



PO Box 12058
Austin, TX 78711-2058

Important Insurance Documents Enclosed

FRANK SWINGLE & ASSOCIATES INC
DBA: SWINGLE COLLINS & ASSOCIATES
13760 NOEL RD STE 600
DALLAS TX 75240-1381

Please forward the Insured's copy to them immediately.

CONFIDENTIALITY NOTICE: This communication may contain confidential, proprietary or privileged information and is intended only for the person to whom the communication is addressed. If you are not the intended recipient, please immediately notify Texas Mutual's information services center at (800) 859-5995 or information@texasm mutual.com and destroy all copies of the communication as your use, disclosure, copying or storage of the communication is prohibited and may be a violation of state or federal law.

Important Notice: Your Texas Mutual policy provides coverage for claims made by Texas employees for Texas benefits only.
If you have employees that need workers' compensation coverage in other states, notify your agent immediately.

2023-04-03



PO Box 12058
Austin, TX 78711-2058

Important Insurance Documents Enclosed

STONEFIELD HOMES LLC
5001 LBJ FWY STE 850
DALLAS TX 75244-6156

Please forward the Insured's copy to them immediately.

CONFIDENTIALITY NOTICE: This communication may contain confidential, proprietary or privileged information and is intended only for the person to whom the communication is addressed. If you are not the intended recipient, please immediately notify Texas Mutual's information services center at (800) 859-5995 or information@texasmutual.com and destroy all copies of the communication as your use, disclosure, copying or storage of the communication is prohibited and may be a violation of state or federal law.

Important Notice: Your Texas Mutual policy provides coverage for claims made by Texas employees for Texas benefits only.
If you have employees that need workers' compensation coverage in other states, notify your agent immediately.

2023-04-03



4/3/23

Information From Your Underwriter

Insured copy

Regarding
STONEFIELD HOMES LLC

Policy no.
0001285647

Policy period
4/7/23 to 4/7/24

Dear Policyholder,

Thank you for placing your account with Texas Mutual Insurance Company. For your convenience, we are enclosing a copy of your workers' compensation policy along with two claim-reporting forms you may use if one of your employees has a work-related accident.

You can also save time by reporting your injuries online at texasmutual.com. Our website also offers services that allow you to view your claim information, create your own customized loss reports, manage your workplace safety programs and stay up-to-date with Texas Mutual® news and events.

As the state's leading provider of workers' compensation insurance, we strive to set the standard in Texas for service, communication, and ease of doing business. If you have any questions, please email us at information@texasmutual.com or call us at (800) 859-5995.

Sincerely,

Lisa Lyngos
Underwriting Team

4/3/23

Welcome Letter
Insured copy

Regarding
STONEFIELD HOMES LLC

Policy no.
0001285647

Policy period
4/7/23 to 4/7/24

Dear Policyholder,

Enclosed is our policyholder packet. Thank you for choosing Texas Mutual Insurance Company. We know you have a choice of workers' compensation carriers, and we are determined to continue to earn your business. As a policyholder-owned mutual company, Texas Mutual is singularly focused on serving you and your employees.

We work hard to help you control your premium, fight workers' compensation fraud and prevent workplace accidents. If your employees get injured on the job, our professionals are committed to helping them get well and return as productive members of the workforce.

Thank you again for your partnership. Please let us know if there is anything we can do to improve our service to you.

Sincerely,



Jeanette Ward
President & CEO

Making the most of Texas Mutual services

Thank you for choosing Texas Mutual Insurance Company. This brief guide will help you get the most value from your Texas Mutual coverage.

Earn dividends

Dividends reward loyal customers who share Texas Mutual's commitment to preventing workplace accidents. Visit texasmutual.com/OwnershipPays to learn more about dividends.

Understand your premium

Your annual premium is an estimate based on your payroll, the type of work your employees perform, your loss history, your safety programs and other factors. At the end of your policy period, we will review your account to determine your actual payroll and/or any operational changes during the policy year. If necessary, we will adjust your premium accordingly. You may get money back, or you may be billed.

Report injuries

- Report injuries the same day they happen, if possible. The fastest way to report injuries is at texasmutual.com. If you cannot report online, you may report by phone at (800) 859-5995, or send a completed DWC-1 form (available on our website – texasmutual.com) by fax to (877) 404-7999 or by mail to Texas Mutual Insurance Company, P.O. Box 12029, Austin, Texas 78711-2029.
- Give the employee a copy of the injury report and the "Employee's Rights and Responsibilities" brochure. The brochure can be located on the Texas Mutual Website or The Texas Department of Insurance Website.
- Keep accurate records of the dates when you take any claim-related action, including when you file a Supplemental Report of Injury (DWC-6 form) or Employer's Wage Statement (DWC-3 form). You are required to give a copy of these forms to the employee at the time of completion.
- You can complete the DWC-3 online by going to Texas Mutual Online (texasmutual.com) and clicking on the Employer Tab. This is the preferred method, but you can also complete the form manually and fax it to our office.
- If you have a network policy, you are required to give the employee a copy of the "Notice of Network Requirements" within three days of new employee hire and at the time of injury. The employer must provide employees with a notice of network requirements, which can be located on our website, in English, Spanish, or any other language common to employees. Additional network requirements can be located on our website.

Prevent workplace accidents

An investment in workplace safety is an investment in your employees and your bottom line. By preventing accidents, you can reduce your workers' compensation costs and improve your productivity. Texas Mutual is your partner in safety. Whether you need help finding free safety resources on our website or advice on a specific safety issue, we are here to help. Simply call us toll-free at 844-WORKSAFE between 8 a.m. and 5 p.m. Central Standard Time (CST) to speak with a knowledgeable, responsive safety services support center representative. You also have access to a multimedia library of 2,000 free training materials in the safety resource center at texasmutual.com.

Launch a return-to-work process When employees miss work due to on-the-job injuries, their employers must find a way to make up for lost production. Meanwhile, injured employees must contend with the depression and financial stress that often come with being away from work. Texas Mutual works with you to get your injured employees well and back on the job. Visit texasmutual.com/safety/rtwtools.shtm for more information and free tools.

Fight fraud Workers' compensation fraud is bad for your business. Our investigators specialize in protecting your premium dollars from the trickle-down effects of fraud. Visit the Fighting Fraud section at texasmutual.com to learn how you can help us stop those who try to cheat the system.

Save time with Texas Mutual® online You can handle most of your workers' comp needs at texasmutual.com. Visit our website to report injuries, get free safety training materials, review claim detail reports, submit interim payroll reports and report suspected fraud.

Get Telephone assistance Use our enhanced automated phone services at (800) 859-5995 between 6 a.m. and 9 p.m. CST to:

- Verify quote and policy status, including issue date and policy period
- Check payment status, including amount and receipt date
- Retrieve return payment information, including check number and issue date
- Confirm deposit and/or premium amount due
- Verify claim number and assigned workers' compensation specialist
- Get address and fax information

Representatives are available between 8 a.m. and 5:30 p.m. CST to help with:

- Interim and final audit information
- Information and enrollment for free policyholder workshops
- Access to password-protected online services and password reset
- Workers' comp health care network information
- Any of your workers' comp needs

Did someone get injured on the job? We hope you never experience a workplace accident, but if you do, you need to know some basic information about the claims process. Visit the Employers section at texasmutual.com, and click on Claims to learn what to do if an employee gets injured on the job.

Register for our email newsletter Texas Mutual's free, monthly email newsletter includes tips on workplace safety, return-to-work, and other strategies for reducing your workers' comp costs and improving your productivity. To register, visit texasmutual.com/news/phenews.shtm.

4/3/23

Privacy Notice

Insured copy

Regarding
STONEFIELD HOMES LLC

Policy no.
0001285647

Policy period
4/7/23 to 4/7/24

Privacy Policy

The management and staff of Texas Mutual Insurance Company are committed to maintaining the confidentiality of non-public, personal information. We do not disclose any non-public, personal information about our customers to anyone, except as permitted by law. We do not sell any information about our customers to mailing list companies or mass marketing organizations.

What information is collected about our customers?

As a workers' compensation insurance carrier, we may collect non-public, personal information directly from our customers or their agents. We use this information only to serve our customers' insurance needs, conduct company business, and fulfill legal and regulatory requirements. For example, we collect information from our customers and their agents, such as:

- company name, address, and federal identification number;
- payroll, assets, and employee class codes; and
- loss runs (history of the number and severity of workplace injuries and illnesses).

We may obtain information from customer transactions and other dealings with us such as payment history and premium balance. From our customers' injured workers, we may obtain contact information, health information, and information regarding wages and benefits. Also, depending on the nature of the transaction, we may collect information from other third parties, including health care providers, other insurance companies, government agencies, information clearinghouses, courts, and other public records.

Confidentiality and security measures

We treat non-public, personally identifiable customer information, including information related to injured workers, as confidential, and we maintain physical, electronic and procedural safeguards to protect personal information. Texas Mutual Insurance Company employees and contractors who have access to our customers' non-public, personally identifiable information are those who need it for business purposes. We also instruct our employees on the importance of maintaining the confidentiality of our customers' information. We may share customer information with third-party vendors as necessary to perform our business operations.

