):

2. Address: **3. Telephone:**

City: State: Zip: **4. Social Security No.:**

5. Date of Birth: _____/_____/_____ **6. Sex:** ☐ M ☐ F **7. Marital Status:**

8. Date of Injury or Last Exposure: **Time:** ☐ a.m. ☐ p.m. **9. Time You Began Work on Date of Injury:** ☐ a.m. ☐ p.m.

10. Date You Stopped Working Due to Injury:

11. Have You Retired? ☐ yes ☐ no If "yes," what was the date you retired:

12. Employer's Name: Supervisor's Name:

Address:

City: State: Zip: Telephone:

13. Job Title/Description:

14. Body Part(s) Injured:

15. Describe How Your Injury Occurred (Specify the cause, what you were doing, and equipment/objects involved):

16. Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address where injury occurred:

17. Please Identify Any Witnesses to Your Injury:

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.

Employee's Signature: _____ **Date:** .

Section II — All Information Must Be Completed by Initial Healthcare Provider

1. Name of Physician/Hospital: **2. FEIN/Social Security No.:**

3. Address:

City: State: Zip: **Telephone:**

4. Date of Initial Treatment: **5. Date Patient May Return to Work:**

6. Have you advised the patient to remain off work 4 or more days?

☐ Yes. Indicate dates: from to

☐ No. If "no," is the patient capable of ☐ Full Duty ☐ Modified Duty If the patient is capable of returning to modified duty, specify any limitations/restrictions:

7. Condition is a direct result of: ☐ Occupational Injury? ☐ Occupational Disease? ☐ Non-Occupational Condition?

8. Did this injury aggravate a prior injury/disease? ☐ Yes ☐ No. If Yes, explain:

9. Description of injury or occupational disease:

10. Body part(s) injured: **11. ICD9-CM Diagnosis Code(s) in order of severity:**

12. Name of physician referred to: **13. If the patient was hospitalized, where?**

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia's Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Signature: _____ **Date:** _____/_____/_____

Who do I contact for information about my claim?

Your claim is managed by Berkshire Hathaway Homestate Companies (BHHC), which specializes in the management of workers' compensation claims. If you have any questions regarding your claim, or if you have not heard from us within 14 days of filing your claim, you should contact us directly at:

Berkshire Hathaway
Homestate Companies
P.O. Box 881716
San Francisco, CA 94188
Claims: (800) 661-6029

How does the claims process work?

When we receive your claim, your claim will be given a claim number and will be assigned to a claims adjuster. The claim number will identify your claim, and your claims adjuster will work with you to ensure that you receive the proper medical care and benefits, and to assist you with an appropriate return to work.

Once we have received your claim application, your claim will be reviewed, and you will receive a decision advising you whether your claim has been approved or denied, and what medical conditions are covered by your claim. If you disagree with the decision, you have a right to protest the denial by filing a written protest with the Workers' Compensation Office of Judges within 60 days from the day you receive the decision.

Protests must be in writing, and must include a copy of the decision being protested. Your protest must be sent to:

Office of Judges
P.O. Box 2233
Charleston, WV 25328-2233

Copies of your protest must also be sent to your employer, and to the West Virginia Offices of the Insurance Commissioner at the following address:

West Virginia Offices of the
Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

Under West Virginia law, by filing a workers' compensation claim you irrevocably agree that any physician may discuss, orally or in writing, your medical history and course of treatment with your employer and with BHHC. This information can include both information regarding your occupational injury or disease, as well as information regarding any prior injury or disease of the portion of your body which is the subject of your workers' compensation claim.

What if I miss work because of my injury?

If you are unable to return to work for four or more consecutive days, you may be eligible for temporary total disability benefits. In order to receive these benefits, your treating physician must certify on the proper forms that you are unable to return to work.

Depending on the nature of your injury, you may also be referred by us for a medical examination, which we will pay for, to evaluate your medical condition and the progress of your recovery. You may also be referred to a case management professional, who will assist you with your efforts to return to work.

You may also be able to return to work during your recovery period. Your claims adjuster may consult with your physician and your employer to determine whether your job duties can be modified to accommodate your injury during your recovery period.

How do I Choose a Physician?

If your illness or injury is an emergency, you should seek medical treatment at the nearest medical facility that can treat your illness or injury.

For treatment that is not emergency treatment, you may select the physician of your choice, so long as that physician

accepts payment from workers' compensation claims.

How Can I Change My Physician?

To change your treating physician, you must obtain prior authorization from your claims adjuster.

How do I get Medications?

Prior authorization is not required for most medications if they are prescribed within the first two weeks after the date on which you were injured. Certain narcotic medications require prior authorization by your claims adjuster after this initial two-week period, and all medications require prior authorization by your claims adjuster after twelve weeks from your date of injury.

