



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Division®

Workers Compensation State Claim Kit

Maine



Table of Contents

BHHC ME Claims Kit Introductory Letter - 05/2026	1
BHHC Requirements for ME Posting Notice - 05/2026	2
ME Form WCB-90 – Workers’ Compensation Poster– 04/2026.....	3
ME Form WCB-1 – Employer’s First Report of Occupational Injury or Disease – 01/2013	4
ME Form WCB-2 – Wage Statement – 06/2026.....	5
ME Form WCB-2B – Fringe Benefits Worksheet– 06/2026.....	6
ME Form WCB-220 – Limited Certificate Authorizing Written Release of Medical-Health Care Info – 10/2023	7
BHHC Medical History Request – 04/2026.....	9
BHHC General Employee Incident Report - 04/2026	10
English.....	10
Spanish	11
BHHC General Supervisor Incident Report - 04/2026.....	12
English.....	12
Spanish	14
BHHC General Witness Incident Report – 04/2026	16
English.....	16
Spanish	17
BHHC Express Scripts First Fill Form (English & Spanish) – 02/2025	18
BHHC Workers’ Compensation Fraud Posters - 04/2026	20
English.....	20
Spanish	21

P.O. Box 881236 San Francisco, CA 94188

(888) 495-8949

bhhc.com

Dear Policyholder,

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

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

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

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

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

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

BERKSHIRE HATHAWAY HOMESTATE COMPANIES



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



Workers Compensation Posting Requirements

Form WCB-90

Workers' Compensation Board Notice to Employees

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

(39-A Maine Revised Statutes § 406)



WORKERS' COMPENSATION

WORKERS' COMPENSATION BOARD REGIONAL OFFICES

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

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

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

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

CARIBOU
658 Main Street, Suite 1
Caribou, ME 04736
207-498-6428
1-800-400-6855

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

Notice to Employees:

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

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

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

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

A l'intention des Employes:

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

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

La loi interdit aux employeurs de classer fallacieusement leurs salariés comme étant des contractants privés aux fins d'échapper à l'assurance compensatrice-employé, aux

indemnités de chômage, ou aux autres charges et retenues dues par employeur. Pour plus de détails sur la législation relative à l'utilisation des services privés, visitez le site internet de Worker Misclassification Task Force (Unité anti-fraude en matière de classification des salariés) : www.maine.gov/labor/misclass.

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

Aviso a los Trabajadores:

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

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

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

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

ENGLISH	Interpreters Available When calling for assistance, please say the name of your language in English and an interpreter will be called for you. Please stay on the line.	POLISH	Tłumacze dostępni na życzenie. Aby uzyskać pomoc tłumacze, proszę powiedzieć po angielsku "Polish" i czekać na linii.	VIETNAMESE	“Cố Thông Dịch Viên” “Khi gọi điện thoại để được giúp đỡ, xin quý vị hãy nói “VIETNAMESE” để chúng tôi cho thông dịch viên giúp quý vị. Xin quý vị chờ trên đường dây.
SPANISH	Tenemos intérpretes a su disposición Si necesita que le atiendan en español por favor diga “Spanish” y le conectaremos con un intérprete. Por favor manténgase en la línea.	RUSSIAN	“К вашим услугам имеются переводчики” “Когда Вы обращаетесь за помощью по телефону, пожалуйста скажите, что Вы говорите по-русски (произнесите “РАШН”), и мы обеспечим Вас переводчиком. После этого, пожалуйста, оставайтесь на линии.”	ARABIC	مترجمون شفيون متيسرون لخدمتكم عند إتصالكم للمساعدة أو لطلب خدمة معينة نرجو منكم أن تذكروا (أ-ز-ب-ك) ونحن سنقدم لكم مترجماً شفيياً . ابقوا على الخط من فضلكم.
PORTUGUESE	Temos intérpretes à sua disposição Se precisar de atendimento em Português, por favor diga “Portuguese” e um intérprete será prontamente chamado. Por favor, aguarde na linha.	CHINESE	提供口譯服務 打電話請求幫助時，請用英語說“拼音呢斯”(CHINESE)——我們將為您提供口譯人員。請不要挂斷電話。	PERSIAN	افراد مترجم در دسترس مي باشند. را كه بدان صحبت مي كنيد به انگليسي ذكر كنيد تا راجع به امري به ما تلفن مي كنيد، لطفاً نام زباني قطع نكنيد. هنگاميكه براي درخواست كمك يا شما تماس گرفته شود. لطفاً روي خط منتظر بمانيد. با يك مترجم براي
ITALIAN	Abbiamo interpreti disponibili Se avete bisogno di assistenza in Italiano, Vi preghiamo di dire “Italian” e un interprete sarà messo a Vostra disposizione. Vi preghiamo di rimanere in linea.	JAPANESE	通訳サービスをご利用いただけます 通訳を必要とされる場合は「ジャパニーズ」とおっしゃり、通訳がでるまでそのままでお待ちください。	SOMALI	Turjunaanno waa la helayaa Marka aad caawinaad inoogu soo yeeranaysid, fadhlan luqaddaada af Ingiriisi inoogu sheeg turjubaan ayaa lguugu yeeri doonaaye. Taleefoonkana ha dhigin.
FRENCH	Des interprètes sont à votre disposition Lorsque vous appelez pour demander de l'aide, prononcez le mot “French” et nous mettrons un interprète à votre disposition. Prière de rester en ligne.	KOREAN	한국어 통역을 이용하실 수 있습니다. 도움이 필요하여 전화를 거실 때 영어로 코리언 (KOREAN)이라고 말씀하시면 통역자를 연결해 드릴 것입니다. 전화를 끊지 마시고 기다리십시오.		