At Texas Mutual Insurance Company, we respect our current and former customers' privacy. We are proud of the strong relationships we have built over the years, and we value your business.

Information we collect on our website

Texas Mutual Insurance Company collects no personal information about you when you visit our website unless you choose to provide this information to us. However, we do collect and store general usage information about visitors coming to our website to help us improve the quality of our services and provide you with a positive experience, and we may combine your information with information we collect from third parties or public sources. We collect the Internet Protocol addresses (including the city, domain address, and service provider), the session identification, and we create an activity log.

We or third party online advertising and analytics companies may use tools and services to gather, analyze, and store information about users, including for statistical purposes, reporting, attribution, analytics, market research, interest-based advertising, ad delivery, and other purposes described in this Privacy Policy. These third parties use cookies, web beacons, and similar technologies that are placed on your computer to help analyze how you use online services. We use Google Analytics, a web analytics service provided by Google, Inc and, on Texas Mutual Online, we also use Acoustic Experience Analytics (Tealeaf) provided by Acoustic. Please use the following link to understand how Google Analytics collects and processes data <https://www.google.com/policies/privacy/partners/>.

United States only operations

Texas Mutual controls and operates its websites from locations in the United States. By using Texas Mutual's websites, you consent to the transfer of your personally identifiable information within and to the United States.

4/3/23

Safety Services

Insured copy

Notice to Policyholder/Agent:

Pursuant to Texas Labor Code §411.066, Texas Mutual Insurance Company is required to notify its policyholders that accident prevention services are available from Texas Mutual Insurance Company at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene, and industrial health services. Texas Mutual Insurance Company is also required to provide return-to-work coordination services as required by Texas Labor Code §413.021 and to notify you of the availability of the return-to-work reimbursement program for employers under Texas Labor Code §413.022.

If you would like more information, contact Texas Mutual Insurance Company at 844-WORKSAFE (967-5723) and safety@texasmutual.com for accident prevention services or 844-WORKSAFE (967-5723) and safety@texasmutual.com for return-to-work coordination services. For information about these requirements call the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) at 1-800-687-7080 or for information about the return-to-work reimbursement program for employers call the TDI-DWC at (512) 804-5000. If Texas Mutual Insurance Company fails to respond to your request for accident prevention services or return-to-work coordination services, you may file a complaint with the TDI-DWC in writing at <http://www.tdi.texas.gov> or by mail to Texas Department of Insurance, Division of Workers' Compensation, MS-8, at 7551 Metro Center Drive, Austin, Texas 78744-1645.

In addition to the services above, Texas Mutual offers thousands of free materials in our Safety Resource Center at texasmutual.com. The resource center is home to an extensive library of free DVDs, posters, handouts and online videos, many of which are available in Spanish. Texas Mutual regularly enhances the resource center to provide tools that meet your ever-changing needs. We understand, however, that you may need to speak with a professional about specific safety issues. With our safety services support center, help is just a phone call away.

Simply dial 844-WORKSAFE (967-5723) between 8 a.m. and 5 p.m. CST. Our knowledgeable, responsive representatives are ready to:

- Help you access streaming videos, interactive tools and other free safety resources at texasmutual.com
- Identify your industry's top safety hazards and suggest best practices that address those hazards
- Conduct virtual surveys of your workplace
- Suggest specific safety programs that address your unique needs

Thank you for choosing Texas Mutual Insurance Company as your workers' compensation carrier. We value your business and will work hard to continue earning it.



TexasMutual®
WORKERS' COMPENSATION INSURANCE
WORK SAFE. TEXAS.



WORKWELL, TX

Health care network information | As of October 1, 2022



Dear Employer,

At Texas Mutual Insurance Company, we are committed to the safety of Texas workers. WorkWell, TX serves as an extension of that commitment, ensuring quality care for employees who are injured on the job.

WorkWell, TX is a workers' compensation health care network certified by the state of Texas. By choosing the network option from Texas Mutual, you keep your costs low with a network discount and our focus on getting injured workers well and back on the job. Our providers have been chosen to treat your employees because of their proven record of success with work-related injuries and illnesses.

A network that offers high-quality care, better results, and savings is a win-win for you and your employees.

To help introduce your employees to WorkWell, TX, this packet offers information and resources, which they must read and sign. Start by reviewing the checklist below to discover what you and your workforce will need to know and do in case an injury occurs.

Employer Checklist

1. Review this packet.
2. Post the **Notice of Network Requirements** in a common area where your employees will see it.
3. Distribute the Notice of Network Requirements to employees when you begin the program, within 3 days of hiring a new employee, and at the time of injury. Keep a record of how, when, where and to whom you delivered the Notice of Network Requirements.
4. Have all employees sign the **Employee Acknowledgment** form and keep it in the employee's personnel file. (An employee who refuses to sign remains subject to network requirements. Document a refusal to sign the acknowledgment in the employee's personnel file.)
5. When an injury occurs, report it immediately to Texas Mutual and if necessary, provide or arrange transportation for the injured employee to the network provider, or emergency facility if appropriate.
6. Work-related injuries must be treated by network-approved physicians. Review the online provider directory on texasmutual.com for a list of network providers. If you or an injured employee needs help locating a provider, you may call WorkWell, TX at (844) 867-2338.

Thank you for choosing WorkWell, TX. If you have any questions, please contact us at (844) 867-2338 or visit texasmutual.com.

Sincerely,

WorkWell, TX Support Team
(844) 867-2338



WORKWELL, TX



WORKWELL, TX

Notice of Network Requirements

(Post in visible area for all employees)

Your employer has chosen WorkWell, TX as its certified workers' compensation health care network in partnership with Texas Mutual Insurance Company, a workers' compensation insurance carrier. WorkWell, TX will manage the health care and treatment you may receive if you are injured on the job or diagnosed with an occupational illness while employed here. WorkWell, TX doctors are trained in treating work-related injuries and illnesses and getting people back to work and back to a productive life.

The information in this packet will help you to seek care for your injury and describes what to do if you are injured while on the job.

What to do if you are injured while on the job

If you are injured at work, tell your employer right away. Your employer will help with any questions you may have about seeking treatment through WorkWell, TX. You may also contact Texas Mutual if you have any questions about your treatment. Our shared goal with your employer is to return you to work as soon as it is safe to do so.

A list of network doctors in your service area is available on texasmutual.com or by downloading the WorkWell, TX mobile app. You may contact us at (844) 867-2338 or at the address below for assistance.

WorkWell, TX
Attn: Network Services
PO Box 12029
Austin, TX 78711-2029

In case of an emergency

If you are injured and it is an emergency, you should seek treatment at the nearest medical care facility immediately. This also applies if you are injured outside the service area. Emergency care does not require preapproval. Texas law defines "medical emergency" as a medical condition that comes up suddenly.

After you receive emergency care, you may need ongoing care. Select a network doctor from the WorkWell, TX network. The doctor you choose will oversee the care for your injury. You must obtain referrals to see another health care provider or specialist from your treating doctor, except for emergency care.

Non-emergency care

Report your injury to your employer as soon as you can. Find a network treating doctor on texasmutual.com or by downloading the WorkWell, TX mobile app. Go to that doctor for treatment.

Treatment prescribed by your doctor may need to be approved in advance. Your doctor needs to request approval from the network for a specific treatment before the treatment or service is provided. You may continue to need further care after completing the approved treatment.

Choosing a treating doctor

If you are hurt at work and it is not an emergency and you live in the network service area, you must choose a treating doctor from the WorkWell, TX network. This is required so that WorkWell, TX covers the costs for the care. If you belong to a health maintenance organization (HMO) at the time of your injury, you may choose your HMO primary care doctor as your treating doctor. You must have chosen the doctor as your primary care doctor before your injury. We will approve the choice of your HMO doctor if they agree to the terms of the network contract and to abide by applicable laws.

For a list of network doctors available in your area, please visit texasmutual.com or download the WorkWell, TX mobile app. The WorkWell, TX provider directory is updated monthly. Doctors who speak Spanish or who are no longer taking new patients will be flagged with an icon on their record.

If your treating doctor leaves the network, we will notify you in writing. You will have the right to choose another treating doctor from the network directory. If your doctor leaves the network and you have a life threatening or acute condition for which a disruption of care would be harmful to you, your doctor may request to continue your treatment for an extra 90 days.

If you live outside of the service area, you may request a service area review by calling Texas Mutual. You should provide proof to support your request. Texas Mutual will inform you of its decision within seven days of receiving your request. If you disagree with Texas Mutual's final decision, you have the right to file a complaint with the Texas Department of Insurance. Your complaint must include your name, address, phone number, a copy of Texas Mutual's decision and any proof you sent to Texas Mutual for review. A complaint form is available on the Department's website.

When waiting for Texas Mutual to make a decision or for the Texas Department of Insurance to review your complaint, you are still expected to use the network for all health care. You may be required to pay for health care services received out of the network if it is decided you do live in the network's service area.

Changing doctors

If you are not satisfied with your first choice of a treating doctor, you can select a different treating doctor from the network directory. We will not deny your choice to see a different treating doctor. Before you can change treating doctors a second time, you must get permission from the network by calling (844) 867-2338.