If your physician prescribes a brand-name medication, and a generic brand of that medication is available, your pharmacist will fill your prescription with the generic brand. If a generic brand of the prescribed medication is available, and you choose to be provided with a brand-name medication, you must personally pay the difference between the cost of the generic brand and the brand-name medication.

If you have any questions regarding medications, you should contact your BHHC claims adjuster at (800) 661-6029.

west virginia
OFFICES OF THE
INSURANCE
COMMISSIONER

1-888-TRY-WVIC

P.O. Box 50540
Charleston, WV 25305-0540

Understanding the West Virginia Workers' Compensation Claims Process:

Information an Injured Worker Needs to Know

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OFFICES OF THE
INSURANCE
COMMISSIONER

Jane L. Cline
WV Insurance Commissioner

Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division®

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

Claim Number/Número de Reclamo

Date of Injury / Fecha de la Lesión

Employee/Empleado

Date of Birth / Fecha de Nacimiento

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

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

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

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

All employment and human resource information including but not limited to: hiring and employment records, payroll and income statements, documentation related to this or any other relevant injury and any other information pertinent to providing benefits and services necessary for the completion of this claim.

Toda información del empleo y de recursos humanos, incluyendo pero no limitado a: expedientes de contratación y empleo, declaraciones de nómina e ingresos, documentación relacionada a esta o cualquier otra lesión relevante, y cualquier otra información pertinente que provea los beneficios y servicios necesarios para completar este reclamo.

The released information is required for the following reasons:

La información liberada es requerida por las siguientes razones:

To provide for adequate preparation, investigation, evaluation, review, and discovery of a claim for workers compensation benefits. Specifically, to determine the causation and the nature and extent of any possible pre-existing, concurrent or aggravating medical conditions with potential medical, legal, or factual implications in the this work-related injury or injuries.

Para proporcionar una preparación, investigación, evaluación, revisión, y descubrimiento adecuado del reclamo de beneficios de compensación de trabajadores. Específicamente, para determinar la causa y la naturaleza y extensión de cualquier posible condición médica pre-existente, concurrente o agravante con potencial médico, legal, o implicaciones fácticas en esta lesión o lesiones relacionadas al trabajo.

To provide the treating physician, consultant or evaluator with medical information necessary to provide you with the best possible medical care and medical advice.

Para proporcionar al médico tratante, consultor, o evaluador con la información médica necesaria para proporcionarle el mejor cuidado médico posible y consejería médica.

To facilitate recovery of all benefits paid toward your workers' compensation claim from any third party responsible for this injury.

Para facilitar la recuperación de todos los beneficios pagados por su reclamo de compensación de trabajadores de cualquier tercer parte responsable de esta lesión.

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

To ensure that you are accurately compensated for any amount of lost wages, time or resources while undergoing evaluation, treatment and recovery for this injury.

Para asegurar que usted se encuentra compensado correctamente por cualquier cantidad de salarios, tiempo, o recursos perdidos mientras se somete a la evaluación, tratamiento, y recuperación de esta lesión.

To obtain any information necessary to appropriately determine further actions as a result of the injury or condition and to prevent further issues for you and other employees.

Para obtener cualquier información necesaria para determinar apropiadamente acciones adicionales como resultado de la lesión o condición, y para prevenir problemas adicionales para usted y otros empleados.

This consent and authorization is effective immediately, and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate on conclusion of the claim without express revocation.

Este consentimiento y autorización es efectivo inmediatamente, y está sujeto a la revocación del abajo firmante en cualquier momento excepto a la extensión en que se hayan tomado acciones en dependencia con esto de aquí en adelante, y si no es revocado anteriormente, terminará con la conclusión del reclamo si no se presenta una revocación expresa.

A copy or fax is as valid as the original.

Una copia o fax es tan válida como el original.

Names, Addresses, and Phone Numbers of Providers/Nombres, direcciones, y números de teléfonos de los proveedores

I have read this authorization and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

He leído esta autorización y entendido completamente su contenido en su totalidad. He hecho preguntas sobre todo lo que no estaba claro para mí y estoy satisfecho con las contestaciones que he recibido. Yo entiendo que tengo derecho a recibir una copia de esta autorización una vez lo solicite.

Signature/Firma

Date/Fecha

PRINT THIS FORM/ IMPRIMIR FORMULARIO

Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division®

Medical History Request

Employee Name _____ **Date of Injury** _____

Employer Name _____ **Completion Date** _____

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

Thank you for your cooperation.

Past Injuries, Disabilities, or Other Medical Conditions

Hospitalizations

Hospital Name & Address	Phone	Date(s) Adimitted

Treating Physicians or Groups

Doctor or Group Name, Address	Phone	Dates of Treatment

RESET FORM

PRINT THIS FORM

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Employee Incident Report

This for should be filled out by the injured employee.