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

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

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

REASON FOR REPORT (check all that apply)

- 2a. ☐ LOST TIME - ONE OR MORE DAYS 2b. WAS EMPLOYEE PAID FOR 1J DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO
3. ☐ LOST EARNINGS BUT NO LOST TIME 4. ☐ MEDICAL/HEALTH CARE 5. ☐ FATALITY DATE OF DEATH: ____/____/____
MM DD YYYY
- 6a. ☐ OCCUPATIONAL DISEASE 6b. DATE OF LAST EXPOSURE: ____/____/____
MM DD YYYY 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____
MM DD YYYY
- 7a. ☐ CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: ____/____/____
MM DD YYYY 7c. DATE CORRECTION SENT TO WCB: ____/____/____
MM DD YYYY

EMPLOYER

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

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

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

EMPLOYEE

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

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ____/____/____ MM DD YYYY		43. DATE OF INCAPACITY: ____/____/____ MM DD YYYY		44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.):		45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ MM DD YYYY	
DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY		DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY		46. TIME OF INJURY (e.g. 1:10 p.m.):		47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO IF YES, GIVE DATE: ____/____/____ MM DD YYYY	
48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):		49. BODY PART(S) AFFECTED (e.g. lower right forearm):		50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):			
51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring):				52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):			
WAS ACTIVITY PART OF NORMAL JOB DUTIES? ☐ YES ☐ NO							
53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO		54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO:		55. HEALTH CARE PROVIDER NAME:		56. MAILING ADDRESS:	
						57. TELEPHONE NUMBER: ()	

PREPARER INFORMATION

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

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

1. REVISION DATE:		FRINGE BENEFITS WORKSHEET		2. WCB FILE NUMBER (REQUIRED):	
EMPLOYEE					
3. EMPLOYEE LAST NAME:		4. FIRST NAME:		5. MI.:	
				6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. EMPLOYEE MAILING ADDRESS:		8. CITY:		9. STATE:	
				10. ZIP:	
				11. PHONE NUMBER:	
12. DATE OF INJURY:		13. SPECIFIC INJURY OR ILLNESS:		14. BODY PARTS (S) AFFECTED:	
EMPLOYER/INSURER					
15. INSURER FILE NUMBER:		16. EMPLOYER NAME:		17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	
18. INSURER NAME:		19. INSURER MAILING ADDRESS AND PHONE NUMBER:			
NOTICE TO EMPLOYEE					
For assistance with your claim, visit: https://www.maine.gov/wcb/Departments/crs/regionaloffices.html or call 888-801-9087.					
Form Instructions: (1) For each Fringe Benefit listed on the form, indicate if the benefit is provided. - If the benefit is provided at no cost to the employer, "No" may be selected. (2) For each Fringe Benefit provided, indicate if the benefit continues while the employee is out of work. (3) For each Fringe Benefit that does not continue, provide a date the benefit ends and the weekly cost of the benefit. - If the date is unknown, "TBD" or "Unknown" are acceptable. - A percentage may be submitted in lieu of a dollar amount for a 401K fringe benefit.					
20. Fringe Benefit	Is the Fringe Benefit provided?	Does the benefit continue while the employee is out of work?	Date Benefit Ends	Weekly Cost to Employer	
Health Benefits (incl. insurance)	Yes ☐ No ☐	Yes ☐ No ☐			
Dental Insurance	Yes ☐ No ☐	Yes ☐ No ☐			
Disability Insurance (inc. short and long term)	Yes ☐ No ☐	Yes ☐ No ☐			
401K	Yes ☐ No ☐	Yes ☐ No ☐			
Life Insurance	Yes ☐ No ☐	Yes ☐ No ☐			
Education/Training	Yes ☐ No ☐	Yes ☐ No ☐			
Pension	Yes ☐ No ☐	Yes ☐ No ☐			
Other (please list):	Yes ☐ No ☐	Yes ☐ No ☐			
Other (please list):	Yes ☐ No ☐	Yes ☐ No ☐			
21. TYPE OR PRINT PREPARER NAME (REQUIRED):		22. TELEPHONE NUMBER (REQUIRED):		23. DATE SENT TO WCB :	
E-MAIL ADDRESS (REQUIRED):		TOLL-FREE NUMBER:		WCB USE ONLY:	



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

Name:

SSN (last 4 digits): XX-XX-

Date of Birth:

Date of Injury/Illness:

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

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

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

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

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

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

☐ None

☐ Exclusions: _____

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

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

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

Acknowledgements:

- **Voluntary:** I understand I have the right not to sign or complete this form. If I exercise that right, the insurer may deny my claim and file a Notice of Controversy (“NOC”). Please note: If a NOC is filed, a Troubleshooter from the Board will contact you and try to resolve the disagreement. More information is available here: www.maine.gov/wcb/employees.html.
- **Redisclosure:** I understand the information provided pursuant to this release can be redisclosed for the limited purpose of determining whether my claim for benefits pursuant to the Workers’ Compensation Act (Title 39-A) is compensable.
- **Revocable:** I understand I may revoke this authorization at any time in writing, subject to the rights of any individual who acted in reliance on the authorization prior to receiving notice of revocation, but doing so may result in a loss of, or reduction in, entitlement to workers’ compensation benefits. I must revoke my authorization by completing and sending WCB Form 220-R to the recipient listed below. The WCB form 220-R is effective only after it is received and does not apply to information that was already disclosed.
- Upon my request, I am entitled to a copy of this authorization and to inspect or copy information disclosed hereunder.
- A copy of this Authorization shall have the same force and effect as the original. Subsequent disclosures may be made under this Authorization.

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

Address of recipient/recipient’s employer:

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

Mail to: _____

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

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

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



Berkshire Hathaway
HOMESTATE COMPANIES

Workers Compensation Division®

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 o 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 sujeta a cambios a cancelación sin aviso previo.