Referrals

You do not have to get a referral if you have an emergency. All other health care and specialist referrals should be made through your treating doctor. All health care services that you request will be made available by the network on a timely basis, as required by your medical condition. This includes referrals. All health care services, including referrals, will be made available within 21 days after your request.

Out-of-network approvals

WorkWell, TX must approve all of your treating doctor or specialist's out-of-network referrals before you visit the provider. If you need to request approval, please call (844) 867-2338.

Payment for health care

Network doctors have agreed to seek payment from Texas Mutual for your treatment. They will not look to you for payment. If you receive treatment from a doctor who is not in the network without prior approval from WorkWell, TX, you may have to pay for the cost of that care. Medical costs for treatment by non-network health care providers may be covered only if one of the following situations occurs:

- Emergency care is needed. You should go to the nearest hospital or emergency care facility.
- You do not live within the service area of the network.
- Your treating doctor or specialist refers you to an out-of-network provider or facility and WorkWell, TX approves the referral.
- You have chosen your HMO primary care doctor. Your doctor must agree to abide by the network contract and applicable laws.

Preadmission, adverse determination and independent review

A list of the procedures and services that need preauthorization is on texasmutual.com. The list in this packet is not intended to be all-inclusive; health care is an evolving science. Procedures and treatments requiring prior approval will also evolve. Treating providers should verify preauthorization requirements by referring to the updated list on texasmutual.com.

If WorkWell, TX denies the request, you or the requesting doctor may ask for a review of that decision. If still dissatisfied, you, your provider or a person acting on your behalf may request an independent review. The preauthorization agent will provide any relevant medical records related to the injury to the independent review group. They may also provide any treatment guidelines used and a list of the doctors who provided care to you.

Complaints

We take your concerns seriously. If you are dissatisfied, you can file a complaint with WorkWell, TX. You may do this if you are not satisfied with any aspect of the network, including care you received. You must file your complaint within 90 days after the date of the event that is the basis for the complaint.

If you have questions about the complaint process you can reach the Grievance Coordinator by phone at (844) 297-5723, by fax at (512) 224-8800, by email at wwtxcomplaints@texasmutual.com, or by mail at the address below.

WorkWell, TX
Attention: Grievance Coordinator
PO Box 12029
Austin, Texas 78711-2029

Texas law does not permit WorkWell, TX to retaliate against you if you file a complaint against the network. We will not retaliate if you appeal the decision of the network. The law does not permit us to retaliate against your treating doctor if they file a complaint against the network or appeal the decision of the network on your behalf.

You have the right to file a complaint with the Texas Department of Insurance. A complaint form is available on the Department's website.

WorkWell, TX Preauthorization List

Hospital/ASC

All non-emergency hospital or ASC (inpatient, outpatient, and observation) admissions including principle scheduled procedures and length of stay. Preauthorization request should include specific hardware, implantables, external delivery system, etc. to be utilized.

Surgery/Procedures/Integral Devices

All non-emergency surgeries represented by AMA CPT codes 10010-69990 and/or G codes which represent a surgical procedure performed in a setting or place of service other than the doctor's office [POS 11]. Preauthorization request should include specified hardware, implantables, external delivery system, etc. to be utilized.

- All botox injections
- All spinal injections (including but not limited to):
 - » Epidural steroid injections
 - » RFTC or cryotherapy/cryoablation
 - » Sacral iliac joint injection
 - » Facet injection
 - » Medical branch block
- Trigger point injections (AMA CPT 20553)
- Bone growth stimulators
- Discograms
- Implantable drug delivery system
- Investigational or experimental procedures or devices as determined by ODG or listed as an AMA category III code. Stimulator devices (including, but not limited to):
 - » TENS units
 - » Interferential units
 - » Neuromuscular stimulators
 - » Dual units
 - » Spinal cord stimulator
 - » Peripheral nerve stimulator
 - » Brain stimulator

Physical Medicine

- All chiropractic treatments
- Manipulations under anesthesia (MUA)
- All PT/OT (unless requestor or rendering provider/facility is participating through Align)
- Biofeedback

Diagnostics

- All initial and repeat MRI and CT scans
- Bone density scans
- Surface electromyography (EMG)
- Unless otherwise specified in this list, all repeat individual diagnostic studies (series) having a billed amount greater than \$350.

Other

- Durable medical equipment (DME), prosthetics and/or orthotics, greater than \$500.00 billed (purchase or accumulated rental or combination of rental/purchase)
- Gym memberships
- Texas Department of Insurance, Division of Workers' Compensation (DWC)
Pharmacy Closed Formulary per 28 TAC §134, Subchapter F.

Alternative Treatment

- Acupuncture outside ODG
- Acupressure
- Yoga

Rehab Programs

- Work conditioning
- Work hardening
- Chronic pain management program
- Medical rehabilitation
- Brain and spinal cord rehabilitation
- Chemical dependency programs
- Weight loss programs

Nursing Home

- Skilled nursing facility, including skilled care within the same facility
- Convalescent care
- Residential care
- Assisted living/group homes

Psychological Testing and Psychotherapy

- Subsequent evaluations
- Subsequent tests or testing
- Therapy

WorkWell, TX Service Area Map



WorkWell, TX Service Area County List

A	Comal Comanche Concho Cooke Coryell Crane Crosby	Gray Grayson Gregg Grimes Guadalupe	Kendall Kenedy Kent Kerr Kimble Kleberg	Newton Nolan Nueces	Stephens Sterling Stonewal Swisher
B	Dallam Dallas Deaf Smith Delta Denton Dewitt Dickens Donley Duval	Hale Hall Hamilton Hansford Hardin Harris Harrison Hartley Haskell Hays Hemphill Henderson Hidalgo Hill Hockley Hood Hopkins Houston Howard Hudspeth Hunt Hutchinson	Lamar Lamb Lampasas Lavaca Lee Leon Liberty Limestone Lipscomb Live Oak Llano Loving Lubbock Lynn	Ochiltree Oldham Orange	Tarrant Taylor Terry Throckmorton Titus Tom Green Travis Trinity Tyler
C	Falls Fanin Fayette Fisher Floyd Fort Bend Franklin Freestone Frio	Iron Jack Jackson Jasper Jefferson Jim Hogg Jim Wells Johnson Jones	Madison Marion Martin Mason Matagorda McCulloch McLennan McMullen Medina Menard Midland Milam Mitchell Montague Montgomery Moore Morris Motley	Rains Randall Reagan Real Red River Reeves Refugio Roberts Robertson Rockwall Runnels Rusk	Upshur Upton Uvalde
D		H	L	P	U
E	Eastland Ector El Paso Ellis Erath			Palo Pinto Panola Parker Parmer Pecos Polk Potter	Van Zandt Victoria
F	Falls Fanin Fayette Fisher Floyd Fort Bend Franklin Freestone Frio	I	M	R	V
G	Gaines Galveston Garza Gillespie Glasscock Goliad Gonzales	Jackson Jasper Jefferson Jim Hogg Jim Wells Johnson Jones	Madison Marion Martin Mason Matagorda McCulloch McLennan McMullen Medina Menard Midland Milam Mitchell Montague Montgomery Moore Morris Motley	Sabine San Augustine San Jacinto San Patricio San Saba Schleicher Scurry Shackelford Shelby Sherman Smith Somervell Starr	W
K	Karnes Kaufman	N			Yoakum Young



Employee Acknowledgment of Workers' Compensation Network

I have received information that informs me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this packet, I understand that:

- I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual Insurance Company at (844) 867-2338 to notify them of my choice.
- I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me to a specialist. If I need emergency care, I may go anywhere.
- Texas Mutual will pay the treating doctor and other network providers for the treatment for my compensable injury.
- I may have to pay the bill if I get health care from someone other than a network doctor without prior network approval.

Knowingly making a false workers' compensation claim may lead to a criminal investigation that could result in criminal penalties such as fines and imprisonment.

Signature

Date

Printed name

I live at:

Street address

City

State

Zip code

Name of employer: _____

Name of network: WorkWell, TX

To the employer:

Each employee must sign this form when you begin the program or within 3 days of being hired, and at the time an injury occurs. Please indicate at which point this acknowledgment was completed.

- Initiating the network program (companywide)
 Initial employee notification (new hire)
 Injury notification (Date of injury: / /)

Keep this completed form in the employee's personnel file. It could be requested by Texas Mutual.

First Fill

Simplifying the prescription process and helping workers take the first step toward getting well

Texas Mutual's First Fill Program enables your employees to get prescribed medication quickly after an injury occurs, even if you haven't had the opportunity to file a claim. Injured workers can get a seven-day supply for each covered prescription with a maximum of \$500 per prescription with just the First Fill form.

Complete the First Fill form on the back of this sheet and advise your employee to present it at a participating Optum pharmacy.

The form is valid for the first fill and cannot be used if the first prescription fill is being requested more than 10 days after the injury occurred.

If additional forms are needed, visit the employer forms section at texasmutual.com.