Name

Employer Name

Date of Incident

Time of incident

Time you began work on day of incident

Address of Incident

City, State

Zip

Offsite? (Y/N)

Yes or No

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

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

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

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

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

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

What did you do after the incident occurred?

The above form is true and correct.

Signature

Date Completed

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Informe de Incidente del Empleado

A ser completado por el trabajador lesionado.

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Hora en que usted empezó a trabajar el día del incidente

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N)

Si/No

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

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

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

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

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

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

¿Qué hizo después de ocurrido el incidente?

El informe anterior es verdadero y correcto.

Firma

Fecha En Que Se Completó El Formulario

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Supervisor's Report of Employment Incident

Employee Name

Employer Name

Date of Incident

Time of incident

Time the employee began work on day of incident

Did the employee report the incident immediately? Yes or No

Address of Incident

City, State

Zip

Offsite? (Y/N)

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

RESET FORM

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Informe de Incidente del Supevisor

Nombre del empleado

Nombre del empleador

Fecha del incidente

Hora del incidente

Fecha en que se informó el incidente

¿Informó el empleado el incidente inmediatamente? Si/No

Dirección del Incidente

Ciudad, Estado

Código Postal

Fuera del sitio? (S/N) Si/No

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

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

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

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

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

¿Qué cambios se pueden realizar para eliminar o reducir el(los) peligro(s) identificado(s) anteriormente?

El informe anterior es verdadero y correcto.

Elaborado por

Puesto

Fecha de elaboración

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Witness' Report/Statement of Employee Incident

Employee Name

Witness' Name

Witness' Phone Number

Witness' Address

City, State

Zip

Offsite? (Y/N)

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

RESET FORM

PRINT THIS FORM

Berkshire Hathaway HOMESTATE COMPANIES
Workers Compensation Division®

Informe de Incidente del Testigo

Nombre del Empleado

Nombre del Testigo

Teléfono del Testigo

Dirección del Testigo

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/No)

Fecha Del Incidente

Hora del incidente

Dirección del incidente

Ciudad, Estado

Código Postal

Fuera del Lugar de Trabajo? (Si/ No) Si/No

¿Presenció el incidente? Si es así, ¿cómo ocurrió?¿Qué deberes laborales estaba realizando el empleado?

¿Qué parte(s) del cuerpo del empleado resultaron lesionadas? Describa el tipo de lesión (tensión, moretón, etc.)

¿Qué dijo el empleado lesionado en el momento de la lesión? ¿El empleado lesionado se quejó de dolor en el momento de la lesión? Si se quejaron de dolor, especifique la(s) parte(s) del cuerpo(s).

¿Qué hizo el empleado después de que ocurrió el incidente?

¿Había otros testigos presentes en el momento del incidente? Si es así, por favor escríbalos aquí.

La forma anterior es verdadera y correcta.

Firma del Testigo

Fecha

RESET FORM

PRINT THIS FORM

MyMatrixx
By EVERNORTH

Temporary Prescription Card

To the Injured Worker:

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

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

Atencion Trabajador Lesionado:

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

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

ID#: _____
Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: G3YA

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

Employee Information

_____
Full Name

_____
Street Address or PO Box

_____
City State ZIP

_____
Date of Birth

_____
Employer Name

To the Pharmacist:

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

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

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

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

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Participating Pharmacy List

AHF PHARMACY
AHOLD CORPORATION
ALBERTSONS
ALIGNRX LLC
AMERITA INC
AURORA PHARMACY INC
BIG Y FOODS INC
BI-LO HOLDINGS LLC
BROOKS/MAXI DRUG
BROOKSHIRE BROTHERS LTD
BROOKSHIRE GROCERY CO
CARDINAL HEALTH
CHEN NEIGHBORHOOD MEDI-CAL CENT
COBORN'S INC.
COSTCO WHOLESALE, INC
CVS CORP
DEDICATED US HOLDINGS LLC
DISCOUNT DRUG MART
ECKERD
EPIC PHARMACY NETWORK
ESSENTIA HEALTH
EXPRESS RX
FAIRVIEW PHARMACY SVCS
FAMILY FARE, LLC
FOOD LION PHARMACY
FRUTH PHARMACY
GENOA HEALTHCARE LLC
GIANT EAGLE PHARMACY
GUARDIAN PHARMACY LLC
HAC INC
HANNAFORD BROS. CO.
HARPS FOOD STORES INC
HARTIG DRUG
HEALTH MART ATLAS LLC
H-E-B LP
HENRY FORD HEALTH SYSTEM
HOMETOWN PHARMCY INC
HY-VEE FOOD STORES INC
INGLES MARKETS
INSTYMEDS CORP
KPH HEALTHCARE SERVICES
KS PHARM LLC
K-VA-T FOOD STORES INC
LEWIS DRUGS INC
LONGS DRUG STORE
MARC GLASSMAN INC
MEDICAP PHARMACY, INC.
MEDICINE SHOPPE
MEIJER PHARMACY
MERCY PHARMACY SERVICES
NCS HEALTHCARE
NEIGHBORCARE PHARMACY
OSBORN DRUGS INC
PATIENT FIRST
PHARMEDQUEST PHARMACY
PHARMERICA, INC
PMR US HOLDINGS
PRESBYTERIAN MEDICAL
PRESCRIBEIT RX
PRICE CHOPPER PHARMACY
PUBLIX SUPER MARKETS, INC
RALEY'S
RECEPT PHARMACY LP
RITE AID CORPORATION
SAFEWAY, INC.
SAM'S CLUB
SUPERVALU PHARMACIES, INC.
TARGET
THRIFTY WHITE STORES
TOPS MARKETS LLC
UNITED SUPERMARKETS INC
WALGREENS
WAL-MART
WEGMANS FOOD MARKETS,
WEIS MARKETS INC