Texas Mutual®
WORKERS' COMPENSATION INSURANCE
W O R K S A F E , T E X A S®



texasmutual.com | worksafetexas.com



Prescription First Fill Form

[page 2 of 2]

Prescription First Fill Instructions

1. Participating Optum pharmacies include Walgreens, CVS, Walmart, Kroger, Target, Costco, Sam's Club, Brookshire, HEB and Tom Thumb. To locate other participating pharmacies, visit www.texasmutual.com/hcn or www.tmesys.com.
2. Complete the form and take to the pharmacy along with your prescription from the provider.
3. This form allows you to fill your initial prescription(s) with a maximum cost of \$500 per covered prescription and a maximum seven day supply.
4. If you have questions, please call us at **(866) 599-5426**, available 24 hours a day, seven days a week.

Bin #: 004261	PCN#: CAL	Group Number: TXSMFF
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Member ID:

Date of injury + SSN combined
as follows: YYMMDD123456789

Member Name:

Injured worker's first and
last name

Employer Name:

Date of Injury:

Pharmacy Help Desk: **(800) 964-2531**

PLEASE NOTE: This form is only **valid within 10 days** of the injury date. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive a pharmacy card, please call us at **(866) 599-5426**.

***Issuance of this letter or dispensing of a prescription does not constitute acceptance
of your claim.***

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

***Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filing.**

CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>	15. Date of Injury (m-d-y) - - -	16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/>	17. Date Lost Time Began (m-d-y) - - -
3. Social Security Number	4. Home Phone ()	5. Date of Birth (m-d-y) - - -	18. Nature of Injury* 19. Part of Body Injured or Exposed*		
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>					
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>	8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>		21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/> 22. Worksite Location of Injury (stairs, dock, etc.)*		
9. Mailing Address Street or P.O. Box					
City		State	Zip Code	County	
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>					
11. Number of Dependent Children		12. Spouse's Name			
13. Doctor's Name					
14. Doctor's Mailing Address (Street or P.O.Box)					
City		State	Zip Code	23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site Street or P.O. Box County	
24. Cause of Injury(fall, tool, machine, etc.)*					
25. List Witnesses					
26. Return to work date/or expected (m-d-y) - - -		27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>	28. Supervisor's Name	29. Date Reported (m-d-y) - - -	

30. Date of Hire (m-d-y) - - -	31. Was employee hired or recruited in Texas? <input type="checkbox"/> YES <input type="checkbox"/> NO	32. Length of Service in Current Position Months _____ Years _____	33. Length of Service in Occupation Months _____ Years _____		
34. Employee Payroll Classification Code		35. Occupation of Injured Worker			
36. Rate of Pay at this Job \$ ____ Hourly \$ ____ Weekly	37. Full Work Week is: ____ Hours ____ Days	38. Last Paycheck was: \$ ____ for ____ Hours or ____ Days	39. Is employee an Owner, Partner, or Corporate Officer? <input type="checkbox"/> YES <input type="checkbox"/> NO		
40. Name and Title of Person Completing Form		41. Name of Business			
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ()		43. Business Location (If different from mailing address) Number and Street			
City	State	Zip Code	City	State	Zip Code
44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code: (6 digit)		46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.	
48. Workers' Compensation Insurance Company			49. Policy Number		

50. Did you request accident prevention services in past 12 months?

YES NO If yes, did you receive them? YES NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X _____ Date _____





CLAIM #	_____
Carrier #	_____

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name	2. Employer phone #
3. Employer mailing address	
4. Insurance carrier name	
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes <input type="checkbox"/> no <input type="checkbox"/> If so, identify contact person and phone # _____	
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes <input type="checkbox"/> Date _____ no <input type="checkbox"/>	
7. Has the employer requested RTW training from DWC or the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/>	
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes <input type="checkbox"/> Date _____ no <input type="checkbox"/>	
9. Has the employer requested accident prevention services from the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/>	

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. <input type="checkbox"/>	a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
<input type="checkbox"/>	b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
<input type="checkbox"/>	c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
<input type="checkbox"/>	d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name	12. SSN (last 4 digits) xxx-xx-	13. DOI
14. Injured worker mailing address and phone #		
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)	16. First day of additional lost time or reduced wages (mm/dd/yyyy)	
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes <input type="checkbox"/> no <input type="checkbox"/> If yes, the date of the 8 th day (mm/dd/yyyy) _____		
18. Date of most recent RTW _____ <input type="checkbox"/> Full duty, full pay <input type="checkbox"/> Limited duty, full pay <input type="checkbox"/> Limited duty, reduced pay	19. Has the injured worker resigned, been terminated or died? yes <input type="checkbox"/> no <input type="checkbox"/> date of resignation _____ date of termination _____ date of death _____ 19a. Reason for resignation/termination 19b. Was the injured worker on limited duty when terminated? yes <input type="checkbox"/> no <input type="checkbox"/>	
20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week	21. Weekly/hourly earnings for the pay period of _____ to _____ : \$ _____ weekly or \$ _____	
Indicated hours are: <input type="checkbox"/> Increase from pre-injury <input type="checkbox"/> Same as pre-injury <input type="checkbox"/> Decrease from pre-injury	Indicated wages are: <input type="checkbox"/> Increase from pre-injury wage <input type="checkbox"/> Same as pre-injury wage <input type="checkbox"/> Decrease from pre-injury wage	

This form to be filed with: The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.

Submitted by: Employer Injured Worker (If no longer working for the employer where injury occurred.)

Signature and Title of person completing this form

Date



NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: 1-866-393-6432. More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

WHAT IS AN OMBUDSMAN? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has a workers' compensation adjuster's license and has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation. Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.



OIEC

CONNECT @OIECTexas @OIECtube oiec.texas.gov

Figure 28 TAC §276.5(c) - April 2018

AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICINA DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel –OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que asiste a los empleados lesionados que no cuentan con representación legal con su reclamación en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: 1-866-393-6432. Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio web de la agencia (www.oiec.texas.gov).

PROGRAMA DE OMBUDSMAN

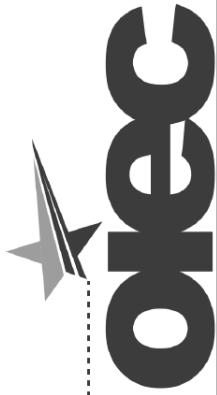
¿QUÉ ES UN OMBUDSMAN? Un Ombudsman es un empleado de OIEC que le puede asistir si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte del Ombudsman es gratuita. Cada Ombudsman cuenta con una licencia de ajustador de compensación para trabajadores y ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation, por su nombre en inglés). Una vez que el procedimiento ha sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarle con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

CONÉCTESE  @OIECTexas   @OIECTube  oiec.texas.gov

Título 28 Código Administrativo de Texas §276.5(c) - Abril 2018



NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE:

STONEFIELD HOMES LLC has workers' compensation insurance coverage from Texas Mutual Insurance Company in the event of work-related injury or occupational disease. This coverage is effective from 4/7/23. Any injuries or occupational diseases which occur on or after that date will be handled by Texas Mutual Insurance Company. An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE:

The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE:

The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

- 1 Prominently displayed in the employer's personnel office, if any;
- 2 Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
- 3 Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
- 4 Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: STONEFIELD HOMES LLC tiene cobertura de seguros de compensación para trabajadores con Texas Mutual Insurance Company para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde 4/7/23. Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por Texas Mutual Insurance Company. Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

- 1 Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
- 2 Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
- 3 El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
- 4 Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División. El infractor podría estar sujeto a sanciones administrativas.

Figure: 28 TAC §1.601(a)(2)(C)

Have a workers' compensation complaint or need help?

Contact your insurance company if you have a question or problem about your premium or a claim:

Texas Mutual Insurance Company

- **Call: Information Services at (512) 224-3800**
- **Toll-free: (800) 859-5995**
- Email: information@texasmutual.com
- Mail: Texas Mutual Insurance Company

Attn: Information Services Center
2200 Aldrich St
Austin, TX 78723-3474

For problems with your policy

If your problem with the premium is not resolved, contact the National Council on Compensation Insurance, Dispute Resolution Services:

- Mail: 901 Peninsula Corporate Circle
Boca Raton, FL 33487-1362
- Fax: (561) 893-5043
- Email: regulatoryoperations@ncci.com
- Phone: (800) 622-4123

If you believe there has been a violation of law related to your workers' compensation policy, file a complaint with the Texas Department of Insurance:

- Call: (800) 252-3439
- Online: www.tdi.texas.gov
- Email: ConsumerProtection@tdi.texas.gov
- Mail: MC 111-1A
P.O. Box 149091
Austin, TX 78714-9091

For employees with claim issues

If one of your employees has a problem with a claim, contact the Texas Department of Insurance, Division of Workers' Compensation, Compliance and Investigations:

- Mail: MS-8
7551 Metro Center Drive, Suite 100
Austin, TX 78744
- Fax: (512) 490-1030
- Email: DWC-ComplianceReview@tdi.texas.gov
- Phone: (800) 252-7031

Figure: 28 TAC §1.601(a)(2)(C)

¿Tiene una queja de compensación para trabajadores o necesita ayuda?

Comuníquese con su compañía de seguros si tiene una pregunta o problema relacionado con su prima de seguro o con una reclamación:

Texas Mutual Insurance Company

- **Llame a: Information Services al (512) 224-3800**
- **Teléfono gratuito: (800) 859-5995**
- Correo electrónico: information@texasmutual.com
- Dirección postal: Texas Mutual Insurance Company
Attn: Information Services Center
2200 Aldrich St
Austin, TX 78723-3474

Para problemas con su póliza

Si su problema con la prima de seguro no es resuelto, comuníquese con el Consejo Nacional de Seguros de Compensación (National Council on Compensation Insurance, por su nombre en inglés), Servicios para la Resolución de Disputas:

- Correo postal: 901 Peninsula Corporate Circle
Boca Raton, FL 33487-1362
- Fax: (561) 893-5043
- Correo electrónico: regulatoryoperations@ncci.com
- Teléfono: (800) 622-4123

Si usted piensa que ha habido una violación a la ley, la cual está relacionada con su póliza de compensación para trabajadores, presente una queja ante el Departamento de Seguros de Texas:

- Llame al: (800) 252-3439
- En línea: www.tdi.texas.gov
- Correo electrónico: ConsumerProtection@tdi.texas.gov
- Correo postal: MC 111-1A
P.O. Box 149091
Austin, TX 78714-9091

Para empleados que tienen problemas con sus reclamaciones

Si uno de sus empleados tiene un problema con una reclamación, comuníquese con la Sección de Cumplimiento e Investigaciones (Compliance and Investigations, por su nombre en inglés) del Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation, por su nombre en inglés).

- Correo postal: MS-8
7551 Metro Center Drive, Suite 100
Austin, TX 78744
- Fax: (512) 490-1030
- Correo electrónico: DWC-ComplianceReview@tdi.texas.gov
- Teléfono: (800) 252-7031

Workers' Compensation and Employer's Liability Policy

NCCI Carrier Code: 29939

Information Page

Insured copy

Item 1 Insured name and address STONEFIELD HOMES LLC 5001 LBJ FWY STE 850 DALLAS TX 75244-6156	Policy number 0001285647																																				
	Federal tax ID 853149010																																				
	Entity LLC																																				
	Interim adjustment Quarterly 33% - 3 Reports																																				
Producer 25305 FRANK SWINGLE & ASSOCIATES INC DBA: SWINGLE COLLINS & ASSOCIATES 13760 NOEL RD STE 600 DALLAS TX 75240-1381	Branch Dallas																																				
	Renewal of 0001285647																																				
Item 2 The policy period is from: 4/7/23 To: 4/7/24 12:01 a.m. standard time at the insured's mailing address																																					
Item 3 A. Workers' Compensation Insurance: Part One of the policy applies to the Workers' Compensation Law of the states listed here: Texas B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in item 3A. The Limits of our Liability under Part Two are: <table style="margin-left: 20px;"> <tr> <td>Bodily Injury by Accident</td> <td>\$1,000,000.00</td> <td>Each Accident</td> </tr> <tr> <td>Bodily Injury by Disease</td> <td>\$1,000,000.00</td> <td>Policy Limit</td> </tr> <tr> <td>Bodily Injury by Disease</td> <td>\$1,000,000.00</td> <td>Each Employee</td> </tr> </table> C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here: None D. This policy includes these endorsements and schedules: see Schedule of Endorsements attached.	Bodily Injury by Accident	\$1,000,000.00	Each Accident	Bodily Injury by Disease	\$1,000,000.00	Policy Limit	Bodily Injury by Disease	\$1,000,000.00	Each Employee																												
Bodily Injury by Accident	\$1,000,000.00	Each Accident																																			
Bodily Injury by Disease	\$1,000,000.00	Policy Limit																																			
Bodily Injury by Disease	\$1,000,000.00	Each Employee																																			
Item 4 The premium for this policy will be determined by our manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"></th> <th style="text-align: right;">Payroll</th> <th style="text-align: right;">Premium</th> </tr> </thead> <tbody> <tr> <td>Total payroll and estimated manual premium</td> <td style="text-align: right;">\$324,556.00</td> <td style="text-align: right;">\$2,277.00</td> </tr> <tr> <td>Description</td> <td style="text-align: right;">Factor</td> <td style="text-align: right;">Amount</td> </tr> <tr> <td>Waiver of Subrogation</td> <td style="text-align: right;">46.00</td> <td></td> </tr> <tr> <td>Increased Limits Factor 1,000,000/1,000,000/1,000,000</td> <td style="text-align: right;">0.014</td> <td style="text-align: right;">32.00</td> </tr> <tr> <td>Increased Limits Balance to Minimum Premium (\$150)</td> <td></td> <td style="text-align: right;">118.00</td> </tr> <tr> <td>Premium Incentive For Small Employer Modifier</td> <td style="text-align: right;">0.850</td> <td style="text-align: right;">(371.00)</td> </tr> <tr> <td>Schedule Modifier</td> <td style="text-align: right;">0.860</td> <td style="text-align: right;">(294.00)</td> </tr> <tr> <td>Healthcare Network Option</td> <td style="text-align: right;">0.120</td> <td style="text-align: right;">(217.00)</td> </tr> <tr> <td>Expense Constant</td> <td></td> <td style="text-align: right;">150.00</td> </tr> <tr> <td>Total estimated annual premium</td> <td></td> <td style="text-align: right;">\$1,741.00</td> </tr> <tr> <td>Minimum premium \$198.00</td> <td></td> <td></td> </tr> </tbody> </table>		Payroll	Premium	Total payroll and estimated manual premium	\$324,556.00	\$2,277.00	Description	Factor	Amount	Waiver of Subrogation	46.00		Increased Limits Factor 1,000,000/1,000,000/1,000,000	0.014	32.00	Increased Limits Balance to Minimum Premium (\$150)		118.00	Premium Incentive For Small Employer Modifier	0.850	(371.00)	Schedule Modifier	0.860	(294.00)	Healthcare Network Option	0.120	(217.00)	Expense Constant		150.00	Total estimated annual premium		\$1,741.00	Minimum premium \$198.00		
	Payroll	Premium																																			
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Minimum premium \$198.00																																					
Issue date: 4/3/23	Countersigned by																																				
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Workers' Compensation and Employer's Liability Policy

Policy number 0001285647 **Issue date** 4/3/23 **Policy period** 4/7/23 to 4/7/24

Extension of Information Page**Item 1: Insured Name Extended**

Insured copy

Additional named insured

PHILLIP JENNINGS CUSTOM HOMES LTD

FEIN

761669392

Entity

Limited Partnership

STONEFIELD HOMES INC

853149010

Corporation

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.
(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)
This endorsement, effective on 4/7/23 at 12:01 a.m. standard time, forms a part of:

Policy no. 0001285647 of Texas Mutual Insurance Company effective on 4/7/23

Issued to: STONEFIELD HOMES LLC



This is not a bill

Authorized representative

NCCI Carrier Code: 29939

4/3/23

**Workers' Compensation and Employer's Liability Policy**

Policy number 0001285647 **Issue date** 4/3/23 **Policy period** 4/7/23 to 4/7/24

Extension of Information Page**Item 1: Locations**

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Location	Address	Effective	Expires
00003	STONEFIELD HOMES LLC 5001 LBJ FWY STE 850 DALLAS, TX 75244-6156	4/7/23	4/7/24

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Workers' Compensation and Employer's Liability Policy

Policy number 0001285647 **Issue date** 4/3/23 **Policy period** 4/7/23 to 4/7/24

Schedule of Operations

Item 4: Premium Calculation

Insured copy

Class codes for primary named insured

State	Location	Code	Classification	Premium basis total estimated annual remuneration	Rate per \$100 of remuneration	Estimated annual premium
4/7/23 to 4/7/24						
42	00003	5403	Carpentry-Private one or Two Family Residences-& Drivers	If any	6.890	0.00
42	00003	5606	Contractor-Executive Supervisor or Construction Superintendent	199,707.00	1.040	2,077.00
42	00003	8742	Salespersons or Collectors-Outside	If any	0.320	0.00
42	00003	8810	Clerical Office Employees NOC	124,849.00	0.160	200.00
Estimated manual premium						
	0930		Blanket Waiver: ALL TEXAS OPERATIONS 04/07/2023 - 04/07/2024		0.020	46.00
	9812		Increased Limits Factor 1,000,000/1,000,000/1,000,000		0.014	32.00
	9848		Increased Limits Balance to Minimum Premium (\$150)		1.000	118.00
	9885		Premium Incentive For Small Employer Modifier		0.850	(371.00)
	9887		Schedule Modifier		0.860	(294.00)
	9874		Healthcare Network Option		0.120	(217.00)
	0900		Expense Constant		1.000	150.00
Total payroll and Texas total premium				\$324,556.00		\$1,741.00

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Workers' Compensation and Employer's Liability Policy

Policy number 0001285647 **Issue date** 4/3/23 **Policy period** 4/7/23 to 4/7/24

Extension of Information Page Item 3: Endorsement Schedule

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State	Endorsement	Description
42	TM LRC 2008	Limited Reimbursement for Texas Employees Injured in Other Jurisdictions
42	TM MV 2011	Mutuals - Membership and Voting Notice
42	TM PC 2003	Policy Conditions Endorsement
42	WC 00 00 00 C	Policy Conditions Form
42	WC 00 00 01 B	Policy Coverage Document (Declarations Page)
42	WC 00 04 06	Premium Discount Endorsement
42	WC 00 04 14 A	Notification of Change in Ownership Endorsement
42	WC 00 04 22 C	Terrorism Risk Insurance Act Coverage Endorsement
42	WC 42 03 01 J	Texas Amendatory Endorsement
42	WC 42 03 04 B	Blanket Texas Waiver of Our Right To Recover from Others Endorsement
42	WC 42 03 08	Partners, Officers and Others Exclusion Endorsement
42	WC 42 04 07	Texas- Audit Premium and Retrospective Premium Endorsement
42	WC 42 04 08 A	Network Discount Endorsement

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4/3/23

WORKERS' COMPENSATION AND EMPLOYERS LIABILITY POLICY

WC 00 00 00 C

Insured copy

In return to the payment of the premium and subject to all terms of this policy, we agree with you as follows:

GENERAL SECTION

A. The Policy

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in Item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

B. Who Is Insured

You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership, and if you are one of its partners, you are insured, but only in your capacity as an employer of the partnership's employees.