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

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Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division®

$1000 REWARD

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

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

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

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

1 (800) 300-JAIL

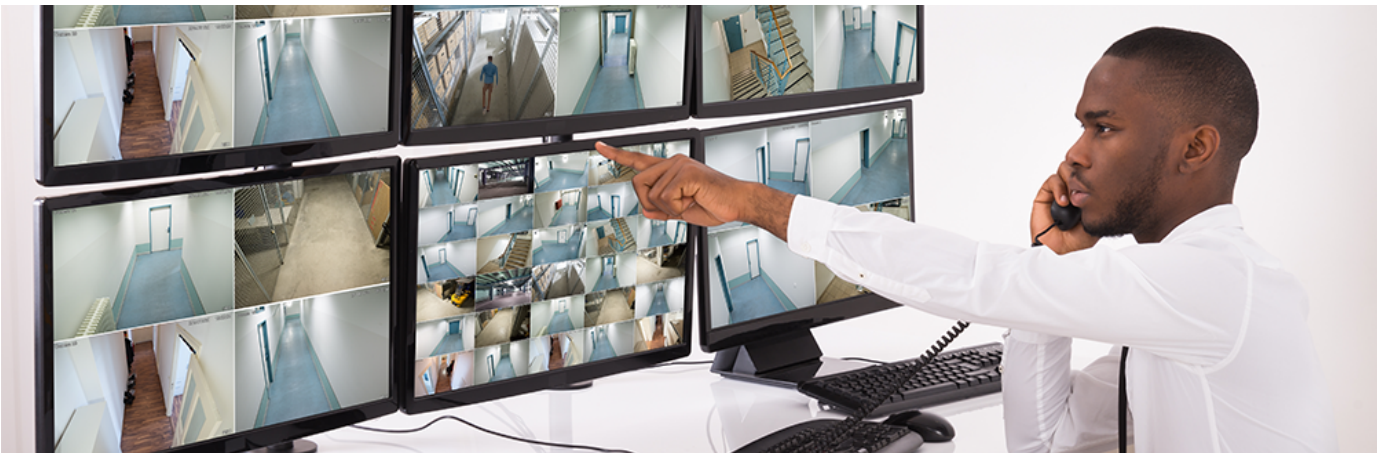
*Maximum reward of $1,000 per conviction. In the event that more than one individual submits information regarding the same fraudulent claim, BHHC will equally divide the reward among those providing information used in obtaining the conviction. BHHC reserves the right to determine what information,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

AM BEST A++ Superior

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

M.F.ENG.21.2.5.1

Berkshire Hathaway
HOMESTATE COMPANIES
Workers Compensation Division®



$1000 RECOMPENSA

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

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

Ayúdenos de su parte. El poner a estos delincuentes fuera de op eraciones nos beneficia a todos, incluso esto ayuda a mantener los réditos bajos de la as eguranza de su empleador.

Si usted tiene información sobre un reclamo fraudulento por favor llame de inmediato a nuestra LINEA GRATUITA DE FRAUDE.

1 (800) 300-JAIL

*La recompensa máxima es de $1,000 por convicción. En caso de que más de una persona presente informaciones sobre la misma demando fraudulenta. BerkshireHathaway dividirá la recompensa por partes iguales entre aquellas persones que aportaron informaciones para obtener la convicción. Berkshire Hathaway se reserva el derecho de determinar qué informacion presentará a la agencia judicial correspondiente. El proceso de crímenes es la responsibilidad exclusiva de las autoridades, que pueden decidir si el proceso debe entablarse or no. Cualquier disputa que pudiera surgir en la interpretación de esta ofreta será resuelta por la propia Compañia de Seguros Berkshire Hathaway. Este programa está sujeto a cambios a cancelación sin aviso previo.

AM BEST A++ Superior

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For the latest Best Credit Rating, access ambest.com.

M.F.SP.21.2.5.1