C. Workers Compensation Law

Workers Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include any federal workers or workmen's compensation law, any federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

D. State

State means any state of the United States of America, and the District of Columbia.

E. Locations

This policy covers all of your workplaces listed in Items 1 or 4 of the Information Page; and it covers all other workplaces in Item 3.A. states unless you have other insurance or are self-insured for such workplaces.

PART ONE – WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay promptly when due the benefits required of you by the workers compensation law.

C. We Will Defend

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. Other Insurance

We will not pay more than our share of benefits and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. Payments You Must Make

You are responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;
3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

If we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

G. Recovery From Others

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them.

H. Statutory Provisions

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law. Enforcement may be against us or against you and us.
4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the workers compensation law that apply to:
 - a. benefits payable by this insurance;
 - b. special taxes, payments into security or other special funds, and assessments payable by us under that law.
6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

Nothing in these paragraphs relieves you of your duties under this policy.

PART TWO – EMPLOYERS LIABILITY INSURANCE

A. How This Insurance Applies

This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

B. We Will Pay

We will pay all sums that you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered by this Employers Liability Insurance.

The damages we will pay, where recovery is permitted by law, include damages:

1. For which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
2. For care and loss of services; and
3. For consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee; provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and
4. Because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. Exclusions

This insurance does not cover:

1. Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. Bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. Any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. Bodily injury intentionally caused or aggravated by you;
6. Bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Sections 901 et seq.), the Non-appropriated Fund Instrumentalities Act (5 U.S.C. Sections 8171 et seq.), the Outer Continental Shelf Lands Act (43 U.S.C. Sections 1331 et seq.), the Defense Base Act (42 U.S.C. Sections 1651 et seq.), the Federal Coal Mine Safety and Health Act (30 U.S.C. Sections 801 et seq. and 901 - 944), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;
9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 U.S.C. Sections 51 et seq.), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. Bodily injury to a master or member of the crew of any vessel, and does not cover punitive damages related to your duty or obligation to provide transportation, wages, maintenance, and cure under any applicable maritime law;
11. Fines or penalties imposed for violation of federal or state law; and
12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. Sections 1801 et seq.) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for damages payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding, or suit we defend:

1. Reasonable expenses incurred at our request, but not loss of earnings;
2. Premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. Litigation costs taxed against you;
4. Interest on a judgment as required by law until we offer the amount due under this insurance; and
5. Expenses we incur.

F. Other Insurance

We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

G. Limits of Liability

Our liability to pay for damages is limited. Our limits of liability are shown in Item 3.B. of the Information Page. They apply as explained below.

1. Bodily Injury by Accident. The limit shown for "bodily injury by accident-each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.
A disease is not bodily injury by accident unless it results directly from bodily injury by accident.
2. Bodily Injury by Disease. The limit shown for "bodily injury by disease-policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease-each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee.
Bodily injury by disease does not include disease that results directly from a bodily injury by accident.

3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. Recovery From Others

We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

I. Actions Against Us

There will be no right of action against us under this insurance unless:

1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgment.

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability.

The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

PART THREE – OTHER STATES INSURANCE

A. How This Insurance Applies

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If you begin work in any one of those states after the effective date of this policy and are not insured or are not self-insured for such work, all provisions of the policy will apply as though that state were listed in Item 3.A. of the Information Page.
3. We will reimburse you for the benefits required by the workers compensation law of that state if we are not permitted to pay the benefits directly to persons entitled to them.

4. If you have work on the effective date of this policy in any state not listed in Item 3.A of the Information Page, coverage will not be afforded for that state unless we are notified within thirty days.

B. Notice

Tell us at once if you begin work in any state listed in Item 3.C. of the Information Page.

PART FOUR – YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.

4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE – PREMIUM

A. Our Manuals

All premium for this policy will be determined by our manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance.

C. Remuneration

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis. This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. all your officers and employees engaged in work covered by this policy; and
2. all other persons engaged in work that could make us liable under Part One (Workers Compensation Insurance) of this policy. If you do not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured their workers compensation obligations.

B. Classifications

Item 4 of the Information Page shows the rate and premium basis for certain business or work classifications. These classifications were assigned based on an estimate of the exposures you would have during the policy period. If your actual exposures are not properly described by those classifications, we will assign proper classifications, rates and premium basis by endorsement to this policy.

D. Premium Payments

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid.

E. Final Premium

The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

If this policy is cancelled, final premium will be determined in the following way unless our manuals provide otherwise:

1. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.

2. If you cancel, final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short rate cancellation table and procedure. Final premium will not be less than the minimum premium.

F. Records

You will keep records of information needed to compute premium. You will provide us with copies of those records when we ask for them.

G. Audit

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX – CONDITIONS

A. Inspection

We have the right, but are not obliged to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant that your workplaces are safe or healthful or that they comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights we have under this provision.

B. Long Term Policy

If the policy period is longer than one year and sixteen days, all provisions of this policy will apply as though a new policy were issued on each annual anniversary that this policy is in force.

C. Transfer of Your Rights and Duties

Your rights or duties under this policy may not be transferred without our written consent.

If you die and we receive notice within thirty days after your death, we will cover your legal representative as insured.

D. Cancellation

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancellation notice.
4. Any of these provisions that conflicts with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

E. Sole Representative

The insured first named in Item 1 of the Information Page will act on behalf of all insured's to change this policy, receive return premium, and give or receive notice of cancellation.

LIMITED REIMBURSEMENT FOR TEXAS EMPLOYEES INJURED IN OTHER JURISDICTIONS

**IMPORTANT NOTICE!
PLEASE READ THIS ENDORSEMENT CAREFULLY**

This policy does not provide "other states" insurance coverage. This endorsement provides reimbursement coverage to you for those Texas employees who are described in the Texas Labor Code §§406.071-.072. Therefore the coverage is for injuries to your Texas employees that occur in another state if (i) the injury would have been compensable had it occurred in Texas and (ii) the employee has significant contacts with Texas or the employment is principally located in Texas. An employee has significant contacts with Texas if the employee was hired or recruited in Texas, and (i) the employee was injured not later than one year after the date of hire; or (ii) has worked in Texas for at least ten working days during the twelve months preceding the date of injury.

Employees hired or recruited by you outside Texas to work in another state are specifically excluded from the terms and provisions of this policy. If you conduct business in states other than Texas, you must comply with those state laws. You must promptly notify your agent before you begin work in any jurisdiction other than Texas. We are **not** authorized to provide workers' compensation insurance in any jurisdiction other than Texas. You are responsible for all of your legal obligations for your failure to comply with requirements of the workers' compensation laws of any jurisdiction other than Texas.

Part Three Other States Insurance of the policy is deleted and replaced with the following:

I. Limited Reimbursement Provision

A. How this endorsement applies

This endorsement will reimburse you after you have made payments for benefits for injuries to your Texas employees required of you in another jurisdiction. This reimbursement provision only applies to bodily injury by accident including death or bodily injury by disease including death incurred by your employee who qualifies for Texas workers' compensation benefits under Sec. 406.071 of the Texas Labor Code.

1. Bodily injury must arise out of and in the course of the injured employee's temporary employment by you in a state other than Texas.
2. Bodily injury by accident must occur during the policy period.
3. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last injurious exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
4. The employee incurring bodily injury must be eligible for Texas workers' compensation benefits and must make a written election of workers' compensation benefits in the state in which the bodily injury occurred in lieu of Texas workers' compensation benefits. You must send us written notice of such election within 10 days of receiving notice yourself. Failure to provide such notice means any reimbursement will be made in accordance with the Texas Labor Code.

B. Reimbursement

1. We will reimburse you for the amount you have paid as workers' compensation benefits for employees, as defined above, under the workers' compensation law of any state listed in the schedule.
2. We will deduct from the benefits so reimbursed any amounts we have paid as Texas benefits to the employee for the same injury for which the other jurisdiction's benefits are required.
3. Sections D through G of Part One of the policy will apply to reimbursement provided by this endorsement. Sections A, B, C and H of Part One of the policy will not apply to reimbursement provided by this endorsement.
4. We will reimburse you for reasonable attorney's fees you have paid to defend the injury claim in another jurisdiction.

II. Exclusions, Limitations and Conditions

The following conditions apply to the reimbursement afforded by this endorsement:

1. Nothing in this endorsement confers jurisdiction in another state or constitutes our doing business in another state.
2. Reimbursement will be made in Texas.
3. Travis County, Texas is the sole venue for any lawsuit involving reimbursement under this endorsement.
4. This endorsement provides reimbursement only in Texas and fully releases and indemnifies us and holds us harmless from any liability arising from your failure to obtain workers' compensation coverage in another jurisdiction.
5. The reimbursement provided by this endorsement excludes:
 - a. bodily injury, including death, to an employee while employed in a jurisdiction where you have secured your obligation under the workers' compensation law by other insurance or by self-insurance;
 - b. bodily injury, including death, to an employee while employed in a state where you affirmatively rejected the workers' compensation law; or
 - c. fines or penalties arising out of your failure to comply with requirements of the workers' compensation law of any state.

III. Premium

The premium basis and rates for work by Texas employees in jurisdictions other than Texas are the same as if the work had been done in Texas.

IV. Schedule

Designated States: All states of the United States of America except North Dakota, Ohio, Washington and Wyoming.

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Authorized representative

NCCI Carrier Code: 29939

4/3/23



**WORKERS' COMPENSATION AND
EMPLOYERS LIABILITY POLICY**

TM MV 2011
Insured copy

MUTUALS - MEMBERSHIP AND VOTING NOTICE

The insured is notified that by virtue of this policy, he is a member of Texas Mutual Insurance Company, and is entitled to vote either in person or by proxy at any and all meetings of said Company. The Annual Meetings are held in its Home Office, 6210 E Highway 290, Austin, Texas, on the fourth Tuesday of June in each year, at 1:00 o'clock p.m. each year unless the Board of Directors of Texas Mutual Insurance Company specifies otherwise.

MUTUALS – PARTICIPATION CLAUSE WITHOUT CONTINGENT LIABILITY

No Contingent Liability: This policy is non-assessable. The policyholder is a member of the company and shall participate, to the extent and upon the conditions fixed and determined by the Board of Directors in accordance with the provisions of law, in the distributions of dividends so fixed and determined.

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The named insured ratifies and accepts the terms and conditions of the policy to which this endorsement is attached as well as the terms listed below.

1. Policies that are on an interim reporting basis may not be financed. Texas Mutual Insurance Company may cancel coverage if it determines that interim reports have been financed in violation of this prohibition.
2. The named insured certifies that the payroll established by classification codes in the application for coverage is a true and reasonable estimate for the period of coverage requested and will promptly report any material change in payroll exposures to Texas Mutual Insurance Company. Texas Mutual Insurance Company may adjust premium for the policy upon receipt of such information.
3. The named insured and its affiliates permit Texas Mutual Insurance Company access to all of their employment information and records filed with the Texas Workforce Commission, and hereby waive the confidentiality of such information and records.
4. All obligations of the named insured are performable in Travis County, Texas and said county will be the legal venue for any suit arising from this contract. Maintenance of an action in Travis County, Texas does not work an injustice to the named insured and is in the interest of the parties, and transfer of the action would work an injustice to the parties. Any suits must be filed in Travis County, Texas.
5. If the insured defaults on payment of any premiums due under any policy issued, then all premiums due and unpaid shall become due and payable at Texas Mutual Insurance Company's offices in Austin, Travis County, Texas.
6. All information supplied to Texas Mutual Insurance Company by the named insured or its agent in the application for insurance or otherwise is true and complete; nothing material regarding its operations has been omitted; and the named insured intended Texas Mutual Insurance Company to rely on such information in issuing this policy. The named insured assumed the duty of full disclosure of such information and that Texas Mutual Insurance Company has no duty to inquire further regarding such information. The named insured is not violating any provision of the Texas Workers' Compensation Act and is not subcontracting any work to a subcontractor with the intent to avoid liability as an employer.
7. The named insured will not cause any certificate of insurance to be issued for the purpose of satisfying the workers' compensation insurance requirements of any third party, including any governmental entity, unless the remuneration paid to the individual workers performing such work is disclosed to Texas Mutual Insurance Company and included in the premium calculation of the named insured. If the named insured causes a certificate of insurance to be issued for the purpose of allowing the employees of a person other than the named insured to perform work at any job site where workers' compensation is required, and such workers are not covered by workers' compensation insurance, such action by the named insured is a material breach of this insurance policy and constitutes fraud upon Texas Mutual Insurance Company.
8. The named insured has appointed the agent whose name appears on the application as its agent in fact and agrees that any representations made on its behalf by that agent are the representations of the named insured, unless there is an express written agreement between Texas Mutual Insurance Company and the agent that the agent acts on behalf of Texas Mutual Insurance Company.
9. Acceptance of this policy with all endorsements and tender of the deposit premium constitute the insured's agreement with all of the terms and conditions thereof, and the insured's acknowledgement of the obligation to pay all premiums due for the policy.

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Issued to: STONEFIELD HOMES LLC



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Authorized representative

NCCI Carrier Code: 29939

4/3/23

PREMIUM DISCOUNT ENDORSEMENT

The premium for this policy and the policies, if any, listed in Item 3 of the Schedule may be eligible for a discount. This endorsement shows your estimated discount in Item 1 or 2 of the Schedule. The final calculation of premium discount will be determined by our manuals and your premium basis as determined by audit. Premium subject to retrospective rating is not subject to premium discount.

Schedule

Estimated Eligible Premium

1. State	First \$5,000	Next \$95,000	Next \$400,000	Balance
TEXAS	0.00%	9.50%	11.90%	12.40%

2. Average percentage discount 0.00%
3. Other Policies:
4. If there are no entries in Items 1, 2, and 3 of the Schedule see the Premium Discount Endorsement attached to your policy number:

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PO Box 12058, Austin, TX 78711-2058

texasmutual.com | (800) 859-5995 | Fax (800) 359-0650



**WORKERS' COMPENSATION AND
EMPLOYERS LIABILITY POLICY**

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NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

Experience rating is mandatory for all eligible insureds. The experience rating modification factor, if any, applicable to this policy, may change if there is a change in your ownership or in that of one or more of the entities eligible to be combined with you for experience rating purposes. Change in ownership includes sales, purchases, other transfers, mergers, consolidations, dissolutions, formations of a new entity and other changes provided for in the applicable experience rating plan manual.

You must report any change in ownership to us in writing within 90 days of such change. Failure to report such changes within this period may result in revision of the experience rating modification factor used to determine your premium.

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TERRORISM RISK INSURANCE PROGRAM

This endorsement addresses the requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2019. It serves to notify you of certain limitations under the Act, and that your insurance carrier is charging premium for losses that may occur in the event of an Act of Terrorism.

Your policy provides coverage for workers compensation losses caused by Acts of Terrorism, including workers compensation benefit obligations dictated by state law. Coverage for such losses is still subject to all terms, definitions, exclusions, and conditions in your policy, and any applicable federal and/or state laws, rules, or regulations.

Definitions

The definitions provided in this endorsement are based on and have the same meaning as the definitions in the Act. If words or phrases not defined in this endorsement are defined in the Act, the definitions in the Act will apply.

"Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments thereto, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2019.

"Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security, and the Attorney General of the United States as meeting all of the following requirements:

- a. The act is an act of terrorism.
- b. The act is violent or dangerous to human life, property or infrastructure.
- c. The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.
- d. The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

"Insured Loss" means any loss resulting from an act of terrorism (and, except for Pennsylvania, including an act of war, in the case of workers compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or at the premises of United States missions or to certain air carriers or vessels.

"Insurer Deductible" means, for the period beginning on January 1, 2021, and ending on December 31, 2027, an amount equal to 20% of our direct earned premiums, during the immediately preceding calendar year.

Limitation of Liability

The Act limits our liability to you under this policy. If aggregate Insured Losses exceed \$100,000,000,000 in a calendar year and if we have met our Insurer Deductible, we are not liable for the payment of any portion of the amount of Insured Losses that exceeds \$100,000,000,000; and for aggregate Insured Losses up to \$100,000,000,000, we will pay only a pro rata share of such Insured Losses as determined by the Secretary of the Treasury.

Policyholder Disclosure Notice

- 1 Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses occurring in any calendar year exceed \$200,000,000 the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible.
- 2 Notwithstanding item 1 above, the United States Government will not make any payment under the Act for any portion of Insured Losses that exceed \$100,000,000,000.



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- 3 The premium charge for the coverage your policy provides for Insured Losses is included in the amount shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate	Premium
TEXAS	0.00	\$0.00

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Authorized representative

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4/3/23

TEXAS AMENDATORY ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because Texas is shown in Item 3.A. of the Information Page.

GENERAL SECTION

B. **Who Is Insured** is amended to read:

You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership or joint venture, and if you are one of its partners or members, you are insured, but only in your capacity as an employer of the partnership's or joint venture's employees.

D. **State** is amended to read:

State means any state or territory of the United States of America, and the District of Columbia.

PART ONE - WORKERS' COMPENSATION INSURANCE

E. **Other Insurance** is amended by adding this sentence:

This section only applies if you have other insurance or are self-insured for the same loss.

F. **Payments You Must Make**

This section is amended by deleting the words "workers' compensation" from number 4.

H. **Statutory Provisions**

This section is amended by deleting the words "after an injury occurs" from number 2.

PART TWO - EMPLOYERS LIABILITY INSURANCE

C. **Exclusions**

Sections 2 and 3 are amended to add:

This exclusion does not apply unless the violation of law caused or contributed to the bodily injury.

Section 6 is amended to read:

6. Bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America, Mexico or Canada who is temporarily outside these countries.

D. **We Will Defend**

This section is amended by deleting the last sentence.

PART FOUR - YOUR DUTIES IF INJURY OCCURS

Number 6 of this part is amended to read:

6. Texas law allows you to make weekly payments to an injured employee in certain instances. Unless authorized by law, do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE - PREMIUM

- A. **Our Manuals** are amended by adding the sentence:

In this part, "our manuals" means manuals approved or prescribed by the Texas Department of Insurance.

C. **Remuneration**

Number 2 is amended to read:

2. All other persons engaged in work that would make us liable under Part One (Workers' Compensation Insurance) of this policy. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured workers' compensation insurance.

E. **Final Premium**

Number 2 is amended to read:

2. If you cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.

PART SIX - CONDITIONS

- A. **Inspection** is amended by adding this sentence:

Your failure to comply with the safety recommendations made as a result of an inspection may cause the policy to be canceled by us.

C. **Transfer of Your Rights and Duties** is amended to read:

Your rights and duties under this policy may not be transferred without our written consent. If you die, coverage will be provided for your surviving spouse or your legal representative. This applies only with respect to their acting in the capacity as an employer and only for the workplaces listed in Items 1 and 4 on the Information Page.

D. **Cancellation** is amended to read:

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We may also decline to renew it. We must give you written notice of cancellation or nonrenewal. That notice will be sent certified mail or delivered to you in person. A copy of the written notice will be sent to the Texas Department of Insurance – Division of Workers' Compensation.
3. Notice of cancellation or nonrenewal must be sent to you not later than the 30th day before the date on which the cancellation or nonrenewal becomes effective, except that we may send the notice not later than the 10th day before the date on which the cancellation or nonrenewal becomes effective if we cancel or do not renew because of:
 - a. Fraud in obtaining coverage;
 - b. Misrepresentation of the amount of payroll for purposes of premium calculation;
 - c. Failure to pay a premium when payment was due;
 - d. An increase in the hazard for which you seek coverage that results from an action or omission and that would produce an increase in the rate, including an increase because of failure to comply with reasonable recommendations for loss control or to comply within a reasonable period with recommendations designed to reduce a hazard that is under your control;
 - e. A determination by the Commissioner of Insurance that the continuation of the policy would place us in violation of the law, or would be hazardous to the interests of subscribers, creditors, or the general public.

4. If another insurance company notifies the Texas Department of Insurance - Division of Workers' Compensation that it is insuring you as an employer, such notice shall be a cancellation of this policy effective when the other policy starts.

Add the following to the policy:

PART SEVEN - OUR DUTY TO YOU FOR CLAIM NOTIFICATION

A. Claims Notification

We are required to notify you of any claim that is filed against your policy. Thereafter we must notify you of any proposal to settle a claim or, on receipt of a written request from you, of an administrative or judicial proceeding relating to the resolution of a claim, including a benefit review conference conducted by the Texas Department of Insurance - Division of Workers' Compensation. You may, in writing, elect to waive this notification requirement.

We must, on the written request from you, provide you with a list of claims charged against your policy, payments made and reserves established on each claim, and a statement explaining the effect of claims on your premium rates. We must furnish the requested information to you in writing no later than the 30th day after the date we receive your request. The information is considered to be provided on the date the information is received by the United States Postal Service or is personally delivered.

COMPLAINT NOTICE:

THE DISPUTE RESOLUTION PROCESS

THIS DISPUTE RESOLUTION PROCESS DOES NOT APPLY TO WORKERS COMPENSATION CLAIMS.

Proceed as follows if you have a dispute about your policy related to:

- Rates,
- The application or interpretation of rules contained in the various National Council on Compensation Insurance, Inc. (NCCI) manuals (including, but not limited to, classification codes and experience rating),
- Rating programs,
- Endorsements, or
- Forms.

First, contact the carrier that issued the policy and attempt to resolve the dispute directly. If the dispute is not directly resolved with the carrier, then contact NCCI, to ask for assistance through the dispute resolution process described in NCCI's **Basic Manual**. You may obtain dispute resolution services only after you have made a reasonable attempt to first resolve the dispute directly with the carrier and have paid undisputed premium that may be due to the carrier.

Send your request for assistance by mail to NCCI—Dispute Resolution Services, 901 Peninsula Corporate Circle, Boca Raton, FL 33487-1362; or by fax to 561-893-5043; or by email to regulatoryassurance@ncci.com.

NCCI will first work with you and the carrier to try to resolve the dispute. If you are unable to resolve the dispute to your satisfaction with NCCI's help, then you may ask NCCI to refer the dispute to the Texas Appeals Board (Board). NCCI is the Administrator to the Texas Appeals Board, and a staff member from TDI, appointed by the Commissioner, serves as the chair of the Board.



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Within 30 calendar days of the date that the Appeals Board issues a decision, the policyholder may appeal the decision to the Texas Department of Insurance. To appeal a decision of the Appeals Board, contact the Texas Department of Insurance, Office of the Chief Clerk, Mail Code 113-2A, P.O. Box 149104, Austin, TX 78714-9104; or by fax to 512-490-1064; or by email to chiefclerk@tdi.texas.gov.

THIS NOTICE OF THE DISPUTE RESOLUTION PROCESS IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART, TERM, OR CONDITION OF THIS POLICY.

CLAIM COMPLAINT:

If there is a workers compensation claim complaint involving one of your employees, then contact the Texas Department of Insurance—Division of Workers' Compensation, System Monitoring and Oversight, 7551 Metro Center Drive, Suite 100, MS-8, Austin, TX 78742; or by fax to 512-490-1030; or by e-mail to DWC-ComplaintResolution@tdi.texas.gov.

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Authorized representative

NCCI Carrier Code: 29939

4/3/23



WORKERS' COMPENSATION AND
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WORKERS' COMPENSATION AND
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TEXAS PARTNERS, OFFICERS AND OTHERS EXCLUSION ENDORSEMENT

The policy does not cover bodily injury to any person described in the Schedule.

The premium basis for the policy does not include the remuneration of such persons.

You will reimburse us for any payment we must make because of bodily injury to such persons.

Schedule

Name, title

HEIDI FRISTOE, LTD PARTNER SPOUSE

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WORKERS' COMPENSATION AND
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TEXAS - AUDIT PREMIUM AND RETROSPECTIVE PREMIUM

Section D of Part Five of the policy is replaced by the following provision:

PART FIVE - PREMIUM

D. Premium Payments

You will pay all premium when due. You will pay the premium even if part or all of a workers' compensation law is not valid. The billing statement or invoice for audit additional premiums and/or retrospective additional premiums establishes the date that the premium is due.

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TEXAS HEALTH CARE NETWORK ENDORSEMENT

This endorsement indicates that you have elected under this policy to provide workers' compensation health care services to your injured employees through a certified workers' compensation health care network that we have either established or contracted with, as provided in Chapter 1305 of the Texas Insurance Code and in Title 28, Chapter 10 of the Texas Administrative Code.

We will provide you with information concerning the use of our certified workers' compensation health care network(s) in our service area(s) and your rights and responsibilities as a participant in our network program. This includes information describing the service area(s) applicable to you and your injured employees as required in NCCI's *Basic Manual for Workers' Compensation and Employers' Liability Insurance*. In accordance with Chapter 1305 Texas Insurance Code and Title 28, Chapter 10 of the Texas Administrative Code, we will also provide you with information that is required to be given to your employees, including an employee's notice of network requirements and an employee acknowledgement form.

Your premium may have been reduced because you have agreed to participate in our certified workers' compensation health care network. The amount of the premium reduction is shown on the Information Page of this policy. The reduction is estimated at the policy inception and adjusted at final audit of the policy. The reduction may be pro-rated if you elect to participate in a certified workers' compensation health care network during the policy year or if you terminate your participation in our certified workers' compensation health care network before the policy expires. The premium reduction you received may be forfeited if we determine that you have failed to provide the notice of network requirements and employee acknowledgement form to your employees in accordance with Chapter 1305.005(d) and 1305.451 Texas Insurance Code and Title 28, Chapter 10 of the Texas Administrative Code.

Minimum premium policies are not eligible for this premium reduction.

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